Comprehensive Integrated Approach to HIV Prevention and Care in Nigeria (CIHPAC)

End of project evaluation report
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This report has been received with thanks from the external evaluation team. This report has been reviewed by SFH and comments made to enable the external CIHPAC evaluators make appropriate corrections and presentation.

This report will be presented to USAID through SFH.

Ifeanyi Okekearu (CIHPAC project manager and Head HIV division, Society of Family Health, November 2011)
AB  Abstinence and Be Faithful
AOTR  Agreement Officer Technical Representative
BCK  Basic Care Kit
BCC  Behavior Change Communication
BM  Behavior Maintenance
CIHPAC  Comprehensive Integrated Approach to HIV & AIDS Prevention and Care
HCT  HIV Counseling and Testing
IPC  Interpersonal Communications
LDD  Long Distance Drivers
LFF  Living Faith Foundation
FBO  Faith Based Organization
MPP  Minimum Prevention Package
NASFAT  Nasrul- Lahi-L-Fatih Society of Nigeria
NASHIN  NASFAT HIV & Aids Initiative
NYSC  National Youth Service Corp
NACA  National Agency for the Control of AIDS
PADEF  Partnership Assessment and Development Framework
PLP  People Living Positively
PE  Peer Educator
PEP  Peer Education Plus
PET  Peer Educator Trainers
PLACE  Priorities for Local AIDS Control Effort
PSRHH  Promoting Sexual and Reproductive Health for HIV & AIDS reduction
SFH  Society for Family Health
STI  Sexually Transmitted Infections
SACA  State Agency for the Control of AIDS/State Action Committee on AIDS
VOS  Venue Outreach Staff
DOTS  Directly Observable Treatment – Short Course
FSW  Female Sex Workers
FACA  FCT Agency for the Control of AIDS/FCT Action Committee on AIDS
LACA  Local Agency for the Control of AIDS/Local Action Committee on AIDS
LDD  Long Distance Drivers
PEP  Peer Education Plus
OSY  Out of School Youth
FOSY  Female Out of School Youth
MOSY  Male Out of School Youth
PITT  Prevention Intervention Tracking Tool
PLP  People Living Positively
PLHIV  People Living with HIV
PSI  Population Services International
TW  Transport Workers
USM  Uniformed Service Men
USAID  United States Agency for International Development
VFH  Voice for Humanity
WIN  Women In Special Need.
WWI  Working With Influencers
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BACKGROUND

The Society for Family Health (SFH) commissioned an independent end of project evaluation of its Comprehensive Integrated Approach to HIV Prevention and Care in Nigeria (CIHPAC) funded by USAID. The evaluation of the project was carried out by a team of independent consultants, with SFH providing logistic support, while USAID acted as observers. The goal of the evaluation was to document the outcome trends of the project. Specifically the aim of the evaluation was to: determine the relevance, appropriateness, effectiveness and sustainability of the strategies implemented under CIHPAC, document lessons learnt and articulate a set of recommendations for improving future administration, coordination, and implementation of projects of similar scale.

CIHPAC is a five year Comprehensive Integrated Approach to HIV Prevention and Care in Nigeria funded by USAID through a cooperative agreement with SFH in partnership with Population Services International (PSI) and over 56 indigenous Civil Society Organizations (CSOs) in 22 selected project States in Nigeria. It commenced as an initial grant of $9.8million and $1 million for the Voice for Humanity Project but SFH was awarded an additional grant of $23,655,143, to scale up implementation over an additional 2 year period (April 2008 to December 2009) and a further one year no cost extension to implement the project till December 2010.

The Project aimed at creating, strengthening and supporting the adoption of healthy reproductive and HIV prevention behaviors among the poor and Most At-Risk Populations (MARPs) in selected states and thereby contribute to reinforcing the national response to HIV & AIDS prevention in Nigeria. Its mandate was to adopt a multipronged and integrated approach that includes increasing the community knowledge of HIV risks; promoting behavior change; reducing stigma; enhancing access to HIV-prevention products and services (including HCT and STI treatment); as well as enhancing the capacity of local civil society organizations and service providers to effectively implement interventions to address the epidemic.

METHODOLOGY

Assessment activities began with a review of documents related to the program. The information gained was then used to formulate questions for informants as well as guide interpretation of quantitative data. Existing data in the project MIS provided the basis for quantitative analyses of program achievements. Estimations of program impact and contribution to national/state HIV & AIDS goals in the respective states were based on program data and information distilled from in-depth interviews with the SACAs of the states visited. Qualitative information was generated primarily through interviews at implementation sites. Quantitative data was probed or verified during interviews with knowledgeable informants on the field. To help ensure that comparable types of information were collected from a variety of sources, the team used standard question guides for interviewing key informants.

FINDINGS

BCC interventions reached, in most cases more than the number of people earlier planned with prevention messages. Peer outreach and education, both in the general community and at the drop-in centers in tertiary institutions (through one-on-one counseling as well as within small- and large-group activities between 2006 and 2009) reached 734,923 young boys and girls, an increment of 131% above the planned target. The achievement of over 100% target is associated with many reasons; including intense mobilization, influence of gatekeepers, program approaches and skills of the implementing partners. Peer sessions enabled young people to access information about HIV risks, clarified misconceptions about HIV transmission and filled information gaps on effective prevention strategies resulting in self reported changes in knowledge and awareness levels of young people. Many young people affirmed that the knowledge gained from peer education sessions had helped them to re-appraise personal risks and empowered them to take effective steps to avoid high risk behaviors that increased their vulnerability to HIV & AIDS. Immense mileage was given to the effectiveness of the project by the use of innovative communication techniques like IPCs especially using picture codes, VFH, special events and the distribution of high impact promotional materials like wrist bands,
key holders, t-shirts and fez caps. The picture codes on STIs worked really well as a good entry point for discussing sex and HIV & AIDS in situations where there was resistance to HIV & AIDS education. Also, self-reported positive changes in sexual behaviors such as delay in sexual debut, reduction in the frequency of sexual intercourse and sexual partners as well as reduction in the occurrence of teenage pregnancies was high. Whilst the various training manuals contained STI information, demonstrated understanding of the connection between HIV and STIs was quite weak.

The Condom and Other Prevention (COP) Component

Many members of key target population namely; Transport workers, Out of School youths, Uniformed Service men and women and FSWs were part of the COP intervention. However, FSWs benefitted most from correct condom use demonstrations which addressed concerns and myths about the efficacy of condoms. The number of persons reached with condom and other prevention activities varied widely between 2006 and 2009, but achieved 94% of planned reach. Oral testimonies from peer educators and peers attest to unprecedented uptake and demand for condoms resulting from increased awareness on the efficacy of condoms through correct and consistent use education and demonstrations. Condom use and demand increased significantly during the CIHPAC intervention. FSWs attested to many instances where they had refused sex with clients who offered much higher than usual payments for sex without condoms. Many brothel owners interviewed confirmed that they actively enforced the no condom, no sex policy in their brothels. Awareness of STIs increased and self reported cases of increased health seeking- and condom use behaviors amongst targeted populations, to reduce vulnerability to STIs was high. CIHPAC engagement with community structures and institutions was exemplary, especially the engagement with community influencers (influential people and parents) who provided strategic support- advocacy to community gatekeepers, monitoring activities of peer groups, establishing linkages between peer groups and local government authorities and mobilizing community support for peer education activities.

Behavior Maintenance

Over 200 CBOs were formed from the CIHPAC project across the country. These CBOs have received seed grants and various institutional and human capacity development supports which enabled them to continue with behavior change activities at the community level to some extent. In some states, CBOs are networked and function as established coalitions. For instance, the ‘Make We Talk coalition’ in Benue state, which has increased opportunities for funding and support from government directly. Many CBOs and coalitions of CBO are now actively engaged in resource mobilization through proposal development and advocacy in many states visited. A handful have received grants through SACA from the World Bank HIV and AIDS Fund(HAF).

The capacities of more than 61 local organizations were built on HIV related policy development – with an achievement of over 169% between 2006 and 2009. In the same period 486 local organizations’ institutional capacities were built, compared to a plan of 364 (surpassed by 134). While the project planned to build or strengthen the institutional capacity of 836 persons, 1,251 persons (over 150% increment) were trained. Even though capacity for policy influencing was built, there was a slow pace in actions taken to engage in policy processes. Whilst the reason for this could not be strictly attributed to any one circumstance, there were indications that much of the time was spent in capacity building than taking a quick action in policy analysis and advocacy.

CIHPAC trained and engaged FBOs in the behavior change initiatives at state and community levels, which strengthened behavior change programming in the faith-based response to HIV and by implication strengthened the integration of FBOs in the state level prevention response. This is exemplified by CIHPAC’s work with women with special needs- widows, separated, divorced, ostracized women and single parents, an emerging high risk group previously under-served by HIV prevention and behavior change initiatives. The project as managed by the implementing team therefore responded to the changing face of the epidemic.
CIHPAC supported the development and roll out of the Minimum Prevention Package for HIV prevention, through its involvement in the National Prevention Technical Working Group (NPTWG) which has re-focused government priorities and helped to promote an enabling environment for community level HIV prevention initiatives. CIHPAC also supported state-level interactive forum on policy and advocacy targeted at the media, traditional and religious leaders, SACAs and other stakeholders create enabling environment for HIV prevention at the state level and also promote support for CIHPAC interventions at the community level.

Stigma and discrimination against People Living with HIV & AIDS
There were considerable achievements by CIHPAC in this area. The project's BCC activities contributed to improved both (accuracy of knowledge of HIV messaging) and reduction of prevalence of (what) among the general population. This has contributed to increased acceptance of PLWHAs and increased disclosure. This increased the number of PLWHAs who openly declared their status and participated in community outreach programs. Self reported changes in sexual (increased condom use) and non sexual (decreased alcohol use, increased number of PLWHAs on ARVs) amongst PLWHAs increased as a result of the communication interventions by CIHPAC. More than 5,571 persons were trained on stigma and discrimination compared to the plan of 3,880 between 2006 and 2009(143%)

Increased access to HCT services
CIHPAC created demand for HCT through its Peer education, IPC community outreach activities among the most at risk persons (MARPs) and the general population. CIHPAC supported HCT service provision by directly managing mobile HCT services at the community level. Activities yielded consistent and unprecedented increases in the number of persons reached over the span of the project. Sixteen mobile HCT services outlets were established between 2006 and 2009. As at 2010, a total of 425 persons were trained on HCT and over 150,000 persons counseled and tested received the result of their HIV status, compared to the planned 40,000 persons in the beginning of the project (this was surpassed by 297%).

The TB/HIV Component
CIHPAC supported awareness creation initiatives on TB prevention, TB treatment opportunities, referrals, TB/HIV co-infection and promoted access to TB-DOTS centres through IPC conductors at the community level and mass media and mid media campaigns at the national level. 13 TV slots per quarter on National Television was aired, including 4,098 spots aired in Hausa, Pidgin, Igbo and Yoruba in 32 radio stations across the country. At the community level, IPC conductors created awareness on TB-HIV through specific interpersonal communication guide produced by the project.

Orphans and Vulnerable children
CIHPAC through USAID designated implementing partners provided vulnerable children and their families basic care kit (BCK). The USAID funding schemes for work with OVCs has significant impact on the HIV impact mitigation and care continuum process as this project has helped in improving health and livelihood of OVC and families. BCKs enhanced malaria, and diarrhoeal disease prevention and treatment as well as improved basic sanitation and hygiene practices amongst PLWHAs and their families. The insecticide treated nets was effective especially for pregnant women. In many centres, it was a huge motivation for women to access PMTCT services and indirectly has reduced the number of children born with HIV. At the DOD hospital Enugu for instance, because of the BCKs, uptake of PMTCT increased and 100% success was recorded in the prevention of mother to child transmission of HIV amongst women accessing PMTCT in the facility within the period under assessment.

Strategic Information: Operations Research, Monitoring and Evaluation
CIHPAC’s contribution to overall use of data to guide implementation in Nigeria is impressive given the efforts at NARHS plus 2008 and support to other studies. Several supportive researches were funded by
CIHPAC. NARHS plus, The IBBSS, and others like Niger bus and the BSS which influenced interventions like the Prisons, PEER, Corridor, PLACE, VFH projects women with special needs, physically challenged.

CIHPAC was generally a success as most targets in the contractual agreement with USAID were exceeded, often doubled. Analysis of intermediate or proxy variables for impact suggest that the project has contributed substantially to national HIV & AIDS goals and making a major difference for both priority at-risk groups and the population as a whole.

RECOMMENDATIONS

Coordination and Collaboration
Linkages between SFH and other NGOs involved in delivering HIV services should be strengthened as key to extending the scope of interventions implemented in order to better achieve the minimum package rather than striving to implement as one organization. This will result in a functional package of services where all elements are available and linkages between organizations ensures that beneficiaries of one organization can also access services of another.

Service nesting
- CBO offices can function as outlets/refill points where products and services can be assessed by young people. For example HCT, Condoms etc.

Program implementation
- Directly programming for in-school- youths, through education and HIV focused CSOs may be more effective than using the NYSC PET project because of the inherent bureaucracies therein.
- There is a major need to build in literacy and numeracy skill development for Out of School Persons in communities and inmates in prison.
- Investment needs to be channelled into the psychosocial development of young people by building community social facilities, table tennis boards, football posts, nets and ball, basket ball pitches. This can be managed by CBOs and may be a potent income generating source.
- SFH needs to increase the complement of staff to include M&E officers and finance assistant in the regional offices.
- Systems for documentation and knowledge management need to be decimated to the regional offices.
- The program should scale up the current BCC content to include information on concurrent sexual practices and cross generational sex both within the general population and for socially excluded groups, with campaign materials addressed specifically to individual vulnerable populations.
- In communications to support HIV & AIDS services, more content needs to be carved for PMTCT among the general population and vulnerable groups.
- Program elements that directly support the delivery of services and products to clients should be given priority for funding- condom distribution, HCT and STI screening.
- Viable private alternatives for product distribution (partnerships with MTN, coca cola etc) may expand coverage and enhance cost effectiveness.
• Programmatic and referral linkages between prevention and BCC programs and livelihood programs, (IGA) can enhance the impact of prevention programs.

• Although the project disseminates its work by participating in national working and technical groups, it needs to explore opportunities to share with other stakeholders that are active in HIV & AIDS prevention. Use of operations research and developing innovative use of its MIS documentation and knowledge management, could better share its impressive lessons and best practices to benefit a wider audience.

• SFH should improve on capacity building for program staff and partner organizations. Likewise, USAID should do same for SFH.
1.1 Background

The multisectoral response to HIV & AIDS in Nigeria is coordinated through a three tier committee approach- NACA, SACA and LACA. Whereas NACA coordinates the entire national response; SACA and LACA coordinate the state and local government levels. Recent context of HIV & AIDS programming in Nigeria indicate a relatively stable HIV prevalence with a national rate of 4.6% ANC Sentinel survey 2008. However, the incidence is worst in some parts than others, and wide variations between urban and rural areas. The situation suggests sub-epidemics occurring within the epidemic, and no State is unaffected. The infection is across all age groups, but many new infections occurred among young people 15-24years – a group that BCC strategies had not sufficiently addressed. No adequate focus on the most at-risk groups including young people who were already sexually active, sex workers, and mobile population. Access and uptake of HCT was a major challenge.

Civil society organizations including the faith based and networks of positive persons play a crucial role in the national level response, but capacity for innovative and integrated programs to reach the excluded and ‘the hard to reach” groups is low. The epidemic is largely being fueled by low risk perceptions of HIV and high risk behaviors like multiple partnering, low condom use as a result of inadequate knowledge of HIV transmission, prevention and low health seeking behaviors amongst most at risk groups. Stigma and discrimination is high and upward trend in the numbers of children infected with the virus, through mother-to-child-transmission, or who had lost one or both parents to the disease.

At the community level, various factors such as increased poverty, low risk perceptions on HIV, which manifest in increased rates of multiple sexual partnering and high informal transactional sex, contribute to HIV spreads. Gender inequalities, high rates of drug and alcohol, high misconceptions about condom efficacy and HIV transmission, high stigma and decreasing age at first sexual debut viciously exacerbate the epidemic.

In 2007, in a move to strengthen the national prevention response in Nigeria, a national prevention strategy was launched which emphasized a new global strategy. The strategy emphasized minimum package approach, aimed at implementing a package of effective HIV prevention interventions in a coordinated fashion to reach high risk populations. However, the strategy was not widely disseminated, as it is poorly coordinated across the country.

1.2 Comprehensive Integrated Approach to HIV & AIDS Prevention and Care (CIHPAC)

The Comprehensive Integrated Approach to HIV & AIDS Prevention and Care (CIHPAC) program was funded by the United States Agency for International Development (USAID) to support Government of Nigeria in reducing incidence of new HIV infections and mitigate the impact of the pandemic. The Society for Family Health (SFH) implemented the CIHPAC program in partnership with Population Services International (PSI), and through over 56 local partner organizations, as well as USAID implementing partners in focal states. The program intervention was funded for five years from 2005 to 2009, and a no cost extension to end of 2010. The program has presence in 22 States and all the regions of Nigeria.

The CIHPAC Project implementation commenced with initial grant of $9.8 million and $1 million was later added for the Voice for Humanity Project. In 2008, the program grant was increased by $23,655,143 to scale up implementation thereby bringing to project funding the sum of $34,318,945. However, due to prevailing circumstances; USAID de-scoped the funding in July 2010 to $27,557,474, and this sum became the final worth of the project.
The goal of the program was to create, strengthen and support the adoption of healthy reproductive and HIV prevention behavior among poor people and Most At-Risk Populations (MARPs) in selected States to reinforce the national response to HIV & AIDS prevention in Nigeria.

The program employed a multi pronged and integrated approach, which involves increasing community knowledge of HIV risks, promoting behavior change, reducing stigma, enhancing access to HIV-prevention products and services (including HCT and STI treatment), as well as enhancing capacity of civil society organizations and service providers to address the epidemic. The specific objectives are to:

- increase behaviors conducive to the prevention of HIV/STI transmission among MARPs;
- create an enabling environment for behavior change and program sustainability in collaboration with other partners;
- reduce stigma and discrimination against People Living with HIV & AIDS; and
- increase access to HCT services

**Intervention Strategy and Activities**

The CIHPAC program target work with various stakeholders, included Federal and State Ministries, Departments and Agencies, Donors, Faith Based Groups, Civil Society Organizations, Community Leaders and Influencers, Community Based Organizations, National Union of Road Transport Workers, Parents Teachers Associations, Brothel Owners, Traditional leaders, Armed Forces, amongst others. This created enabling environment for the program activities and to achieve the objectives.

The program took advantage of established model and resources, especially developed through a seven year (2002-2008) DFID supported program – Promoting Sexual and Reproductive Health for HIV & AIDS reduction (PSRHH): Peer Education Plus (PEP). The model utilized Social Marketing and Behavior Change Frameworks, which suggest that behavior change can be encouraged by raising greater awareness of risks and benefits associated with certain behaviors, in conjunction with increasing access to the necessary tools to support the desired behavior change. This model enable effective identification of specific subsets of the population considered to be at most risk, classification of the specific risk determinants to be addressed through behavior change interventions and appropriate strategies for addressing them. Two main strategies that stand out:

1. **Targeting and Segmentation Strategy.** In this case, the program prioritized communities with no previous HIV prevention interventions and by combining epidemiological and other factors, communities with at least three MARPs group within defined proximity setting were selected. The groups identified and reached by the program are:
   a. In-School Youths,
   b. Out of School Youths,
   c. Sex Workers,
   d. Transport Workers,
   e. Uniformed Services
   f. Prison Inmate
   g. Women with Special Needs

2. **Communications Strategy.** This focused on the implementation of the 12 month PEP model to deliver a variety of activities targeted at each identified group.

**Partnership**
The CIHPAC project implemented interventions in over 200 sites located across more than 22 States in Nigeria and engaged cumulatively over 56 local NGO partners in a yearly round of one-off grants; in which a set of partners implemented activities over a one year period. At least 200 Community Based Organizations (CBO) were nurtured, mentored and technically supported to implement sustainability behavior maintenance interventions in all locations sequel to successful behavior change interventions.

The partnership selection was simplistic and was administered through signed MOUs. Whereas the network of civil society organizations in each state (CiSHAN) played a corroborative role in this process, SFH used Partnership Assessment and Development Framework (PADEF) to screen and select from all the organizations shortlisted by CiSHAN for the program. An abridged version of PADEF, which takes 2-3 days, was conducted with the selected organizations (full PADEF is conducted within 5-7 days). At the project inception, substantial effort was made to develop the capacity of selected local implementing partners to roll out CIHPAC in the target States. Over 106 dedicated staff of partner organizations on the program implementation, and about 600 of CBO representatives in over 200 communities was trained in behavior change and maintenance.

Intervention site and community facilitators’ selection was led by the implementing CSOs in its entirety with remote support from SFH. In the course of the program, over 2000 community facilitators were trained and deployed (amongst the key target populations) on the program.

**Program Areas**
The program involved several aspects of HIV & AIDS programming with specific strategies as follows:

- Abstinence and Be Faithful
- Condom and Other Prevention
- Tuberculosis (TB)/HIV
- Orphan and Vulnerable Children (OVC) / Basic Care Kits (BCKs)/Positive Living People (PLP)
- HIV Counseling and Testing (HCT)
- Systems Strengthening
- Strategic information

**Communications Strategy**
A combination of communication channels such as Interpersonal Communication, Peer Education and community awareness was employed with messages tailored to target groups. For instance, in the prisons and in school youths, Abstinence was promoted as the key message, whereas amongst out of school youths and female sex workers, consistent condom use was promoted these were complemented with national mass media campaigns and free distribution of health products such as condoms and lubricants. The target community groups with the program interventions strategies are:

- In School Youth (through NYSC/University) – Abstinence.
- FBOs, General Population/Youth – Abstinence and Be Faithful.
- Out of School Youth – Abstinence, Be faithful (Consistent Condom Use)
- Sex Workers – Consistent Condom Use and STI Treatment.
- Transport Workers – Be faithful and Consistent Condom Use.
- Uniformed Service – Be Faithful and Consistent Condom Use.
- Prison Inmates - Abstinence
- Women with Special Needs – Abstinence or Consistent Condom Use
Service Delivery Strategy
CIHPAC provided mobile HCT services and also linked up with designated service providers in the targeted states for referral purposes to address treatment of STIs and other health services. For instance DOD hospital in Enugu and this increased the health seeking behavior of targeted populations and demand for services at the designated centers. The program provided over 200,000 Basic care kits (over the life span of the project) comprising of a 20 liters lidded bucket with spigot, long lasting insecticide treated nets, Water Guard and oral Rehydration salts for orphans and vulnerable children, their families and those infected with HIV, who are within the project beneficiary’s location of the USAID IPs who implemented OVC programs at community and facility levels.

Community Level Activities
The program was implemented at national and community levels. The community level intervention was the frontline of the program. The Peer Education Plus (PEP) model was the fulcrum of the interventions at the community level as well as condom distribution. The PEP model as conceptualized (though can be modified) is a 12 month intervention process, in three phases:

1. One to Two months community entry phase (mapping, advocacy visits, open community meeting, selection of peer facilitators and baseline study).
2. Six to Eight months Intensive phase (peer education sessions, drama, IPC, community outreaches, IEC materials distribution and special events etc. supported by intensive condom distribution, mobile HCT and referral for STI and TB treatment).
3. One -Two month exit phase (formation of CBOs obligated to continue the provision of interventions at the community level, final P M&E).

Whereas this was generally the case in most of the interventions targeted at MOSYs, FOSYs, TWs, ISY and USMs, a 3-6-3 adaptation was implemented with the FSWs due to their highly mobile nature. The peer education model is a facilitation process, using participatory and interactive learning on HIV & AIDS and other STIs prevention, and life skill education for targeted groups of youth Peer groups meet at least twice a month to discuss module after module of a pre-designed curriculum. The discussion lasts not more than two hours depending on how much time participants have to be at the meeting. At the end of the intensive phase, peer groups are nurtured to form CBOs to continue to maintain behavior change activities. In addition, some CBOs that emerged from the PSRHH project were integrated in the behavior maintenance activities.

National Level Activities
The national level of intervention was designed to provide overarching support to the community level interventions and to create an enabling environment at the national level for the support of community focused BCC interventions. The following were carried out:

- **Mass TV and Radio media.** SFH produced and aired 26 episodes of radio drama in 4 languages in 40 radio stations across the country in 2009. SFH developed the PEP media tool using various media materials produced by BBC-WST for SFH such as audio, video and photo-story snap shots.
- **TB-HIV interpersonal communication guide.** The guides were used by community IPC conductors for outreaches and referrals to DOTS centers in all the target states.
- **TB-HIV campaigns in 4 languages across the country.** SFH aired 4098 spots in Hausa, Pidgin, Igbo and Yoruba in 32 radio stations across the country. The key messages were TB prevention, TB treatment opportunities through referrals and access to TB-DOTS centres (promoting access to TB-DOTS centres) and the relationship between TB and HIV noting the effect of TB to PLWHAs.
- SFH also continued its Gold Circle Condom Campaign

The Minimum Prevention Package (MPP)
At the inception of CIHPAC, the minimum prevention package strategy was evolving in Nigeria. This was launched in 2007, but not integrated into the CIHPAC until 2009. CIHPAC originally was implemented as integrated program of behavior change and social-marketing for HIV prevention, Strategic information was provided through peer education and outreach for FSW, MOSY, FOSY, USM, ISY and prison inmates, as well as drop-in centers in tertiary institutions. This was to increase awareness of HIV and reduce stigma among the general population. Special events were organized to ensure wider outreach of behavior change, as Mobile HCT services were provided. CIHPAC strategy aligned to the MPP requirement of program reaching target populations with at least 3 interventions-considering strategic areas of Self as captured in Peer Education; the individual's community as in community awareness events, Issues of Vulnerability and addressing special needs as captured by special events and other components of the MPP. The Prevention Intervention Tracking Tool was used within the MPP to document processes and results. However given the time of introduction of the MPP, some of the CIHPAC’s implementing partners had challenges with its adaption and application. CIHPAC partners found it challenging to disaggregate and adequately enter the earlier data collected before the introduction of the MPP. Also, the strategy for data collection and management was rapidly evolving, thus the Prevention Intervention Tracking Tool (PITT) was adjusted to address some of these challenges encountered by the local implementing agencies and the community peer educators to catch up with.

As at the time of this evaluation, the MPP strategy is still struggling to gain momentum in the country’s HIV & AIDS response. Many states have not domesticated its implementation into their strategic frameworks

1.3 Objectives of the Evaluation

The general objective of the evaluation was to demonstrate the outcome and impact of the CIHPAC program intervention and document key lessons to improve future programming. In line with the focus of the program, the evaluation was to examine the changes in knowledge, attitudes and practices of targeted community groups. It was important to show the extent to which the program met it objectives: to increase behaviors conducive to the prevention of HIV/STI transmission; an enabling environment for behavior change and program sustainability in collaboration with other partners; reduction in stigma and discrimination against people living with HIV & AIDS; and increase in access to HCT services. The specific objectives are to:

- Determine the relevance, appropriateness, effectiveness and sustainability of the strategies implemented under CIHPAC;
- Document lessons learnt through the program intervention; and
- Identify ways to leverage the administration, coordination, and implementation of future projects of similar scale.
2.1 General Approach

The approach to the evaluation was to gain insights into the nuances of the CIHPAC program across the regions it was implemented. The evaluation activities began with a review of documents related to the program. The information gained was then used to formulate questions for informants as well as guide interpretation of quantitative data. Quantitative data were generated through existing program information system, which hitherto regularly tracks the program performance. Estimations of the program impact and contribution to National/State HIV & AIDS goals were based on the program data and information distilled from in-depth interviews with the SACAs. Data were however verified during interviews with knowledgeable informants during field visits.

Qualitative information was generated primarily through interviews and focus groups with target community groups, program partner organizations and focal SFH staff. To help ensure that comparable types of information were collected from a variety of sources, the team used standard question guides for interviews and focus groups (see annex). The recommendations by the evaluation are based on impressions from interaction with program staff, collaborators and beneficiaries in all the places visited.

2.2 Major Information Sources

The information for the evaluation came from designated sources as designed at inception. The evaluation team divided tasks amongst members to cover more sources of the information within the period of the evaluation. Interviews and focus groups were conducted by sub-teams to diversify and enrich information gathering. The sources of information for the evaluation are:

i. **Documents** – Key documents and reports related to the CIHPAC project including the Performance Monitoring Plan and Mid Term Review documents made available to the team before the commencement of the assignment were reviewed to distill Information on the status of the project before the commencement of field visits.

ii. **Monitoring System** – The numerous data sets available to the team included data from the field project implementation domiciled in the SFH field offices; implementing partners and target groups as the project MIS was not regionalized and could only be accessed at the national office.

iii. **Field visits** – The assessment team conducted field visits to 12 of the 22 States of Nigeria covered by CIHPAC. Field visits covered 10 of the 16 regions that SFH has delineated for its programming across Nigeria. The Sampling of respondents was entirely purposive and meetings were prearranged by SFH field teams.

iv. **Interviews and focus groups** – In-depth and key informant interview and focus groups with key respondent groups were major source of information for the evaluation. The respondent were project staff and support teams in each state, SACAs; local implementing partners; service providers, beneficiaries, SFH CIHPAC project management team at the Headquarters, as well as relevant government agencies at the national level.

v. **Questionnaire** – Pre-designed questionnaires were distributed amongst SFH staff and implementing partners to capture data on key output on measures of achievements.

2.3 Limitation

Given the number of States selected for visits and for the short period for field data collection, it was not possible for the evaluation team to visit all the sites pre-selected for data collection. The results to be presented therefore based on only the places visited and over generalization may be imperative.
Since the evaluation did not include all the States where interventions took place, the evaluation did not use any means of verifying the aggregate performance information provided by SFH head office from the States not included in the evaluation. Only the target population and program teams in the States visited were met with, and it was not possible within the time of the evaluation to verify the figures provided by SFH as targets met.
3. Analysis of Achievements by Objectives and Key Interventions
The findings of the evaluation are presented below under each of the specific program objective and other key intervention areas that did not fit under the specific objectives (see 1.2 under Introduction). The analysis focused on key outcome elements and information to demonstrate the changes in knowledge, attitudes and practice. The successful program activities and outputs that contributed to the outcomes were highlighted to show how the program brought about the changes that are recorded.

Increased behaviors conducive to the prevention of HIV/STI transmission among MARPs (project objective #1)

Behavior Change (BC)
The BC strategy was based on a balanced mix of program components with ‘abstinence, being faithful, condom and other prevention as major themes. Generally, the BC strategy significantly increased self reported changes in sexual behaviors through high impact communications activities such as peer education, interpersonal communication (IPC), community awareness and special events like road shows, sports and games. These activities not only provided access to factual information for young people about HIV risks, transmission, prevention and condom efficacy-consistent and correct use but also provided access to condoms and HCT. Two complementary and mutually reinforcing interventions: Abstinence and be faithful, condom and other prevention are discussed under this objective.

The Abstinence and be faithful
This intervention targeted ISYs (Secondary schools), Faith Based Organizations, Prisons and Tertiary Institutions. Whereas delayed sexual debut was the key target message emphasized for young people in secondary schools, it was a message mix for the other targeted groups. In secondary schools the implementation was not direct. Anti AIDS clubs established through the NYSC PETS project, to provide access to information, knowledge and skills for HIV prevention amongst students was supported by CIHPAC. These clubs were reached through NYSC facilitators, who were trained on the PEP model and provided with IEC materials to facilitate the anti-AIDS clubs in selected secondary schools.

For young people in tertiary institutions, the program implemented interventions through drop-in youth centers which provided a message mix to promote condom use, partner reduction, STI recognition and HCT. Activities were mostly IPCs; road shows where brand promotion materials like wrist bands and face caps in scripted with relevant prevention messages were distributed to promote desirable behaviors. At the prison, the program modified the PEP to six months to include and promote abstinence amongst the inmates.

Measures of success
Peer outreach and education both in the general community and at the drop-in centers in tertiary institutions through one-on-one counseling as well as within small- and large-group activities between 2006 and 2009 reached 734,923 young boys and girls, compared to the program target of 559,456. It trained 66,405 peer educators and IPC conductors compared to the program plan of 50,102. This increment in peer educators and IPC conductors as well as the over 131% increase in target population reached over planned targets indicates successful program implementation. The significant of these figures were not measured in relation to the population size of the target communities, however, it indicate effectiveness of reach to target population as designed in the CIHPAC project.

Peer sessions enabled young people to access information about HIV risks, clarified misconceptions about HIV transmission and filled information gaps on effective prevention strategies. Self reported changes in knowledge and awareness levels of young people were very high. Many young people affirmed that the knowledge gained from peer education sessions had helped them to re-appraise personal risks and empowered
them to take appropriate steps to avoid high risk behaviors that can increase their vulnerability to HIV & AIDS.

Also, self-reported positive changes in sexual behaviors such as delay in sexual debut, reduction in the frequency of sexual intercourse and sexual partners as well as occurrence of teenage pregnancies were common changes across the communities visited. Community leaders, influencers and peers all described the situations unlike in the past it is now not very common to see young never married girls that is pregnant. Whereas it was common in the past to see young men hanging in isolated corners, beer parlors indulging in alcohol binges or in primary schools abusing psychoactive substances, which impair their judgment and ability to make decisions that protect them against HIV & AIDS, many young people now engaged in social or economically productive activities. Peers and peer educators also describe how peer sessions have built their self esteem and worth, creating enabling environment for their psychosocial re-modeling through sports and life skills education. Goal setting and improved self esteem has helped them to deal with pressures to engage in unprotected sex. Observed cases of young girls in Kano who has formed themselves into productive social club-producing and selling handmade crafts and items , such as local perfumes and jewelrys

Community support for peer education activities increased compared to the high level of resistance at the inception of the CIHPAC. Parents encouraged their wards to be at the peer education sessions, and there was increase in the participation of the youth. The approach of CIHPAC was effective in mobilizing community support for the HIV & AIDS prevention project.

At the prison the program had considerable influence on the inmates who turned out in large numbers to attend peer sessions. It was reported that the peer education sessions were usually attended by more inmates than the number provided for by the program. As a result, the peer educators struggled with managing the number of participants during each peer session and program events. For instance, at Ikoyi prison Lagos, record that whereas provision was made for 150 inmates, over 300 turned out during special events. This indicates that the program mobilized well at the prison and there was huge support and interests in the program.

The above evidence together with others reported below indicate that this program intervention was largely successful, though difficult to assess the absolute contribution of Abstinence and be faithful interventions to the perceived sexual behavior changes that occurred as a result of the program interventions. The changes reported are based on reflections by respondents on sexual behaviors, feelings of self worth, and perceptions of personal risk as a result of increased knowledge of HIV & AIDS. The increase in perception of the consequences of HIV infection has motivated the adoption and substitution of less risky behaviors for high risk ones by the young people.

The changes in behaviors were more or less a result of multiple interacting and mutually reinforcing factors. The effectiveness of any one intervention strategy cannot be rated above another and in isolation. It is difficult to alienate the impact of other corroborating factors such as increased confidence in the efficacy of condoms and increase in use and availability on these changes. Equally important is the immense use of innovative communication techniques like IPCs, VFH, special events and distribution of high impact

“I used to play around a lot with many girls in this community. People know me very well. But since I got into this program, I no longer jump around and have sex with girls. As guys we used to discuss it amongst ourselves with pride but I don’t do this anymore because I have learnt a lot about HIV, I know the consequences and I don’t think it is worth it, so, I want to wait till I am married. Besides, people know me that I am in this program and I have been very active in some of the programs like rallies and community teaching and they watch me every day and so I cannot just go about doing what I preach that people should not do- they will laugh at me”

Peer educator, Bauchi
promotional materials like wrist bands, key holders, t-shirts and face caps. These were observed to be the most effective strategies that promoted the acceptance and adoption of the desired sexual behavior change.

The picture codes on STIs worked really well, it was a good entry point for discussing sex and HIV & AIDS in situations where there was resistance to HIV & AIDS education. The various training manuals contained STI information, but demonstrated understanding of the connection of HIV was quite weak. This may need some strengthening. It was the view of many young people that the picture codes would make the best impact, if real life pictures were used.

There were instances where peer groups engaged in community sanitation drives, where peers themselves went round the community and cleaned targeted hazardous spots. In some cases, markets were cleaned monthly, access roads into the community or to important spots like the traditional or community leaders’ residence or palace, community square. This ignited a lot of attention on the peer education process, created enabling and supportive environment for its activities. Yet in other cases, special events like sanitation was used to co-opt service providers- peers targeted service providers, especially those whose services were needed but were resistant to buy-in to the program. As reported in one location, peer groups, selected a day, to visit the service provider and provide total clean up of the facility in a mass sanitation drive and that way co-opted these into providing free or highly subsidized services in the communities. These were observed to be effective strategies that promoted the acceptance of the program and adoption of the desired sexual behavior change amongst targeted groups.

The Condom and other prevention Component

The objective of this intervention was to promote behavior change and adoption of safer sexual practices through sustained use of HIV & AIDS related products and services. The social marketing and communication strategies supported the sales of Gold Circle condom at a highly subsidized and affordable rate of N20 for a packet containing four piece of condom. To motivate people to go for condom, free sample of Gold Circle was distributed during sensitization meetings and special events. Many of the FSWs interviewed seem to have benefitted most from correct condom use demonstrations which addressed concerns and myths about the efficacy of condoms. This helped in the movement of the FSWs to achieve the No Condom No Sex policy in some locations.

Measures of success

The number of persons reached with condom and other prevention activities varied widely between 2006 and 2009. At the end of 2009, only 496,649 persons were reached compared to 530,901 that planned by the program (94% performance). Although 2010 data were not available to the evaluators to compare the benchmark, oral testimonies from peer educators and their peers indicate increase in uptake and demand for condoms during the program. This is as a result of increased awareness of the efficacy of condoms through education and demonstrations on correct and consistent condom use. The shortfall was not unconnected to initial resistance to condom education at the inception of the program. By the time of writing this report, the quantity of condoms distributed during the program was not available, thus difficult to determine quantitatively the extent to which this objective element was achieved. However, focus groups with peer educators and CBOs revealed overwhelming demand for condoms at various program sites.

Evidences from interviews with various respondents also corroborate increase in condom use and demand by the target population. In many brothels visited during the evaluation, the “NO CONDOM NO SHOW [SEX]” policy is ardently implemented. Many participants recalled how they have refused sex with clients who
were not ready to use condom. In spite the huge offer made by such clients, the FSW would insist on having sex with condom. Many brothel owners interviewed confirmed their support and enforcement of the policy in the brothels. The efficacy of this policy has been proved elsewhere by SFH Research Unit, using “mystery clients” as strategy to monitor compliance with the “no condom, no sex” policy. The survey report indicated 100% compliance by the FSWs visited.

It was found that some FSWs have taken advantage of the increase in demand for condom by also collecting commercial quantities of condom from SFH detailers and selling such condom in their stock piles to clients in order to augment their income. Condom use and other prevention strategies seem to have worked well in many of the program sites, but this can be further validated through a survey research. Generally, the evaluation revealed an increase in awareness of STIs and health seeking behaviors amongst the target populations. Also important is that the project has helped many FSWs to improve their skills on correct and consistent use of condom.

“You know in this our business, we always experience condom breakage and before you know it, it is too late to do anything. Before if my customers agree to use the condom, I just lie down and let them wear the condom. I only feel with my hands to make sure it is there. But I have noticed that many of my customers do not know how to correctly wear condom, therefore it easily breaks. Through this project we have learnt not only how to correctly wear condoms but to insist on putting it on the customers ourselves. We even teach some customers how to wear the condom in this place.”

Peer educator-brothel based program, Makurdi

Create an enabling environment for behavior change and program sustainability (BM) in collaboration with other partners (project objective #2)

Behavior maintenance (BM)
In order to sustain behavior change initiatives at the community level the project employed multilevel engagements to create an enabling environment for the sustenance of initiatives. As a result, the project embarked on community systems strengthening and support to policy processes for HIV & AIDS prevention at State and national levels. At the community level, the BM strategy was aimed at supporting the emergence of community based organizations (CBOs) as an extension of the through peer education processes. This is to sustain the technical interventions in its simplest form – continue behavior change initiatives, by consolidating the community systems, community awareness and local partnership. This model is influenced by theory of technical support – which holds that capacity building and support for policy processes at the national and State levels would sustain government and civil society support for community HIV prevention and behavior change initiatives.

Even though the measuring the effectiveness of this strategy was not part of the original thinking of the project and beyond its scope, nevertheless, the main thrust of using community structures and systems to sustain HIV prevention through behavior change and enabling environment to support the process, generally worked well at the various project sites visited.

Measures of effectiveness
CIHPAC engagement with community structures and institutions was exemplary. The strategy focused on working with community influencers (influential people and parents) who provided strategic support to enable the implementation of program activities. The approach of working with influencers provided strategic supports to the peer education activities at the community level. The supports helped successful advocacy to community gatekeepers, monitoring of peer group activities, linkages between peer groups and local government authorities and mobilization of community support for peer education activities.
As one of the trust in PEP approach is the nurturing of CBOs for program sustainability, the CIHPAC project went out with a deliberate effort to ensure CBOs are formed in all communities where the project was implemented. Over 200 CBOs were formed through the CIHPAC project across the country. Some of the CBOs have received seed grants with various institutional and human capacity development supports to enable them sustain behavior change activities at the community level. In some States, the CBOs have networks and established coalitions for the course of HIV prevention in their communities. In Benue State one of the CBO coalitions, adopted the "make we talk" name. This group had evolved into an NGO and with great capacity that they participated in implementing the PLACE intervention with direct support from the CIHPAC project in the latter years of the CIHPAC project. The coalition is now being used to provide leadership and coordination of all the CBOs through the project.

CSOs and their CBOs have been trained in documentation and resource mobilization to expand their capacity for self-reliance and sustainable programming. The project planned to build capacities of 36 local organizations, but 61 local organizations were trained in HIV policy development. From 2006 to 2009 the project achieved more than the set target, achieving about 169% of target. The project contributed to institutional capacities building of 486 local organizations, compared to planned target of 364(achievement of 134%). Institutional capacity building was organized for 1,251 persons as against planned 836 persons (achieved by 150%). The project has empowered many CBOs and Coalitions of CBOs that now actively engage in resource mobilization through proposal development and advocacy across the States visited. In the same period, the capacities of 534 persons were built in HIV related policy development compared to the planned 640 (a short fall of 17%). These groups are actively engaging at local and state levels with policy influencing on HIV-especially work place policy and stigma reduction.

CIHPAC trained and engaged FBOs in the behavior change initiatives at State and community levels. This expanded behavior change programming into the faith based response to HIV and by implication strengthened the integration of FBOs in the State level prevention response. This was exemplified by CIHPAC’s work with women with special needs – widows, separated, divorced, ostracized and single parents women. This group was identified as emerging high risk group that was previously excluded in HIV prevention and behavior change initiative, and were reached with BCC by the project. The evaluation noted several reported cases of changes in sexual behavior, especially increased condom use among the target groups.

CIHPAC supported the development and roll out of the Minimum Prevention Package for HIV prevention. This was through involvement in the National Prevention Technical Working Group (NPTWG), which has re-focused government priority and strengthened enabling environment for community level HIV prevention initiatives. Some of the reported outputs from this group include the development and dissemination of national prevention plan, the MPP document, harmonized manuals and tools for peer education, amongst others.

SFH conducted State-level interactive forum on policy and advocacy with targeted media, traditional and religious leaders, SACAs and other stakeholders. These forums were conducted to further open up the enabling environment for HIV prevention at State and community levels. The traditional leader in one of the communities in Kano has through this process provided further support to the female CBOs in the community-giving them protection, accommodation and his blessings to conduct HIV prevention outreaches.
Reduce stigma and discrimination against People Living with HIV & AIDS (project objective #3)

The cross cutting activities on stigma and discrimination were conducted mainly through peer education, IPCs with PLWHAs, community awareness creation and mass media campaigns at the national level. The interventions helped to promote knowledge, acceptance, and disclosure of HIV status at the community level. The peer education activities contributed to increase in understanding of stigma and to change the myths related to fear of casual transmission. The project encouraged PLWHAs as role models of the community outreach activities, to spread information on HIV & AIDS and correct the misconceptions about PLWHAs. The IPC contributed in promoting positives knowledge, adherence, positive living and prevention. The project also provided material support (including BCKs) to PLWHAs. This helped in reduction of incidences of diarrhea as result of water as the waterguard provided in the BCKs and LITN (mosquito nets) also reduced cases of malaria as reported by the PLWHAs.

“…Support Group members are inter-marrying, starting businesses and living healthy lives. The sense of hopelessness is gone. This project has encouraged them to know that life continues and to pursue our dreams.”

Annur Support Group member, Kaduna
Measures of effectiveness

The CIHPAC project recorded considerable achievements through the BCC activities. The majority of the general population in the project gained accurate knowledge of HIV & AIDS, acceptance of PLWHAs and increase in disclosure of HIV status. Many participants reported positive changes in sexual (increased condom use) and non sexual behaviors (decrease in alcohol use, increase in number of PLWHAs on ARVs).

The leader of the Dooshima support group in Makurdi reported that marriage between discordant couples and concordant couples was on increase. This may not be unconnected to increase in important and accurate knowledge of HIV & AIDS. The PLWHA respondents demonstrated positive behaviors and reduction in re-infection rates. Between 2006 and 2009, over 5,571 persons were trained in stigma and discrimination, compared to 3,880 persons intended for training. The project surpassed its target by the measure of performance of more than 143%.

The BCC activities led to increase in accurate knowledge of HIV & AIDS amongst the general population. This subsequently has led to acceptance of PLWHAs and disclosure of status – several PLWHAs declared their status openly and participated in community outreach activities. The support groups visited affirmed increase in membership registration and attendance at support group meetings since the CIHPAC project.

Increase access to HCT services (program objective #4)

CIHPAC created demand for HCT through its Peer education, IPC and community outreach activities among the most at risk persons (MARPs) and the general population. HCT was supported through mobile HCT services at the community level. The mobile HCT facility witnessed consistent and unprecedented demand and increases in the number of persons reached in the period of the project.

Measures of effectiveness

Between 2006 and 2009, 16 mobile HCT services outlets were established by the project and 207 persons were trained in HCT. In the same period HCT service was provided to 118,903 people from various communities. As at 2010, a total of 425 persons were trained on HCT and over 150,000 persons counseled and tested received the result of their HIV status, compared to the planned 40,000 persons in the beginning of the project (this was achieved by 297%).

Aside the huge outreach with the mobile HCT service, many respondents to the evaluation reported unprecedented demand, which surpassed the project provision for the HCT services. Many a time, people were turned back because the test kits were exhausted for that day HCT activity.

3.5 Other interventions

The TB/HIV Component

Under the TB/HIV component, the program focused on prevention of TB by promoting awareness and visibility of DOTS centers through branding and sensitization of the people. Interventions were targeted at both community and national levels. Interpersonal Communication Conductors (IPC) recruited as frontlines of the community level intervention. At the national level, CIHPAC supported the National Tuberculosis/Leprosy efforts with mass media campaigns. National level activities reinforced community IPC interventions using mid-mass media such as mobile drama shows (road shows).
**Measures of effectiveness**

The project as designed presented limited quantitative information for assessing the outcomes of this component, but interviews with participants indicate that the intervention has worked relatively well. CIHPAC contributed to awareness creation initiatives on TB prevention, TB treatment opportunities, referrals, and TB/HIV co-infection. The program promoted access to TB-DOTS centres through IPC conductors at the community level, mass media and mid media campaigns at the national level. Through the program 13 TV slots were made per quarter on National Television to air information on TB. There were 4,098 slots aired in Hausa, Pidgin, Igbo and Yoruba in 32 radio stations across the country during the period. At the community level, IPC conductors created awareness on TB-HIV through specific interpersonal communication guide produced by the program.

**Orphans and Vulnerable children**

CIHPAC provided vulnerable children and their families basic care kit (BCK) through implementing partners of other USAID funding schemes working on OVCs to extend its impact on the HIV impact mitigation and care continuum. One time activity to promote malaria, diarrhoeal disease prevention and treatment as well as improved basic sanitation and hygiene practices amongst PLWHAs and their families was conducted. Kit components included: one long-lasting insecticide treated net (LLIN); one safe water storage vessel with spigot (std. 20 litre bucket with lid); one bottle of WaterGuard, a point-of-use water treatment product; ORS sachets; hand soap; and a combination of relevant IEC materials.

**Measures of effectiveness**

Data on the actual amount of BCKs procured and supplied by CIHPAC could not be ascertained at the time of this report. However, evidence from interviews conducted across several states with IPs, established that BCKs had effectively improved the quality of life of PLWHAs. The insecticide treated nets was the most effective especially for pregnant women. In many centres, women were highly motivated to access PMTCT services. This has contributed to reduction in the number of children born with HIV. At the DOD hospital in Enugu for instance, because of the BCKs, uptake of PMTCT has increased, and 100% success was recorded in the prevention of mother to child transmission of HIV amongst women accessing PMTCT in the facility.

Many participants reported reduction in diarrhoeal diseases, and this was corroborated by relevant health staff of facilities that received BCKs. As reported, hospital attendance for diarrhoeal diseases amongst PLWHAs who received BCKs dropped during the period of use.

**Strategic Information: Operations Research, Monitoring and Evaluation**

CIHPAC’s efforts in this area were focused on supporting a series of tracking studies (behavioral, epidemiological and performance related) and using the data for effective and evidence-based decision. However, at the community level emphasis was on periodic data generated through PM&E. Therefore data use was more at the national level for program design and modification. But generally in terms of the overall use of data to guide implementation, this fairly worked well as evidence showed that several supportive researches were funded by CIHPAC. NARHS plus (National HIV&AIDS and Reproductive Health Survey with HCT testing for general population), the IBSS, and others like Niger bus and the BSS. Some of these researches influenced interventions like the Prisons, PEER, Corridor, PLACE; VFH projects women with special needs, physically challenged or disabled population.
Analysis of effectiveness of Project coordination and management

Program structure and Management
The CIHPAC project management structure seemed adequate and fairly suited for the project implementation. The decentralized operations seemed to have worked relatively well as it provided an effective technical and administrative support hub for the project implementation at the community level. Its integration into the existing SFH operations, as opposed to creating a parallel management structure was exemplary and enabled seamless support from other enabling functions of SFH- field operations (condom social marketing) upon which CIHPAC’s effective implementation was inevitably dependent, easier coordination of CIHPAC and leveraging across SFH multi funded operations. However it is reasoned that project would have been enriched is each of the 16 SFH regions had M&E and finance officers given the work load required in these areas. Also at the national level, more hands could have enhanced coordination and effective management.

Coordination and management
The coordination of CIHPAC could have worked better. The management approach was more or less top-down – decisions and plans were communicated down from HQ to the territorial and regional offices, though this was for operational reasons as explained. The decentralized structure has the potentials to provide more technical nuances, but was not adequately utilised, as most actions were driven only from the HQ. Although quarterly project meetings were organized, it was mostly to update the field staff on new development and changes to the project, garner their inputs and support for decisions reached and create shared understanding for operations. It was mostly “short-circuiting”, because discussions were sometimes based on the decisions made or about to make as communicated from donor to SFH HQ and then to the field operations. Apart from the bits and pieces of information through the project meeting and other sources, some field staff, especially those who joined the project midway hardly accessed the full project proposals and performance monitoring plan, and as a result could not attain full understanding of the project conceptual model. Staff who started from inception had intensive training in the CIHPAC project design and implementation, but this was not effectively documented for retraining and training of new staff on the project.

Many enquiries on targets and outcomes which were expected to be available at the regional and territorial offices were frequently referred to the HQ team. Another key observation is that, CIHPAC project was implemented as an annual one off round with different partners. As at the time of this evaluation, the project was implementing the final 2009/2010 round and field offices found it challenging to present cumulative data on targets and achievement. This was particularly challenging in instances where the CIHPAC project officer had not been with the project from inception.

Program support
The program support mechanisms to local implementing organizations and intervention sites exist and were more or less regular, frequent and effective. Monthly coordination meetings with implementing partners and monthly meetings between partners and implementing structures at the community front which was used effectively to provide ongoing support and mentorship to partners. Reporting mechanisms were clear and implemented to the letter, and monitoring and supervision was regular and effective. This contributed to consistent program focus, shared understanding and effective implementation of strategies.

The system of data management (MIS) was robust at the national level, with the full complements of technical skills in place, but it seemed skeletal and largely ineffective at the field level. The regional teams did not have M&E support staff domiciled which posed a huge challenge to data management. As has been said earlier, regional and project focal teams merely operated as conduits for data to the HQ where it was used to make decisions. There was little evidence to show how data was decimated for state specific decision making.
There was a robust Performance Monitoring Plan (PMP) which captures key project output indicators but silent on outcome/impact indicators and this posed some challenge demonstrating some of the outcome indicators of the project. However this process of performance monitoring seems to have satisfied the requirement of the donors as captured in PEPFAR indicator guide.

Tools for collecting data included PITT, MIS that was fed into by monthly and quarterly project and financial reports. Baseline and midterm evaluation reports guided the project implementation, though not readily accessible to field staff.

**Financial management**
Generally, financial flow was good with infrequent hiccups. Partners attested to the efficiency of the flow in most cases. However, the flow was not as good for SFH from USAID and the local implementing partners. Frequent changes in funding priorities by USAID, delay the release of funds seriously challenged the effective implementation of the project.

The retirement process was observed and except for one state or region, the process seemed smooth. Partner organizations were encouraged to first retire any balance of unused fund to SFH before financial reports can be submitted. Though a standard financial management procedure, this practice caused delay in processing and release of funds to the partners to execute program, causing backlog and inability of the partner organization to fully execute all program activities stipulated each month. However attempts were made by SFH to instill quarterly release of sub-grants, though these had challenges as SFH received monthly funding from USAID.

**Collaboration with Stakeholders**
Interface with HIV & AIDS stakeholders was effective and productive, especially with NACA, SACAs, NEPWHAN, USAID, as well as other key stakeholders on the project like the Police, Prisons, FBOs and the Private sector. Project activities clearly complemented national strategies. The project regularly delivered program reports and monitoring data to NACA and SACA, and so, contributed substantially to the national HIV & AIDS database.

Project staffs consistently participated in national prevention technical working group meetings and similar technical working committees at the state level which provided key opportunities for national and state policy influencing. This made it possible to provide technical assistance to national and State level prevention strategic plans. These meetings provided a forum for sharing lessons from CIHPAC implementation with other national and international stakeholders.

**Flexibility and adaptability**
The rapidly changing response to HIV often requires programs to be extremely flexible and adaptive to changes in strategies and policies. CIHPAC management was particular adept at reading changes in the environment and quickly found alternative mechanisms. Hisbah disbanding of brothel based FSWs in Kano; Prison breaks in Kaduna and Bauchi are a few examples, which constituted huge risks to the project- but SFH managed to keep focus - a testimonial of the creativity and adaptability of CIHPAC. In Bauchi prisons for instance, it was interesting to note that many of the prisoners who returned back willingly after the prison break were peers and peer educators, because CIHPAC had changed their orientation and self esteem they had learnt to be responsible citizens.

**Sustainability planning for CSOs and CBOs:**
The sustainability strategy built into the project facilitated the emergence of self organized groups of peers into community based organizations. Institutional and human capacity support was provided to activate these CBOs who are expected to carry on behavioral change activities within their communities. Capacity building on Proposal writing, fundraising, Entrepreneurship, income Generation Activities followed by linkages with
donors and funders created an opportunity for the CBOs to mobilize resources to continue their mandates. However issues of dependency still exists owing to the relative inability of other donor to respond to the funding needs of the CBOs. Although a few have been lucky to get funding and support from SACAs and other programs, many are still languishing in the dilemma of self actualization.
The CIHPAC project was driven by evidence, based on realities of the epidemic at its implementation time. It was also dynamic as some necessary changes and modifications were introduced midway into the project. The project was supported by internal and external research strategies, such as the National AIDS/HIV and Reproductive Health Survey, Behavioral Surveillance Survey, MARCs Tracking Survey (MTS), Quality Assurance Surveys, Niger-Bus and Project MAP (measuring Access and Performance) to shape the design and implementation of the key project strategies and activities. For instance, the Prison intervention was preceded by a survey that provided the basis for the intervention. The women in Special Needs and physically challenged program was based on the findings from NARHS – plus 2007, which indicates higher HIV prevalence and vulnerability rates among the groups.

Despite the inherent challenges and the observable shortfalls, the project had made useful contributions and achievements, surpassing expected results on many performance indicators. Some of the valued achievements of the project have been highlighted below.

Project coordination and Management
Although, the project implementation was decentralized, the critical management process was heavy at the headquarters—this has its challenges as it seems to limit most major decisions at the centre. This could result to delays. Information sharing was therefore restricted to what is critical and on needs basis as such regional offices and focal persons did not have copies of vital project documents needed to effectively coordinate implementation on the field—such as the original CIHPAC project proposal. Field offices therefore reported activities and targets based on Performance Monitoring Plan as many of the field staff and focal persons (especially the new staffs) were unclear about the conceptual model of the project and outcome indicators. Quarterly reports were presented based on the indicators in the USAID COP narratives, which did not adequately capture the specific objectives of CIHPAC and some of the activities such as the TB, OVC and other activities.

Project implementation
The project did very well in targeting and coverage. For instance reaching people living with disabilities and widows (WIN) with communication campaigns was very innovative and commendable. However, an issue of vulnerability such as lack of livelihood sustenance was a recurring challenge that the project could not connect to other programs that offered training on skills for livelihood security. In some FSW communities, this was an important concern, especially for those who were prepared to quit sex work.

Whereas communication efforts for youth were oriented on abstinence, being faithful and condom use; there was limited content on issues around concurrent relationships and cross-generational sex. The project integrated effectively with SFH institutionalized socio-marketing program, especially in ensuring access to condoms. However there were concerns if condom distribution would continue at the same scale to some communities after the project has ended. Strategic partnerships with telecommunication giants like MTN and beverage giants like coca cola can be explored to leverage on their distribution network to saturate hard to reach areas with products.

While Mobile HCT was demonstrated as an arsenal for effectively reaching hard to reach populations, the project, did not envisage the sustainability of this approach, given the present situation of low capacity of government to manage HCT in the country. The project promoted linkages mobile HCT to the national Heart-to-Heart centers in the communities. But it could have been done better with facility based HCT services as it was observed through the evaluation. It may be necessary in the future for project of this magnitude, to invest in strengthening and or developing facility based services in local health centers, drop in youth centers or training CSOs/CBOs to offer parallel services to sustain access to services well after project ended.

Comprehensive prevention that includes PMTCT needs to be strengthened or at best linkages to these services integrated into prevention programs of this kind, especially for interventions targeted at PLWHAs. Effective referral monitoring did not always work, especially for TB IPC interventions. Many clients were lost to follow up. For instance, in Port Harcourt the conductors did not have any standard tracking method for those they have referred to facilities. They could not objectively know those who actually have gone for testing at the facility.
Except for phone calls made sometimes to ask if those referred have gone to facility, no other way of knowing if test were actually taken. Synergy amongst the IPC conductor was poor. Some embarked activities outside their localities where they cannot follow up and the conductor in the locality do not know to follow up either. Sometimes people were referred to facilities not providing the services required. It seemed that accurate information about the facilities providing TB services was not provided to the IPC conductors.

The involvement of SACAs was quite rudimentary. While it is one thing for SACA to be aware of project programming, through the requisite pre-inception advocacy and subsequent sharing of reports, it is another thing to be actively involved. Except in few States, SACA did not actively participate in the project as would be expected. Even though there is existing gap in the capacity of SACAs to meet their monitoring and coordination responsibilities, it was unfortunately not the mandate of CIHPAC to address these gaps. Suggestions are that the CBOs can be inaugurated at State level where formal handover of the CBOs to SACAs can be made. At least, it will keep the CBOs constantly in the lists by SACAs to build relationship thread upon which CBOs can follow up for funding and support.

IEC materials were very effective but many were not translated to specific local dialects, which made its use somewhat limited. Card games were widely accepted and effective but the joker game is not very common at community level and so many could not play with them. More common card games like the “WHOT” may be more effective. Another case is the VFH which needs to be translated into more local languages to consolidate on its advantages in effective communications.

The project also did well with local branding to enhance project visibility—such as the branding of walls, kiosks, shops of influencers and some other fixed structures in the community with IEC materials and products as done in the various transport corridors. Audio tapes with key messages were also distributed to long distance drivers, but the number of audio cassettes available was not adequate given the high demand. The VFH audio device was also provided for most communities.

Implementing the MPP
When CIHPAC introduced the MPP, there was some challenge getting partners to understand how to use the PITT to report on the activities implemented at community level and vigorous on site mentoring worked well to bring partners up to par with the MPP requirements. And whereas, CIHPAC was already implementing the MPP minimum interventions package, there were gaps in the implementation. CIHPAC implemented 3 basic interventions—Peer education, Peer education Plus (special events etc) and community awareness campaigns. It went even further to include Mobile HCT. This worked really well but there remained gaps in the ability of CIHPAC to fully link with other service providers to provide comprehensive interventions as opposed to doing it all alone. For instance, whereas information on STIs was being provided through peer outreach and IPC, there was no concrete linkage for ensuring that clients and peers who needed services are referred through specially designed referral cards to specific STI treatment clinics. It was more or less a loose arrangement. Issues like drug abuse were treated in peer sessions but drug abusers who wanted to change their drug use behavior, did not have the benefit of the linkage with services that provide treatment for drug abusers to leverage on, for example psychiatric hospitals or psychiatric units of secondary and tertiary health centers.

Sustainability
It appears that the sustainability ingrained into the CIHPAC project is skewed more to project sustainability and assumed that, keeping the community structures active is potent enough to guarantee behavior change. There are critical gaps in this assumption. First, the CBOs are designed to provide a much reduced intensity of information as did CIHPAC and it makes little logic that this will work. The expectation would have been for CBOs to target high impact interventions and vigorously implement these to maintain the dose of messaging. Other support services upon which the success of CIHPAC depended like mobile HCT would not be on ground to support the work of the CBOs.
Perhaps most important is the content of the messaging which should not be the same as the BC stage, a mixture with emphasis on new information bothering around motivation for behavior change amongst young people and strategies to address factors that promote behavior relapse- social, cultural, gender, environmental and service determinants like product availability, counseling services and HCT would be necessary. Therefore, for effective behavior maintenance, projects of this nature must go beyond “structural sustainability at community levels” and focus much more on ensuring that structures established have the capacity to provide sufficient and effective scale and coverage of interventions to target population as well as appropriate messaging.

Impact of CIHPAC on the HIV epidemic
Understanding the context upon which CIHPAC was implemented, combined with an analysis of the data on the project output/outcome afore presented, evidence points conclusively that both the availability of and access to HIV & AIDS key services improved in target communities during the project period. Project-supported HCT reached increased numbers of people and the demand is still increasing. This is an indication of the efficiency of the project in enabling access to information and improved knowledge of HIV amongst target populations. Male condoms were regularly available in many shops and through peer educators, peers and IPC conductors. Innovative approaches and researches were used to find new opportunities for offering information and services to a wider spectrum of under served population- for example PLACE, working with widows and the physically challenged. Communication activities reached substantial numbers of people, particularly through IPCs. There is no doubt therefore that the project has had substantial impact on the HIV & AIDS epidemic.

The prison interventions presented another innovative way to impact on HIV prevention. At Owerri prison, program has led to the formation of the Prison Officers’ Anti-AIDS Club and Hope for Humanity Club for the inmates within the prison community. Unlike before the inmates demonstrated detailed and accurate knowledge of HIV & AIDS, positive attitude and behavior change. They displayed their knowledge of HIV & AIDS related issues in various ways, including tell tales, songs, drama, and speeches to their understanding of meaning of HIV & AIDS, modes of transmission, misconceptions, prevention, risky behavior, stigma, treatment, care, HCT and positive living. See side box for comments by the Deputy Controller of the Owerri Prison.

I am satisfied by the extent of HIV & AIDS work in the prison by CIHPAC program. This is because I have seen the program has impacted on the entire prison community. The behavior of some inmates who practice same sex is changing as the program exposed the danger of risky sexual behavior. HIV & AIDS stigma is on decline because the inmate and officials within the community have acquired knowledge of HIV & AIDS and how to behave towards any person who is HIV infected. Unlike before the program has helped to break the silence on HIV & AIDS, as more people now come out during HCT exercise.

IDI/Deputy Controller of Owerri Prison/Nov.2010

Contribution to National priorities and goals
A primary goal of the national HIV & AIDS prevention program in Nigeria is to reduce the rate of new HIV infections by 55% by 2010 and to have 95% of the general population and specific groups, make appropriate behavioral changes (safer sex, abstinence etc) by 2006 (National Prevention Strategic Plan 2007). Projections from sentinel surveys estimated that at least 346,150 new infections would occur in the adult population.

By 2009, CIHPAC had reached at least 496,649 persons with condom and other prevention messages, 734,923 young boys and girls were reached with abstinence and being faithful messages. Given the relative stability in HIV prevalence rates in the foregoing years after CIHPACs inception, and considering the performance of CIHPAC through proxy variables for impact, clearly, CIHPAC made substantial difference nationally in the availability and access to information, HCT services, and products for HIV prevention and behavior change for most at-risk groups and the population at large and this surely has contributed in no small measure to enabling sexual behavior changes in a vast majority of the targeted populations in the communities where the project activities were implemented.
• Behavior change among the target populations is correlated with intensity of exposure to the program activities.

• Building trust in the efficacy of condom use for HIV prevention is a critical element for behavior change and maintenance.

• Integrating intensive BCC, access to condoms with HCT and STI services results in wider coverage of target groups, and higher utilizations of services and that way, few missed opportunities exist to provide program beneficiaries with the complement of effective HIV prevention interventions. Besides, Behavioral change and transformation is not automatic, interventions that are sustained over a period of time, that are intensive, adequate, and relevant and have the necessary services integrated work best.

• Targeting interventions in a strategic manner based on a need assessment such that interventions are delivered where they are most likely to reach populations most-at-risk for HIV infection ensures effectiveness.

• Careful selection and training of peer educators is critical to the success of the peer education model especially when the community is involved. It strengthens ownership and ensures commitment of peer educators.

• Involvement of community stakeholders (parents, community leaders and service providers like community pharmacists/chemists, prison wardens, venue and brothel owners and police commanders and other opinion leaders) as influencers strengthens community support for peer activities and encourages ownership and sustainability because adults are more supportive and participate most in activities that they are involved in.

• Although the initial training of the peer educators over a one week period is short given the volume of information to be absorbed. However the monthly meetings with program officers of local implementing agencies to review monthly activities allow for additional training for the peer educators and their existing knowledge is reinforced. This process is important, as group activities encourage the less assertive to gain confidence over time. Secondly, regular field monitoring especially joint monitoring with CIHPAC program officers from SFH offers a unique opportunity for supervisors to clarify misconceptions on timely basis.

• Well trained peer educators, even when they are young people, have the potency to provide HIV & AIDS education to their peers and unintended target groups such as adults through community out reaches if adequately supported. Especially, the use of high impact, quality culturally appropriate promotional materials like wrist bands, drink covers, hijabs and posters give mileage to BCC efforts at community level.

• Effective project monitoring requires intensive on site support and this can be obtained through the adoption of appropriate and easy to understand tools.

• Prevention works especially if the scope of prevention programs is targeted at the most vulnerable to infection and marginalized groups.

• There must be a balance and link between prevention, care and support for programs of this nature to be relevant and effective.

• Sustainability of prevention programs at community level is deeply rooted in how much government prevention coordination mechanisms are integrated into community programs.
• Poverty is still a major vulnerability factor and until it is reasonably alleviated behavior maintenance or sustainability may not be effective

Recommendations

Coordination and Collaboration
Linkages between SFH and other NGOs involved in delivering HIV services should be considered as key to extending the scope of interventions implemented in order to better achieve the minimum package rather than striving to implement as one organization. This result in a functional packaging of services where all elements are available and linkages between organizations ensures that beneficiaries of one organization can also access services of another. For instance HCT may be provided by an NGO under the Global fund or DFID program that provides HCT, while SFH handles BCC or SFH can map a list of available service providers and enter into partnerships with these as part of the project design to create a network for clinical services and treatment of STIs.

Service nesting
CBO offices can function as outlets/refill points where products and services can be assessed by young people, for example HCT, Condoms, etc. Directly programming for in-school youths, through education and HIV focused CSOs may be more effective than using the NYSC because of the inherent bureaucracies there. Also, involvement of the school teachers and parents as influencers can achieve results just as much as the out-of-school youths program.

There is a major need to build in literacy and numeric skill development for Out of School Persons in communities and inmates in prison. Linkages could be created with the relevant agencies working in non-formal education/adult learning or participatory models like STAR or Reflect (by Action aid) can be integrated into the PEP model to address this. Education creates knowledge for better choices in life and for all round health and human well being.

Young people need a rallying point to come together - do things together- solve problems, be entertained, take a break from the stress of life, building / sustaining cooperation and team spirit. Investment needs to be channelled into the psychosocial development of young people by building community social facilities, table tennis boards, football posts, nets and ball, basket ball pitches. This can be managed by CBOs and may be a potent income generating source.

SFH needs to increase the complement of staff to include M&E officers and finance assistant in the regional offices who report through the regional heads to the HQ team. The situation that exists at present has a potential to choke project as regional offices often manage several projects and do not have enough hands to support a large portfolio of projects. Also, systems for documentation and knowledge management need to be decimated to the regional offices. USAID relationship with SFH should evolve from top down to a partnership based on mutual respect, from information dissemination to effective communication through dialogue on critical issues such as changes in funding.

The flexibility of VFH devices has to be explored with the necessary developers. A cartridge system that allows for updating information and programs that can be delivered will give mileage to its effectiveness. It is a tool that must be utilized because even with power outages, it can still reach sizable numbers of people and are among the most cost-efficient ways to reach people.

The program should scale up the current BCC content to include information on concurrent sexual practices and cross generational sex both within the general population and for socially excluded groups, with campaign materials addressed specifically to individual vulnerable populations.

In communications to support HIV & AIDS services, more content needs to be carved for PMTCT among the general population and vulnerable groups. Program elements that directly support the delivery of services and products to clients should be given priority for funding, such as condom distribution, HCT and STI screening.
Also, viable private alternatives for product distribution (partnerships with MTN, coca cola etc) may expand coverage and enhance cost effectiveness.

A ready supply of packaged product for condom products, both male and female together may help improve choices for women. Programmatic and referral linkages between prevention and BCC programs and livelihood programs, (IGA) can enhance the impact of prevention programs.

Although the project disseminates its work by participating in national working and technical groups, it needs to explore opportunities to share with other stakeholders that are active in HIV & AIDS prevention. Use of operations research and developing innovative use of its MIS documentation and knowledge management, could better share its impressive lessons and best practices to benefit a wider audience. The CIHPAC Project is rich in lessons learnt and should better document and disseminate these such as targets on service delivery, outcomes and impact. Otherwise it will constantly be a challenge to demonstrate objectively the impact of the project.

SFH should improve on capacity building for example program staff and partner organizations were trained once during CIHPAC and for cases where there were replacements, these replacements were not intensively trained. Mentoring is great but refresher trainings are critical for updating project staff on new information, changing scenarios and strategies and for maintaining and retaining capacity. It also doubles as a good motivation strategy. Likewise, USAID should do same for SFH.

The development of special approach to prison intervention was observed. The PEP model as it were, was abridged to six from nine months to program for prison inmates. The prison intervention was a new model and it would have been given the opportunity to explore the most effective strategy by using full PEP approach, and this was not taken very serious. In such attempt, a rapid assessment ought to have been conducted to know the extent to which the PEP is to be adapted for the prison intervention. Considering the security measures in place at the prison whereby the inmates access to materials (including some PEP materials) is restricted, was six months appropriate period for intervention therein? There is high rate of inflow and outflow of prison inmate, and serious consideration must be given to this for successful prison intervention. It is also important to develop a “how to do” toolkit to guide the full prison intervention.

Whilst the CIHPAC project gained much from previous and existing project (the PSRHH)by SFH, however, it is equally important not assume that some of the project elements are subsume in other projects, thereby creating the challenges of double counting of achievements. It is important to maintain the boundary of each project in future, though program synergy is important.
## Appendix A

### Selected Tables of data analyzed for Program Area – Abstinence and Be Faithful (NYSC, Prisons, FBO, OSY, YFH, GENERAL POPULATION)

#### No of individuals reached through community outreach that promotes HIV & AIDS prevention through abstinence and/or being faithful

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Appendix B: Tools

Key Informant Interview Guide for SFH Head Office Staff
Comprehensive Integration Approach to HIV & AIDS Prevention and Care Project
End of Project Evaluation

PROFILE OF RESPONDENT
- What is your name, professional qualification and experience, length of employment and position in SFH?
- Role in the CIHPAC project from the inception to date, supervision and reporting relationship

PROJECT PERFORMANCE/PROGRESS RELATIVE TO THE OBJECTIVES

Overview of CIHPAC project
- Briefly provide an overview of the CIHPAC project [explore phases, goals, strategies, objectives, program components, key activities, and indicators for tracking these]
- Describe the CIHPAC project structure and leadership operational?
- What were the structural trends in the course of the project if any and why? How did this impact on the project delivery?
- What were the challenges in this regard? And how were they managed to retain the focus of the project

Structure, Function and Capacity
- How did your organizational structure and capacity support the CIHPAC project performance and financial arrangements?
- To what extent your management structure was appropriate for the project implementation and performance?
- How did your management assure that the project was implemented in accordance with stated project requirements?
- How was cross integration and coordination of projects from different funding sources managed across your organization with regard to CIHPAC?
- What were the emergent issues that impacted on your capacity for the project?

Staff Performance Systems
- How was staff performance and productivity reviewed?
- What did you do to bring out the best in staff to achieve the project objectives?
- How were the required numbers of staff deployed for the project implementation

Project implementation Focus
- What was the context upon which CIHPAC was implemented? What was it designed to address? What was the basis/justification for this?
- Which population subsets did CIHPAC target and why? What specific strategies were used to target these?
- What worked well and what didn’t? What were the challenges experienced in this regard

Output/outcomes and impact trends
- What would you describe as the key achievements of CIHPAC?
- What were the kinds of activities that led to these achievements [disaggregated by target group]? Give example in each case.
- What has changed in the light of the context in which CIHPAC was designed as a result of these achievements both expected and unexpected [regard to the situation of the people and issues targeted]? [give evidence backed examples if possible]
- How did you manage the unexpected results within the focus of the project?
- What would you describe as the key impacts as a result of these changes? Why? [give evidence backed examples if possible]
- What is the relevance and effectiveness of the CIHPAC strategies, approaches and objectives within the overall situation in Nigeria
- What challenges did you experience in this regard and how did it impact on the results and achievements?
- What lessons were learnt and how did it impact on the project implementation

Project Management
• What was the project management strategy used for CIHPAC? What were the challenges with regards to this and how was it overcome?
• How was gender focus addressed in this strategy?

Partnership
What was the partnership strategy and operational [what worked well and did not work well?]
How was gender focus addressed by this strategy?

Explore:
• How many partners were involved in the implementation- how were they selected- any criteria or framework for partnership engagement? How this was coordinated-
• How these partners were funded- any cost sharing? How long were the partnership agreements/ were they formalized through MOUs? What was the benefit of utilizing this partnership strategy?
• What kind of collaborations were built into the project to ensure efficient management and success (FMOH, NACA, Umbrella groups at state and national levels) how did this impact on the project
• What were the challenges experienced in this regard and what was the impact on the project? How was this managed to maintain project goal focus.
• What lessons were learnt from the process and how was this used to improve the project implementation.

Program support
• What was the strategy for program support- what was the role of USAID/SFH/PSI.
• Explore whether it was a push or pull system,
• What kind of support was provided to SFH by USAID and what support did SFH give to local implementing agencies to effectively manage the project. How often was this support? How did this impact on the project?
• what worked well and what didn’t,
• What were the challenges and how were these overcome?
• What lessons were learnt from this and how did it impact on the project delivery

Monitoring and supervision (program backstopping)-
• Describe the performance management strategy and plan of CIHPAC.
• What was the benefit to the project? How relevant was this to the project implementation?

Data Capacity and Systems
• How did you collect and analyze data for tracking the project performance?
• How did you use the data and information to support project decision-making and innovation?
• How did your data capacity support the timely submission of reports required of the project to USAID?
• What quality M&E system as well as staff investment did you make to meet the data needs of the project?
• What were the key challenges and how were these managed?
• What lessons were learnt from this and how was it used to improve program implementation?

Finance Management
What was the finance management strategy for the project- sub granting or bulk granting? Explore:
• How were funds released-periodically? What was the yardstick (retirement driven?) and monitored for efficiency-mechanisms?
• What was the accountability framework embedded in the project for tracking efficient use of funds and minimizing wastages,[ how were budgets for IAs managed, Who was coordinating this and what was the role of USAID in this process what was the role of the IAs in this process]
• what’s was the mechanism for fund release from USAID to SFH, what were the challenges experienced
• What were your financial management practices?
• How often were required audits conducted in a timely manner?
• What steps did you take to address identified financial management deficiencies, including any audit findings?
• What was the trend in terms of funding ceilings over the course of the project - did the funding level change? Why? How did it affect the project? How did this affect SFH partnership with IAs?
• How did you budget to reflect the priority project goals and objectives? Give evidence to buttress this
• How was the budget justified, including any maintenance of effort and/or matching fund requirements?
• How did you ensure that financial resources were allocated properly to complete the project objectives? Where they cases where CIHPAC funds were complemented or used to complement other actions? Explain. How did this impact on the project
• How did you manage your expenses to follow the project purpose and priorities?
• What lessons were learnt and how was this used to improve program success.

Communication-
• How would you describe the communication between SFH and the IAs and between SFH and USAID?
• What worked well and what did not?
• What were the challenges and how was this managed? What are your suggestions for improving this in the future

Linkages
• What linkages were formed that enhanced the project implementation, which did not, what worked well and what did not?
• What lessons were learnt and how was this used to improve project implementation.

Sustainability-
• What were the sustainability issues identified during the course of the project
• What was the sustainability strategy?
• What key activities were implemented in this regard, what were the evidenced outcomes, how relevant were these to the sustainability issues, how effective were these to addressing the issues identified?
• What worked well and what did not?
• What initiatives have you built in the project to allow for local ownership?
• What synergies and collaborations have you established with other organizations and stakeholders?
• What resources have you leveraged for the project activities to continue?
• What were the key challenges and what lessons were learnt and how has this impacted on the program implementation

Gender Issues
• What were the relevant gender issues to each project area, including gender impact and expectation?
• How were gender outcome systematically identified, and included as appropriate?
• Which gender-related linkages with other projects and projects were identified and incorporated in CIHPAC project?
• Show how the project information was disaggregated in line with gender requirements

General
• What would you describe as the added value of CIHPAC to the Nigerian situation and in what ways has this contributed to USAID mission goals?
• What are your key recommendations and suggestions for improvement if this project is to be replicated or scaled up?
• Are there any best practices in terms of the project coordination and management that you would like to share?
• How PSI been involved in this project?
• What advantages did it bring into the project?
• Were there any disadvantages experienced?
• What were the key limitations experienced and what lessons have been learnt
PROFILE OF ORGANIZATION
- What is your organization’s name, vision, values, mission, goals, objectives, legal status and year established?
- Describe your leadership, staffing and project structure?
- In what specific program areas will you describe as your areas of competence

Gender
- How many women are members of your organization? How many are in the leadership structure? What are their key roles? (In terms of Planning, coordination, management, technical leadership?)
- How are your activities involving and targeting women?

LEADERSHIP AND STAFFING

Staff Qualifications, Characteristics, and Skills
- What training did your staff receive for this project?
- Show how effective was the training for the work you were expected to do?

Staff Performance Systems
- How was staff performance and productivity reviewed?
- What did you do to bring out the best in staff to achieve the project objectives?
- How were the required numbers of staff deployed for the project implementation?

Workforce Stability
- How did you achieve stability in key management and leadership positions under the project?
- How frequent was the turnover in the project leadership?
- What were the CIHPAC project relevant staff turnover patterns? What was responsible for staff turnover in relation to CIHPAC? How did you consistently and quickly fill vacant positions?
- How did it impact on the project? How was this managed to maintain project focus? What lessons did you learn from this?

PROGRAM PERFORMANCE AS PER CIHPAC

Overview of involvement in CIHPAC project
- In your opinion, what is the CIHPAC project all about? [explore understanding of the goals, strategies, objectives and key activities of CIHPAC]
- What were the issues related to HIV & AIDS in your focal communities that CIHPAC tried to address?

PROGRAM FOCUS/ACHIEVEMENTS
- How was your organization involved in the CIHPAC project? Describe the project areas of CIHPAC you were engaged in, and the activities you implemented? Which groups did you work with on the project and for how long?
- How did you ensure gender balance in your implementation?
- How did you decide on which activities and populations to implement or target?
- How did you ensure gender balance in this regard,
- What worked well and what did not and why?
- List the specific gender based activities and issues addressed
- Which gender-related linkages with other projects and projects were identified and incorporated in CIHPAC project?
- What support did you receive from SFH in this regard- gender mainstreaming?

OUTPUT/OUTCOME TRENDS
- What would you describe as your key achievements in terms of the activities you implemented and the populations you targeted? [Disaggregated by gender] what achievements were recorded that were not envisaged?
- What are the evidenced based changes that CIHPAC has achieved in relation to its goals? Give examples...
• What changes occurred that were not expected and why? How did this impact on the project?
• What were the lessons learned in terms of focusing activities and targeting populations and how did this impact on your achievements in CIHPAC?

PROGRAM Effectiveness/relevance
• How relevant were the project strategies and activities in addressing the issues related to HIV & AIDS in your focal communities?
• How effective were the project strategies and activities in addressing the issues related to HIV & AIDS in your focal communities?
• How successful was CIHPAC in achieving its objectives from your level of involvement in the project?
• Which of the project objectives were most successfully achieved and why?
• Which of the project objectives were least successfully achieved and why?
• What was the impact of the project on the target population? (ask for examples to support expressed views)
• What were the key challenges you experienced in terms of program delivery working on this project? How did you address the challenges you encountered in the project implementation?
• What support did you get from SFH or USAID in order to effectively deliver on the objectives?
• What support did you need that you did not get? How did this affect the project implementation? How did you manage this?
• What lessons did you learn and how did these impact on your implementation- give examples

Project Management
• How would you describe the management of the project? Was it effective?
• What worked well and what didn’t? Give examples
• What particular challenges/limitations did you experience from the management of the project by SFH? How did you manage these?
• What particular challenges did you experience managing the implementation with the communities? How did you manage these? What support did you get from SFH in this regard?
• How would you describe the communication between you and SFH during the project?

FINANCIAL MANAGEMENT
• How was your implementation of CIHPAC funded? Was it by grants from SFH? Did you make any contributions to the funding? If so what and how much?
• How often did you get funds from SFH? What were the challenges in this area [explore fund delays, short payments etc] how did these impact on the project?
• What was the funding ceiling trend? Did you receive the same amounts every month/quarter or year throughout the project? What determined the amount of funds you received from SFH? How adequate was the funds you received from SFH in carrying out your activities? If not adequate how did you manage this challenge?
• What finance management systems did you have in place to manage CIHPAC efficiently? What support did you get from SFH in this regard?
• How often were required audits conducted in a timely manner?
• What steps did you take to address identified financial management deficiencies, including any audit findings?

Financial Efficiency
• How were your work plans and activities generated and priced? [Project Budget Aligned with Goals and Objectives] what support did you get from SFH in this regard?
• How did you ensure that financial resources were allocated properly to complete the project objectives? What support did you get from SFH in this regard?
• How did you track your expenditure performance in line with the project purpose and priorities? What support did you get from SFH in this regard?
• What other support did you get from SFH to enable you manage the project finances efficiently?
• What lessons did you learn with regards to finance management and how did it improve your finance management of the project?
• What suggestions do you have for improving the project management of a project of this nature in the future based on your experiences in CIHPAC?

Data Capacity and Systems
• How did you collect and analyze data for tracking the project performance?
• How did you use the data and information to support project decision-making and innovation?
• How did your data capacity support the timely submission of reports required of the project?
• What support did you get from SFH to do this efficiently/

Project Sustainability-
• How do you plan to continue to fund your activities after CIHPAC ends
• How have you involved the community in supporting your activities?
• How are you collaborating with other stakeholder and the government to ensure your program sustainability?
• What support did you receive from CIHPAC in this regard?
• What suggestions do you have for ensuring sustainability after CIHPAC

General Questions
• What other issues need to be addressed if another project of similar nature were to be implemented and why?

Use of Feedback
• How did you solicit feedback from those targeted by the project and other stakeholders?
• How did you use this feedback within the project?
• What was the “feedback loop” between you and SFH, CBO, and target population?
• What suggestions would you have to improve this project should it be extended?
Focus Group Guide for Target Groups
Comprehensive Integration Approach to HIV & AIDS Prevention and Care Project
End of Project Evaluation

Introduction
Thank you for agreeing to discuss with us today. We are (give your names) working for SFH to evaluate the CIHPAC project. The essence is to document the project for learning purpose. We will ask you some questions and write down your answers. There are no ‘correct’ or ‘wrong’ answers; it is what you think is true that interests us. This will take about 30-40 minutes of your time. In the end we will be happy to answer your questions relating to the project evaluation. We hope you will feel free to speak what you know and think about the project.

- Continue if participants are happy to speak. Otherwise clarify to continue and/or end the process.
- Ask the participants to introduce themselves stating their names and the group they belong to in the community.

Evaluation Questions

1. Please tell us about the way you were involved in the CIHPAC project.
   Probe:
   - What motivated you to be part of the project?
   - What kinds of activities did you participate in during the project?
   - How often were these activities you participated in?
   - What did you like or did not like about these activities?
   - What suggestion would you give to improve on the activities if this project is continued?

2. How has this project benefited you in terms of access to information on HIV & AIDS/T/STIs?
   Probe:
   - Explain what has been learnt
   - How useful was the project in helping you to maintain a healthy life style
   - Are there other ways you have benefited from the project?

3. What has changed in your lives and in the community since this project started?
   Probe:
   - Explain specific examples of changes in behavior related to HIV & AIDS/TB
   - What contributed to the changes?

4. In what way has the project provided you support to adopt the change?
   Probe:
   - How do you plan to continue with this change?
   - What support is the project providing to help you on this?

5. If your friend or close relative is infected with HIV & AIDS/TB/STI how would you respond?

6. In what ways have you used the learning from the project to affect your friends and families or community?

7. What kinds of services were available to you as a result of the project? Probe:
   - Who provided these?
   - How adequate and beneficial to you?
   - What factors enabled/limited your ability to use these services effectively?
   - What did you not like about the services?
   - What did you like about the services provided by the project?
   - What suggestions do you have for improving these services

8. What other suggestions would you give to improve the project in general?

Conclusion: Thank you, we have come to the end of our questions. We have learnt important things from you today. We are very happy for your participation. Do you have any question for us?
In-Depth Interview Guide for CBO Support Group of PLWHA
Comprehensive Integration Approach to HIV & AIDS Prevention and Care Program
End of Project Evaluation

PROFILE OF ORGANIZATION

- What is your organization’s name, vision, values, mission, goals, objectives, legal status and year established?
- Describe your leadership, membership structure and operation
- How do you plan to increase and/or maintain your membership?
- How do you manage your finances? How has CIHPAC supported you in this area
- How do you keep records of your activities? How has CIHPAC supported you in this area
- Do you have an office and facilities for your operations? (tables, chairs, filing cabinet etc., ) if yes, who provided these for you
- Are you registered with the government or any of its agencies?[please sight registration documents] How has CIHPAC supported you in this area

Gender Issues

- How many women are members of your organization? How many are in the leadership structure? What are their key roles? (In terms of Planning, coordination, management, technical leadership?)
- How are your activities involving and targeting women?

PROGRAM DELIVERY

- What kind of activities have you planned to carry out, how did you did you decide on these and why? (which ones are you currently doing and which ones are not and why
- Who do your activities focus on and why? What do you aim to achieve by carrying out these activities?
- In what way did CIHPAC motivate you to choose these kinds of activities?

PROGRAM SUPPORT

- What kind of trainings have you received to enable you function effectively? How many of these were provided by CIHPAC? (If other organizations have provided trainings, find out how they linked with these other organizations)
- What trainings do you need which has not been provided? List them
- In what other ways besides trainings has the CIHPAC project been beneficial to your organization?
- In what other ways do you ant CIHPAC to support you to function more effectively

Project Sustainability-

- How do you currently fund your activities?
- What are your major difficulties/challenges/limitations in this area?
- How do you plan to continue to fund your activities after CIHPAC ends?
- How have you involved the community in supporting your activities?
- How are you collaborating with other stakeholder and the government to ensure your program sustainability?

General Questions

- How did your involvement in CIHPAC motivate you to start this organization?
- How effective was CIHPAC in addressing issues related to HIV & AIDS- what issues were specifically addressed by CIHPAC that you remember?
- What specific activities were used to address these issues that you remember? Do you think that these activities addressed the HIV issues effectively?
- What in your opinion did not work well in CIHPAC
- How were you involved in the CIHPAC program
- What other activities besides the ones conducted by CIHPAC do you know that would be effective in addressing HIV issues in the community?
- How do you plan to conduct this yourself? What support would you require to do this?
- In summary can you tell us a real story that happened on how CIHPAC changed the life of a person you know or how it changed the community in any way?
- Would you want CIHPAC to continue? Why?
- If the CIHPAC project was to continue, what suggestions would you give to make the program even better

In-Depth Interview Guide for Ministry of Health and SACA
Comprehensive Integration Approach to HIV & AIDS Prevention and Care Project
End of Project Evaluation

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TIME: 60 MINUTES

PROFILE OF RESPONDENT
- What is your name, professional qualification and experience, length of employment and position?
- Department and role in the ministry/agency

NATIONAL HIV & AIDS PREVENTION BCC PROGRAM CONTEXT

1. What is the main thrust of the national prevention and BCC strategy for HIV & AIDS in Nigeria? [explore the MPP]
2. What do you know of the project implemented by SFH and funded by USAID? [explore awareness of goals/objectives/outcomes, strategies, activities, focus states and program areas] How long has this project been running?
3. In what ways have you been involved with this project? [Planning, coordination, management, monitoring, technical support and supervision]
4. How does this project fit within the national framework and the national priority agenda for prevention programming in Nigeria? [Explore compliance with MPP and relevance/effectiveness in the Nigerian situation]
5. What will you describe as the added value of CIHPAC in the HIV prevention and BCC arena
6. What policy changes or shift have resulted from the CIHPAC action that you are aware of. How was CIHPAC instrumental to this?
7. In what ways has there been synergy of actions between your agency/dept and the CIHPAC project?
8. What are the key challenges in working with the CIHPAC project and how have you managed this? What opportunities exist?
9. What support have you provided to SFH or SFH provided to you through the CIHPAC project?
10. How do you think the outcomes and impact of CIHPAC can be sustained? What support are you providing to the project in this regard?
11. Should SFH want to scale up the CIHPAC action what suggestions for program effectiveness will you proffer?
In-Depth Interview Guide for USAID Implementing Partner
Comprehensive Integration Approach to HIV & AIDS Prevention and Care Program
End of Project Evaluation

PROFILE OF ORGANIZATION
• What is your organization’s name, vision, values, mission, goals, objectives, legal status and year established?
• Describe your leadership, staffing and project focus.

PROJECT PERFORMANCE RELATIVE TO THE OBJECTIVES

Overview of involvement in CIHPAC project
• Briefly provide an overview of the CIHPAC project that you know [explore knowledge of goals/strategies/objectives/expected output/outcomes]
• What was your organization’s involvement and role in the CIHPAC project?
• Describe the project areas of CIHPAC you were engaged in, and the activities you implemented
• What specific support did you receive and/or provide from or to CIHPAC?
• Who were the key stakeholders that you worked with on the project and for how long?

PROJECT OUTCOME TRENDS
• What would you describe as the key achievements of CIHPAC in the areas in which you have collaborated or have been part of the project? Give examples
• What key changes have resulted from this collaboration? Both expected and unexpected... how? Give examples
• What challenges or limitations did you experience within your involvement with the project and how did you manage these?
• What lessons did you learn from these and how was it used to improve on your collaboration with the project

General
• What other support did you receive from CIHPAC project?
• In what ways do you intend to continue sustaining your process after CIHPAC ends and how has CIHPAC supported you in this regard?
Questionnaire for SFH and USAID Implementing Partners
Comprehensive Integration Approach to HIV & AIDS Prevention and Care Project
End of Project Evaluation

1. Indicate the years you were involved in the CIHPAC project. From: To:

2. Indicate the years the data you are providing covered. From: To:

3. Project Outputs - Please complete the table below to provide the outputs under each project area.

<table>
<thead>
<tr>
<th>A. Abstinence and Be Faithful: Respondents Indicators</th>
<th>Target Value if applicable</th>
<th>Actual Value</th>
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<tbody>
<tr>
<td></td>
<td>M</td>
<td>F</td>
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<tr>
<td>1. Number of individuals reached through community outreach programs that promotes HIV &amp; AIDS prevention through abstinence and/or being faithful</td>
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<td>2. Number of individuals reached through community outreach that promotes HIV &amp; AIDS prevention through abstinence (a subset of total reached with AB)</td>
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<td>3. Number of individuals trained to promote HIV &amp; AIDS prevention through abstinence and/or being faithful</td>
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<tr>
<th>B. Condoms and Other Prevention Indicators</th>
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<tr>
<td>4. Number of targeted condom service outlets</td>
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<tr>
<td>5. Number of individuals reached through community outreach that promotes HIV &amp; AIDS prevention through other behavior change beyond abstinence and/or being faithful (partner reduction, alcohol reduction and condom use)</td>
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<tr>
<td>6. Number of individuals trained to promote HIV &amp; AIDS prevention through other behavior change beyond abstinence and/or being faithful (partner reduction, alcohol reduction and condom use)</td>
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<tr>
<th>C. HIV Counseling and Testing: Respondents Indicators</th>
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<tr>
<td>7. Number of TB patients who received counseling and testing for HIV and received their test results</td>
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<td>8. Number of service outlets providing counseling and testing according to national and international standards</td>
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<tr>
<td>9. Number of individuals who received counseling and testing for HIV and received their test results</td>
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<tr>
<td>10. Number of individuals trained in counseling and testing according to national and international standards</td>
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<tr>
<td>11. Number of HIV+ among individuals counseled and tested and received their results</td>
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<tr>
<th>D. Orphans &amp; Vulnerable Children Indicators</th>
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<tr>
<td>12. Number of PLWHA provided with Basic Care Kit (BCK)?</td>
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<td>13. Number of staff members trained on each of the BCK component with their appropriate usage techniques (Number of providers/caregivers trained in caring for OVC)</td>
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<td>14. Total Primary &amp; Supplemental OVC beneficiaries (0-17 yrs)</td>
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<td>15. Number of BCKs distributed to USAID IPs/ received from SFH</td>
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</tbody>
</table>
### E. TB HIV Indicators

16. Number of TB/HIV focused road shows staged at SFH high risk communities

17. Number of persons reached with TB/HIV focused road shows staged at SFH high risk communities

18. Number of trained IP partner provider staffs using specially designed flip charts to conduct outreaches on TB prevention and management

### F. Policy and Systems Strengthening Indicators

19. Number of FBOs assisted to develop and implement HIV policies and strategic plans

20. Number of FBO leaders trained

21. Number of people trained by the FBO leaders

22. Number of CBOs provided with participatory organizational capacity development

23. Number of people trained in all organizations in community mobilization for stigma reduction and other prevention project

24. Number of other local organizations provided with technical assistance for HIV-related policy development

25. Number of other local organizations provided with technical assistance for HIV-related institutional capacity building

### G. Strategic Information (SI) Indicators

26. Number of individuals trained in SI

27. Number of organizations provided with technical assistance for SI activities

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4. Please provide explanation where you have recorded disparities between the value of targeted outputs and actual outputs obtained below. Please include your means of verification in the explanations.
3. **Project Outcome**: Please complete the table below to provide the outcomes under each of the program area.

<table>
<thead>
<tr>
<th>List Outcome indicators</th>
<th>Expected Outcome</th>
<th>Actual Outcomes</th>
<th>Unexpected Outcomes</th>
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<tbody>
<tr>
<td><strong>A. Abstinence and Be Faithful (NYSC, PRISONS, FBO, OSY, VFH, GENERAL POPULATION)</strong></td>
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<td><strong>B. Condoms and Other Preventions (FSW, TW, FOSY/MOSY, USM CORRIDOR, POSITIVE PREVENTION, TB/HIV, PLACE, PACA)</strong></td>
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<td><strong>C. TB/HIV</strong></td>
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<td><strong>D. Basic care and Support to Orphans and Vulnerable Children (BCK)</strong></td>
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<td><strong>E. Counseling and testing (HCT)</strong></td>
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<td><em>F. Policy and Systems Strengthening (CBO formation, collaborations with CSOs, support to other organizations, collaboration with GON)</em></td>
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<td><em>G. Strategic Information (SI) Indicators</em></td>
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4. Please provide explanation where you have recorded disparities between the expected outcome (quantitative/qualitative) and actual outcome obtained below. Please include your means of verification in the explanations.

5. Show how the project outcomes reflect the achievement of the objectives?

6. Explain the factors that enabled/limited the outcomes of the project intervention and how you managed the process?

7. What lessons did you learn from the process?

8. Staff Qualifications, Characteristics and Skills: Please complete the table below to provide the name, role and qualifications of the key staff directly involved in CIHPAC project implementation

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<thead>
<tr>
<th>Name of Staff</th>
<th>Role</th>
<th>Qualifications/experience</th>
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Appendix D
Bibliography

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