



HIV/AIDS Reduction Program in the Niger Delta (HARPIN)

End of Project Evaluation - Report

By

MiraMonitor Consulting Limited.

Muyiwa Oladosun, PhD. (Lead Consultant)

Charles Ayo Toriola (Consultant), Femi Oladosu, Ifeyinwa Ononye,

Babajide Akinpelu, Emmanuel Oladosu, Patience Bioye, and Saudat Sanni

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ACRONYMS

AB	Abstinence and Be Faithful
ABC	Abstinence, Be Faithful and Condom use
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARH	Adolescence Reproductive Health
ARV	Antiretroviral Therapy
BCC	Behavior Change Communication
CBO	Community Based Organization
CHEW	Community Health Extension Worker
COP	Country Operation Plan
COTR	Contracting Officer's Technical Representative
CRS	Cross-River State
DBS	Dry Blood Sample
EID	Early Infant Diagnosis and Feeding
FGD	Focused Group Discussion
GI	Group Interview
HARPIN	HIV/AIDS Reduction Program in the Niger Delta
HQ	Headquarter
HCT	HIV Counseling & Testing
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HM	Health Moderator
HRH	His Royal Highness
HSIMG	HARPIN Strategic Information Management Guide
IPC	Interpersonal Communication
ISY	In-School Youth
KII	Key Informant Interview
LACA	Local Government Action Committee on AIDS
LGA	Local Government Area
MDA	Ministries, Departments and Agencies
M&E	Monitoring and Evaluation
MIS	Management Information System
MoE	Ministry of Education
MoH	Ministry of Health
MPPI	Minimum Prevention Package Intervention
N/A	Not Applicable
NDDC	Niger Delta Development Commission
NPP	National Priorities Projects
OSY	Out of School Youth
PE	Peer Educator
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary Health Center
PHI	Pro-Health International
PITT	Prevention Intervention Tracking Tools
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
SACA	State Action Committee on AIDS
SBC	Strategic Behavior Communication

SO	Strategic Objectives
STI	Sexually Transmitted Infection
TB	Tuberculosis
TBA	Traditional Birth Attendant
UBE&SNR	Universal Basic Education & Senior Secondary School
USAID	United States Agency for International Development
VCCT	Voluntary Counseling and Confidential Testing

EXECUTIVE SUMMARY

HARPIN was a three-year project implemented by PHI between August 2008 to August 2011 based on PEPFAR funds through USAID/Nigeria, with the aim of providing HIV/AIDS prevention activities in the Niger Delta focusing on Cross River and Rivers states. This end-of-project evaluation was carried out between July and September, 2011 with the main objective of assessing project achievements, challenges, lessons learnt, and recommendations on HIV/AIDS reduction project implementation in the region. A total of 1179 ISY (rivers = 696, cross river = 483), 711 OSY (rivers = 389, cross river = 322), and 480 PMTCT women in cross river state were interviewed using surveyed questionnaires. Four KII and 12 FGD were conducted among beneficiaries, and Twelve KII, three FGD, and two group interviews were conducted among other stakeholders.

Key Findings and Recommendations

- The majority of ISY who participated in this evaluation lived in rural areas (58%), was females (51%), and attended public schools (79%). The majority of OSY lived in rural areas (71%), most were males (57%), and had at least a secondary education (59%). Most PMTCT women were aged at least 25 years (58%), and had junior secondary or lower (98%).
- The project surpassed set USAID targets on sexual prevention for COP 08, and COP 09, and was close to COP 10 targets (based on third quarter statistics). The project met PMTCT targets for COP 09, and was close to the COP 10 targets.
- The majority of ISY (66%) and OSY (91%) reported receiving information on HIV/AIDS and reproductive health and rights, most of the two groups also reported positive change in behavior with respect to abstinence, reduction in the number of sexual partners, non-use of sharp objects, condom use, self discipline and self-esteem, and most were satisfied/very satisfied with the services received and their own involvement.
- Findings showed statistical significant difference in ISY positive behavior change by state and residence, and significant difference in satisfactory/very satisfactory rating of behavior change by sex, and education. Also, data analysis showed significant difference in OSY positive behavior change by residence, and significant difference in satisfactory/very satisfactory rating by education. Future programming need to consider these background factors in designing program tailored to meet their specific needs.
- More OSY (72%) than ISY (56%) received counseling on HIV, and most were satisfied/very satisfied with the services. For ISY, satisfaction in the counseling received differed significantly by state and sex, and for OSY it differed by age, education, and employment status. Findings showed that the majority of PMTCT women (74%) received HIV counseling, had the test (67%), and the majority (65%) got the results, and few were positive (8%). PMTCT women's rating of overall satisfaction on services differed significantly by residence, education, employment status, and number of living children. Future programming effort need to incorporate these factors to ensure maximum participation and cooperation.
- Findings of this evaluation showed that community stakeholders including community leaders, religious leaders, ISY, OSY, and other gatekeepers were well informed and

knowledgeable about HIV/AIDS through series of activities at different platforms but stigma and discrimination is still obvious. Programming may need to address this, through formative research examining socio-cultural factors precipitating HIV stigma and discrimination in the community.

- Evaluation results showed that the human capacity of HARPIN staff were strengthened through formal and informal trainings and workshop, and most trainings relevant to CBOs were stepped down on continuous bases, and the CBOs trained peer educators, and health moderators as well. Continuous trainings and step-down should form part of future programming designed to be effective at the grassroots. Also, CBOs should be empowered more by providing funds for them to engage in independent projects in the community.
- The use of existing community structures worked well in achieving the project's stated objectives, key among which are positive change in behavior regarding HIV/AIDS among ISY, OSY, community leaders, and other community stakeholders. However, findings showed that the use of existing community structure is not sufficient reason to gain acceptance into a community. Programming efforts need to recognize the sensitivity involved in building trust and goodwill at the initial stage of negotiating entry into a community.
- Community PMTCT using PHCs, and TBAs worked well with HARPIN in enlisting pregnant women for HIV test, participation in prophylaxis drugs, and EID, with short-term positive results. In order to get to all nooks and crannies of the community with comprehensive services such as malaria treatment, STI management etc., it may be necessary to incorporate TBAs more into HARPIN programming.
- Evaluation findings showed that the project was over ambitious in terms of scope, coverage, and timing of scale-up. Future programming may need to provide detailed plan to scale-up operations to address gaps in the cooperative agreement. This will be the real realignment necessary to launch the project into greater heights expected by most stakeholders in the future.
- Compared to the beginning, the project fared well in retaining qualified staff, and in standardizing managerial operations. It be necessary in the future to address staff issues including, getting more qualified staff in specific positions like communication expert etc, reviewing conditions of service to include health insurance, and security provisions in difficult terrain, and beef-up volunteer benefits to motivate them more.
- Overall, the project performance may be rated as near satisfactory with lots of rooms for administrative and programming improvement in the future.

INTRODUCTION

Since the advent of HIV/AIDS in Nigeria in 1986, several organizations, both local and international, have been involved in programs geared to mitigate the impact of the disease. In August 2008, Pro-Health International (PHI) received \$5,799,008 PEPFAR funds through USAID/Nigeria for HIV/AIDS Reduction Program in the Niger Delta (HARPIN). It was a three years project implemented by PHI in Cross River and Rivers states to contribute to USAID/Nigeria Strategic Objectives (SO) 14 by targeting youths, couples, and pregnant women with prevention activities, HCT and PMTCT services.

The HARPIN objectives stated in the cooperative agreement are:

- To increase community members' knowledge of HIV transmission, especially youth, pregnant women and TBAs in 18 LGAs of Cross River and Rivers States.
- To increase VCCT Uptake among the people of Cross River and Rivers States.
- To educate communities about HIV/AIDS transmission and reduce the stigma associated with HIV/AIDS.
- To strengthen the capacity of PHI and its partners in carrying out HIV/AIDS prevention activities.

PHI and HARPIN staff reviewed and refocused these objectives in the one year extension received from USAID/Nigeria. Implications of the project objectives stated in the cooperative agreement and the current revised versions are discussed in the management section of this report.

Project Strategies

Peer-Led Approach: This is mainly championed by peer educators (PEs) of in-school youths (ISY), and health moderators (HMs) of out-of-school youths (OSY) that were identified in their respective schools and communities, and trained on how to provide friends, colleagues and people of similar age groups with information on HIV/AIDS, and STIs transmission, and basic knowledge about anatomy, and physiology of the male and female reproductive system, risky sexual behavior, stigma, and discrimination, etc. PEs and HMs educated their peers through exposure to; peer education sessions, small group discussions, and health clubs (for ISY), and community based organizations (CBOs) for OSY.

Community Outreach Approach: This involved visits by CBOs, HMs, and TBAs to intervention communities to identify key gatekeepers and influential personalities e.g. clan heads, wards, village heads, youth leaders, support group leaders, religious leaders, union leaders, and parents who were used as entry points for advocacy on issues surrounding HIV/AIDS, community mobilization, stigma reduction, and gender among others.

Community Dialogue & Support of CBOs: This involved activities by PHI to strengthen CBOs through training to educate and engage community members on harmful social and cultural norms, values, attitudes, and practices through debates, forums, rallies, and interpersonal counseling and communications.

Small Grants Approach: This was designed to give local CBOs the opportunity to provide Behavior Change Communication (BCC) activities at the grassroots as well as enhancing

financial management capabilities. The approach was intended to improve geographical coverage while maximizing impact of project activities.

Minimum Package: The HARPIN minimum package refers to the number of activities that a target population member is exposed to be counted as beneficiary of the project. For ISY, the minimum package is defined as involvement in peer education, small group discussion, and health club. And for OSY, the minimum package is peer education, small group discussion, and interpersonal communication (IPC). Packages for PMTCT women include, HIV counseling and testing, antiretroviral prophylaxis, and early infant diagnosis (EID).

Program Areas

HARPIN is mainly focused on prevention of HIV transmission in selected LGAs and communities with activities targeting specific sub-groups including: (1) in-school-youth (ISY) aged 20 to 29, (2) out-of-school youth (OSY) aged 20 to 39, (3) pregnant women, through prevention of mother to child transmission (PMTCT) services, and (4) collateral sub-groups which includes prevention activities to people that are not in the ISY and OSY age groups.

Main Evaluation Objective

To assess project achievements, challenges, and lessons learnt in HIV/AIDS reduction program implementation in the Niger Delta (with specific focus on Cross River and Rivers States).

Specific Objectives

To evaluate project outcomes and results in terms of:

- Changes in knowledge with respect to HIV/AIDS and sexual health among vulnerable youth in the intervention communities.
- Reduction in risky sexual behaviors among the target sub-groups.
- Meeting the demands for confidential HCT services through referral.
- Increased usage of HCT services among pregnant women.
- Improved accessibility to ARV among HIV positive pregnant women.
- Promoting safer infant feeding practices among HIV positive mothers.
- Improved maternal health services among women of reproductive age.
- Building local capacity including coping strategies, project implementation, and sustainability.

Evaluation Methods

The evaluation employed participatory approach involving consultation with key PHI/HARPIN staff, CBOs, beneficiaries, key community leaders, government agencies including; MoH, MoE, SACA, LACA, and USAID. It employed ex-post comparison design in eliciting information from key stakeholder combining both qualitative & quantitative techniques. The evaluation included

review of project documents key of which are; cooperative agreement, proposal document for one year extension, annual and quarterly reports, service statistics, and training manuals and documents.

Quantitative methods:

Table 1: Quantitative samples distributed across rivers and cross rivers states

<i>Target Group</i>	<i>Rivers</i>	<i>Cross River</i>	<i>Total</i>
In-School Youth (ISY)	696	483	1179
Out-of-School Youth (OSY)	389	322	711
PMTCT (women)	N/A	480	480
Total	1085	1285	2370

N/A ó not applicable

Quantitative methods were employed in sampling ISY, OSY, and PMTCT women. In both Rivers and Cross Rivers states, a total number of 19 schools were purposively selected, 12 from Rivers and seven from Cross River state. Schools were selected to ensure representation of schools that started with the project three years ago, and those that joined recently. Each selected school is taken as a cluster and the interview teams administered a structured questionnaire in a face-to-face fashion to students who were exposed to the project activities. In total, 1179 ISY were interviewed, 696 in Rivers, and 483 in Cross River states.

For OSY, a total of 25 communities were visited by the evaluation team, 17 in rivers, and eight in cross river state. Each community is taken as a cluster of OSY and the evaluation team administered structured questionnaire in a face-to-face fashion to all that were mobilized in each community for the evaluation. In total, 711 OSY were interviewed, 389 in rivers, and 322 in cross river.

The evaluation team in Cross River state visited 11 of the 34 primary health care (PHC) facilities where intervention activities took place (including a few that were less than a year in the project). And all women who came to the health facilities during the evaluation team visit were interviewed using a structured questionnaire. In total, 480 women who visited the facilities or had received either ANC or post-natal care were interviewed.

Table 2: Distribution of Evaluation participants according to quantitative techniques.

<i>Beneficiaries</i>	<i>Rivers</i>	<i>Cross River</i>	<i>Other Stakeholders</i>	<i>Rivers</i>	<i>Cross River</i>
In-school	FGD = 2	FGD = 2	HARPIN field staff	GI = 2 KII = 1	KII = 4
			HARPIN HQ staff	KII = 3	
Out of school	FGD = 1	FGD = 3	School Principals	KII = 6	KII = 4
Peer educators	FGD = 1		MDAs	KII = 2	KII = 1
Health moderators	FGD = 2	FGD = 1	Community Leaders	FGD = 2	FGD = 1
PMTCT-Health Provider	N/A	KII = 3	USAID		
TBA	N/A	KII = 1			
Total	FGD = 6	FGD = 6, KII = 4		GI = 2, KII = 12, FGD = 2	KII = 9, FGD = 1

Note: N/A = not applicable, FGD = Focused Group Discussion, KII = Key Informant Interview, and GI = Group Interview

Key informant interviews (KII), focused group discussion (FGD), and group interviews (GI) were employed to elicit information addressing core evaluation questions. Among beneficiaries (including health provider), a total of 12 FGDs, and 4 KII were conducted and among other stakeholders a total of 21 KII, 3 FGD, and 2 GI were conducted in the two states.

Field Experience

The field work component of the evaluation began in Port-Harcourt, the capital of Rivers state on July 25, 2011 with preparatory activities including presentations on project activities and overview from HARPIN staff. Preparatory activities in Port-Harcourt included selection and training of interviewers for the state, development of qualitative and quantitative instruments, pre-tests of the instruments, photocopying adequate number of instruments and logistics. Preparatory activities at Calabar, the capital of Cross Rivers state included recruitment and training of interviewer, photocopying of instruments, and logistics arrangement.

Data collection was carried out simultaneously at the two states from July 28 through August 2, 2011. The team visited communities in seven LGAs and elicited information from youth, women attending PHC, community leaders, heads of schools, and other stakeholders including government officials.

The level of awareness and advocacy about HIV/AIDS in the communities visited was remarkable, the awareness and support of the HARPIN was evident even in remote communities like Nua-Sogho community in Khana LGA. Mobilization of the beneficiaries was slow in the first few days, but the support received from the community was very impressive. In general, awareness and knowledge about HIV/AIDS was obvious in the communities that the evaluation team visited.

Although most of the ISY had already finished their end of term exams, considerable number were available for interview, and were happy to provide information about HARPIN activities. This showed commitment by beneficiaries to the project and the services rendered. Also, the collaborative efforts of the stakeholders particularly the community leaders and school principals in the state were remarkable.

Limitations of Evaluation

The evaluation relied on retrospective questioning which may have been affected by memory lapse and inability to remember the activities of the last few years. Results of this evaluation would have been better confirmed by comparing with a baseline and/or mid-term evaluation results which may have suggested change in behaviors due to the project intervention. However, there is no evidence to suggest that positive change did not occur in the communities where intervention took place, but ascertaining the magnitude of change of effect of the project may be difficult without baseline and/or mid-term evaluation outcomes.

Due to the transient nature of in-school and out-of-school youth, the proportion of students who either graduated or moved to other locations may not have been adequately captured in the samples. Also, the mobilization effort for the evaluation was slow at the beginning of fieldwork but picked-up as fieldwork progressed. Slow mobilization at the beginning of fieldwork affected schedules and delayed other stages in the evaluation process, thus affecting actual sample sizes obtained. However, slow mobilization did not have any substantial bearing on the scope or quality of the evaluation since quantitative samples were substantial and fairly evenly distributed across sub-groups and communities.

KEY FINDINGS

Background Characteristics: In-School Youth

This section describes the background characteristics of beneficiaries of the HARPIN based on the samples obtained at the time of fieldwork on ISY, OSY, and PMTCT women.

Table 3: Percentage distribution of in-school youth by selected basic characteristics

	In-School (%)
Total (N)	1179
State	
Rivers	59%
Cross River	41%
Sex	
Male	49%
Female	51%
Age group (in years)	
14 or younger	41%
15 to 18	50%
19 or older	9%
Residence	
Rural	57%
Urban	43%
Level of Education	
Primary	1%
Junior Secondary	32%
Senior Secondary	59%
Others	8%
Type of School	
Public	79%
Private	21%
Total	100%

Table 3 shows that the ISY who participated in this evaluation were slightly more of females (51%) than males (42%), and were mostly aged 15 years or older (59%), resident in rural areas (57%), and were more of senior secondary students (59%), in public schools (79%).

Background Characteristics: Out-of-School Youth

Table 4: Percentage distribution of out-of-school youths by selected basic characteristics

	Out-of-School (%)
Total (N)	711
State	
Rivers	55%
Cross River	45%
Sex	
Male	57%
Female	43%
Age group (in years)	
14 or younger	1%
15 to 18	6%
19 to 24	34%
25 to 29	23%
30 or older	36%

Residence	
Rural	71%
Urban	29%
Level of Education	
None	26%
Primary	15%
Junior Secondary	5%
Senior Secondary	45%
Others	9%
Currently Employed/Self Employed	
Yes	43%
No	57%
Type of Employment	
None/Apprenticeship	41%
Trading	22%
Tailoring	6%
Mechanic/Driver	5%
Others	26%
Total	100%

On the background characteristics of OSY, Table 4 showed that the majority were males (57%), aged 25 years or older (60%), who lived in rural areas (71%), had at least a junior secondary education (59%), and were unemployed (57%). Also, the table showed that employed OSY were traders (22%), tailors (6%), and mechanic/drivers (5%).

Background Characteristics: PMTCT Women

Table 5: Percentage distribution of women attending anti-natal/post-natal care by selected basic characteristics

	PMTCT (%)
Total (N)	480
Pregnancy Status	
Pregnant	42%
Not-pregnant	58%
Marital Status	
Single	15%
Widowed/Divorced	4%
Married	81%
Age group (in years)	
19 or younger	13%
20 to 24	29%
25 to 29	32%
30 or older	26%
Residence	
Rural	62%
Urban	38%
Level of Education	
Primary	50%
Junior Secondary	48%
Senior Secondary	2%
Currently Employed/Self Employed	
Yes	54%
No	46%
Type of Employment	

None/Apprenticeship	37%
Hairdresser	9%
Tailoring	11%
Trading	31%
Others	12%
Number of children alive	
None	4%
1 to 3	75%
4+	21%
Total	100%

The majority of women who attended the PHC where HARPIN services were provided were not pregnant (58%) at the time of interview. Most women interviewed were married (82%), aged 25 or older (58%), lived in the rural areas (62%), had mostly junior secondary or primary education (98%), were employed/self-employed (54%) and mainly engaged in trading (31%), tailoring (11%), and hairdressing (9%).

Achievements

This section discusses project achievement based on key USAID/Nigeria indicators of performance and objectives stated in the cooperative agreement.

Target Performance

This section reviews project performance on key USAID indicators from inception to the time of the evaluation based on available data.

Table 6: Selected performance indicators and targets between COP 08 and COP 10

<i>Performance indicators</i>	<i>Expected</i>			<i>Achieved</i>		
	COP 08	COP 09	COP 10	COP 08	COP 09	COP 10*
Sexual Prevention Program						
1 # of individuals reached with individual/small group interventions primarily focused on abstinence and/or being faithful	12,000	15,000	18,182	16,222 (135%)	15,981 (106%)	19,912 (109%)
2 # of targeted population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required	600	19,800	27,273	700 (117%)	20,647 (104%)	25,938* (95%)
3 # of individuals trained to promote HIV/AIDS program	n/a	n/a	n/a	1,431	1,593	1,488
PMTCT Program						
1 # of pregnant women with known HIV status (includes women who tested for HIV and received their results)	n/a	2,400	6,873	n/a	2,468 (102%)	4,913* (71%)
2 # of HIV-positive women who received antiretroviral to reduce risk of mother-to-child-transmission	n/a	n/a	344	n/a	48	270 (78%)
3 Total number of DBS collected for Early Infant Diagnosis (EID)	n/a	n/a	n/a	n/a	15	37
4 # of DBS Positive	n/a	n/a	n/a	n/a	1	7
5 # of DBS Negative	n/a	n/a	n/a	n/a	14	20

Note: Data source from HARPIN report to USAID, * = total achieved for Q1 ó Q3, excluding Q4.

Sexual Prevention Indicator Performance

Table 6 presents USAID targets for the HARPIN and how well these were achieved. In general, the project met and surpassed all sexual prevention targets for COP 08 and COP 09, and close to reaching targets for COP 10 (figures for quarter 4, not included here). On the number of individuals reached with one-on-one or group intervention focused on abstinence and/or be faithful, the project surpassed target by 35% in COP 08, 6% in COP 09, and already surpassed target for COP 10 by 9% excluding figures on the last quarter of the year. Likewise, on population reached with individual and/or small group intervention on HIV based on evidence and/or minimum standards, the project surpassed target in COP 08 by 17%, COP 09 by 4%, and 95% for COP 10 which is close to 100% without fourth quarter figures. No available information on targets set for the indicator on the number of individuals trained to promote HIV/AIDS program.

PMTCT Target Indicator Performance

Table 6 shows statistics for the PMTCT component of the program. Of the five PMTCT indicators presented, two were USAID/Nigeria and three were additional indicators tracked by HARPIN. Statistics in the Table show that the project was close to the target (78%) on number of HIV-positive women who received antiretroviral drugs to reduce risk of mother-to-child transmission (excluding fourth quarter figure). One of HARPIN own tracked indicators is the number of DBS collected for Early Infant Diagnosis (EID). Results show that 15 DBS were diagnosed in COP 09, of which one was positive, and of the 37 DBS collected for EID in COP 10, seven were positive. Thus, the project to some extent contributed to averting HIV transmission between mother and child in the communities where they operated.

Objective I: To increase community members' knowledge of HIV transmission, especially youth, pregnant women, and TBAs in 18 LGAs of Cross River and Rivers States.

Change in knowledge with respect to HIV/AIDS and sexual health

This section discusses findings on exposure to information about HIV/AIDS and how these have changed the perception, and attitudes of the respondents for the better.

Table 7: Percentage of in-school-youth according to types of information received/activities that they were involved with

<i>Types of Information/Activities</i>	<i>In-School (%)</i>
Total (N)	1179
Adolescent Reproductive Health & Rights	66%
HIV/AIDS	83%
Care & Support for HIV/AIDS	48%
Life Building Skills	44%
Peer Education	66%
Health Club Activities	36%
Small Group Discussions	30%

As Table 7 above shows, three main information/activities that most ISY reported been exposed to are; HIV/AIDS (83%), adolescent reproductive health and rights (66%), and peer education (66%), followed by care and support for HIV/AIDS patients (48%), and life building skills (44%).

Table 8: Percentage of out-of-school youth according to types of information received/activities exposed to during the life of the project.

<i>Types of Information/Activities</i>	<i>Out-of-School (%)</i>
Total (N)	711
Adolescent Reproductive Health & Rights	96%
HIV/AIDS information/services	98%
Care & Support for HIV/AIDS	98%
Condom Messaging	91%
Peer Education	84%
CBOs Activities	80%
Interpersonal Communications (IPCs)	83%

Findings in Table 8 compared to that in Table 7 shows that in general, more OSY than ISY reported receiving information/activities through HARPIN. Most OSY reported receiving information/services on HIV/AIDS (98%), care and support for HIV/AIDS (98%), and adolescent reproductive health and rights (96%). Others information/services received are; peer education (84%), interpersonal communication (83%), and participation in CBOs activities (80%).

Ratings of Information/Services Received

This section examines ISY and OSY perceived quality of information/services in order to ascertain whether these were beneficial or not.

Table 9: Percentage distribution of in-school respondents according to ratings of quality of information/activities exposed to during the project life

Indicators of services					Total (N)
	Not Satisfactory/don't know	Fairly Satisfactory	Satisfactory	Very Satisfactory	
Information received about HIV/AIDS	4%	7%	45%	44%	1108
Behavior Change	2%	6%	48%	44%	1077
HCT information	5%	9%	50%	36%	276
Support Group Activities	1%	5%	40%	54%	330
Overall Satisfaction	1%	4%	40%	55%	978

As Table 9 shows, most ISY reported satisfactory/very satisfactory on information received about HIV/AIDS (89%), behavior change (92%), HCT information (86%), and support group activities (94%). Overall, most ISY (95%) rated information/activities exposed to as satisfactory/very satisfactory.

Table 10: Percentage distribution of out of-school respondents according to ratings of quality of information/activities exposed to during the project life

Indicators of services					Total (N)
	Not Satisfactory/don't know	Fairly Satisfactory	Satisfactory	Very Satisfactory	
Information received about HIV/AIDS	1%	5%	55%	39%	662
Behavior Change	1%	6%	53%	40%	657
HCT Services Received	1%	3%	56%	40%	340
Support Group Activities	1%	2%	38%	59%	125
Overall Satisfaction	1%	2%	30%	67%	490

Similarly, Table 10 shows that the majority of OSY rated the information/activities exposed to during the life of the project including; HIV/AIDS, behavior change, HCT services, support group as satisfactory/very satisfactory (94%, 93%, 96%, and 97% respectively). And overall, most OSY rated information/activities exposed to as satisfactory/very satisfactory (97%).

Changes in knowledge with respect to sexual health

This section examines whether any change occurred among ISY and OSY as a result of exposure to the project information/services.

Table 11: Percentage of youths according to knowledge of things/activities before and after participating in the project

<i>Things/Activities</i>	<i>In-School</i>		<i>Out- of School</i>	
	<i>Before (%)</i>	<i>After (%)</i>	<i>Before (%)</i>	<i>After (%)</i>
Male reproductive organs	59%	88%	90%	93%
Female reproductive health	58%	86%	91%	92%
Definition of puberty	42%	85%	73%	87%
Ovulation	32%	80%	74%	85%
Fertilization	36%	82%	62%	89%
Pregnancy	52%	86%	93%	94%
Sexually transmitted disease	41%	84%	66%	91%
Gender & sex roles	19%	72%	65%	77%
Substance abuse	22%	76%	68%	79%
HIV/AIDS	50%	86%	86%	92%
Life building skills (condom messaging for OSY)	20%	75%	55%	75%
Peer education	28%	84%	57%	83%
Total (N)	1179		711	

Results in Table 11 shows that more ISY reported knowledge after than before exposure to project information/activities in terms of; male reproductive organs (59% vs. 88%), female reproductive organs (58% vs. 86%), ovulation (32% vs. 80%), and fertilization (36% vs. 82%).

Qualitative findings of ISY in all communities visited in both cross river and rivers suggest improved knowledge about HIV/AIDS and change in behaviors. Excerpts below, one from KII with a school principal, and FGDs with ISY peer educators and ISY summarize opinions on changes in knowledge about HIV/AIDS as a result of the project intervention.

øThere are marked differences in the attitudes of the students. They are now free to tell themselves to abstain from sex that is not a part of life as they think. There is a feeling of friendship within the group and there are no longer shy to talk or interact with people. They don't feel ashamed to speak about reproductive organs in males and females. (Vice-Principal, Rivers State).

øPE1: I use to have stage fright but after I join the club and we were taught how to communicate and also about HIV/AIDS and how to educate our peers I became bold to talk to others. PE2: I didn't know much about HIV but when the peer educators came and taught me I now know much about HIV/AIDS and can spread the message across and educate others. PE3: Basically before the program I know nothing about sex education but after am more inform. (PE1 to PE3, are from Peer Educator ISY FGD, Cross River).

øISY1. I was not into healthy living before but now as a result of the project, it has really enable me to live a healthy life, and I know more about HIV, STI. ISY2. I do not use to endure with affected person and I did not know that HIV can be acquired from one person to another. I thought HIV can be transfer through mosquito but I know better now. ISY3. I thought HIV can be transmitted from one person to another not knowing that it can be transmitted through so many ways. ISY4. Before I thought a virgin cannot contract HIV/AIDS not until I attended their meeting that I actually got the message. ISY5. I was naïve about HIV/AIDS before it came to my knowledge that there was a program in the school that helps you to create mental images about AIDS and how it affects human being. (ISY1 to ISY5, from ISY FGD, Cross River).

In general results for OSY on knowledge increase with respect to exposure to specific project information/activities were similar to those of ISY. However, more OSY compared to ISY had knowledge about specific project information/activities before and after intervention. Table 9 show that after exposure to project information/activities, more OSY reported knowledge about sexually transmitted diseases (41% vs. 84%), gender and sex roles (19% vs. 72%), and substance abuse (22% vs. 76%), HIV/AIDS (50% vs. 86%), life building skills (20% vs. 75%), and peer education (28% vs. 84%).

Qualitative findings from health moderators and OSY in the excerpts below corroborate survey results on increased awareness and knowledge about HIV/AIDS, reduction in myths and misconceptions about HIV, and perception about discrimination against PLWHA.

HM1: “The program has helped correct my impression and assumptions about HIV/AIDS. **HM2:** As health worker my friend introduced me to the program (A health moderator workshop organized by Pro-Health) through this means I have been creating awareness about the virus. **HM2:** Initially I used to think AIDS was contacted through sex alone and discrimination used to be the order of the day that was before exposure to the program. I felt it was for prostitutes alone even black and white thing and those who have sex with animals. I even thought you get it through “juju.” **HM3:** As a result of the program my level of knowledge has increased from 50% to 85% through new knowledge of the HIV/AIDS scourge. **HM4:** Before I don’t know anything about female condoms, now I do. **HM5:** PLWHA can live a normal life but before I felt it was the

Changes in behavior with respect to HIV/AIDS

This section presents findings on changes in behavior as a result of better knowledge and understanding of HIV/AIDS, ways of transmission, and myths and misinformation about the disease.

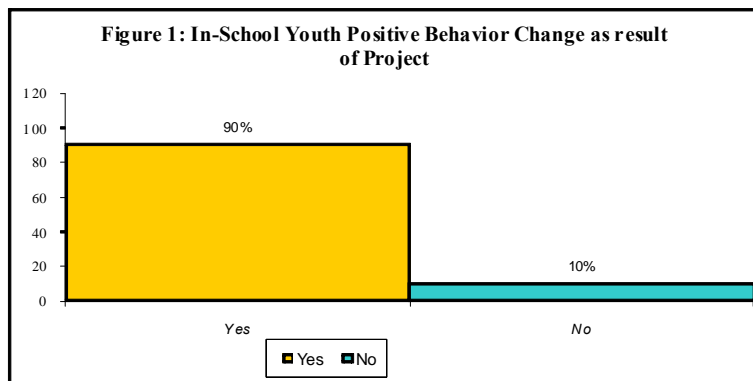


Figure 1 shows that most ISY (90%) reported positive change in behavior as a result of exposure to project information/activities. Positive behavior change was defined based on qualitative ISY and OSY responses key of which are: avoiding sex, not having sex with many people, condom use, avoiding use of sharp objects, improved interaction with colleagues and others, improved hygiene, being careful in all things and discipline and self esteem.

Excerpts in the two boxes below further corroborate youth responses on positive behavior change.

ö**ISY6:** I benefited in the (HARPIN project) in the area of information about protection. **ISY7:** It has informed my character and my level of interaction when am in the midst of peers has changed. **ISY8:** I benefit not have sex with so many people and STI.ö (**ISY6 to ISY8, from FGD in Cross River**).

ö**ISY9:** That someone with STI can transfer it to me I should lick his penis. Avoid pregnancy so as not to drop out of school. **ISY10:** I learnt that we should avoid sex so that we will not get teenage pregnancy. I learnt that for the girls if they have menstruation they should take their bath three times. **ISY11:** That husband and wife should be faithful to each other. **ISY12:** I learnt that we should be very careful with all the things we do. (**ISY9 to ISY12, from FGD, Rivers**).

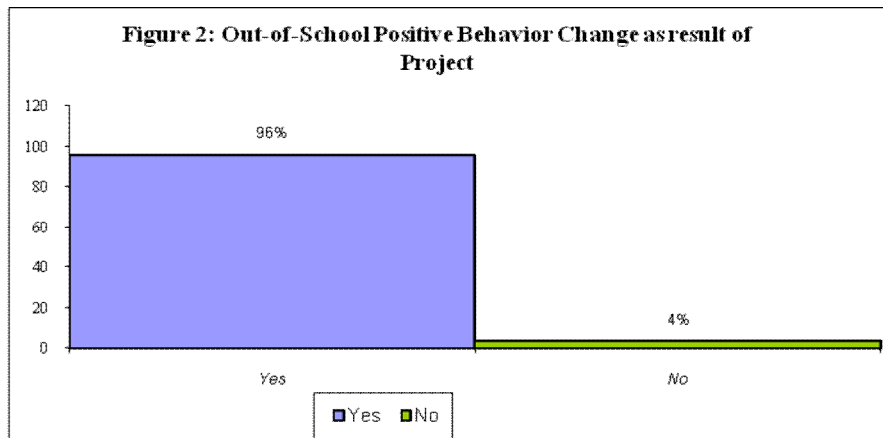


Figure 2 also shows that most OSY reported positive change in behavior as a result of exposure to project information/activities. In general, results from qualitative data analysis corroborate the positive change in behavior experienced among youths who participated in the project activity irrespective of whether they were ISY or OSY.

OSY1: öFor my own side if I meet with a girl, I use condom now. Like if I go with a girl, I will not pregnant the girl so I have learnt how to go with a girl. **OSY2:** What I have benefited is how to take care of myself because of HIV by using condom to protect me. Like now ehn, like razor that someone use, I know I will not use it again because I that through the razor, I can contact the disease again. I benefit some things because of clipper, when I enter a barbing salon, I will tell the person to burn it so that I will not contract any HIV. **OSY3:** My life has changed since my involvement in the project and I have been able to extend the teachings by spreading the awareness. I have benefited a lot because I no longer share sharp objects.ö

Table12: Percentage distribution of ISY according to satisfaction rating on positive behavior change by selected basic characteristics

<i>Background characteristics</i>	<i>% Positive behavior change</i>	<i>% Satisfaction ratings on behavior change</i>			
		Not satisfactory	Fairly satisfactory	Satisfactory	Very satisfactory
Total (N)	1077				
State					
Rivers	87%	3%	7%	49%	42%
Cross River	95%	1%	5%	46%	48%
P-value	0.000			0.196	
Sex					
Male	89%	1%	8%	47%	44%
Female	92%	3%	4%	48%	45%
P-value	0.117			0.016	
Age group (in years)					
14 or younger	92%	1%	4%	50%	45%
15 to 18	90%	3%	7%	46%	47%
19 or older	87%	4%	8%	46%	42%
P-value	0.187			0.228	
Residence					
Rural	93%	4%	7%	43%	45%
Urban	88%	2%	8%	48%	41%
P-value	0.005			0.603	
Level of Education					
Primary	89%	11%	-	56%	33%
Junior Secondary	90%	1%	4%	55%	41%
Senior Secondary	90%	3%	7%	44%	47%
Others	94%	1%	10%	51%	39%
P-value	0.647			0.006	

Note: statistical significance is at 0.05, 0.01, and 0.001 levels.

Findings in Table 12 above shows significant difference in positive behavior change of ISY across state, and residence. More ISY in cross river than rivers states reported positive behavior changes after been involved in project activities (95% vs. 87%, p-value = 0.000), and more rural than urban ISY reported positive behavior change (93% vs. 88%, p-value = 0.005).

Also, results in Table 12 indicate significant differences in satisfaction rating on positive behavior change by sex, and by levels of education. More females than males reported that they were satisfied/very satisfied with their behavior change due to involvement in the project (93% vs. 91%, p-value = 0.016). More ISY with at least a junior secondary education than those with no education rated positive behavior change as satisfactory/very satisfactory (96% vs. 89%, p-value = 0.006).

OSY Positive Behavior Change, Satisfaction Ratings & Background Characteristics

Table 13: Percentage of out-of-school respondents according to satisfaction on positive behavior change by

selected basic characteristics

Background Characteristics	Positive Behavior change	Satisfaction Ratings on Positive Behavior Change			
		Not Satisfactory	Fairly Satisfactory	Satisfactory	Very Satisfactory
State					
Rivers	95%	1%	5%	51%	42%
Cross River	97%	1%	4%	55%	39%
P-value	0.418	0.283			
Sex					
Male	97%	1%	6%	51%	40%
Female	95%	%	%	%	%
P-value	0.338	0.157			
Age group (in years)					
14 or younger	100%	0	0	75%	25%
15 to 18	94%	0	0	63%	34%
19 to 24	95%	1%	3%	59%	36%
25 to 29	97%	2%	6%	52%	38%
30 or older	96%	1%	6%	49%	43%
P-value	0.833	0.706			
Residence					
Rural	95%	1%	6%	55%	37%
Urban	98%	1%	1%	54%	44%
P-value	0.047	0.043			
Level of Education					
None	98%	1%	3%	53%	43%
Primary	94%	1%	7%	65%	25%
Junior Secondary	94%	-	3%	56%	41%
Senior Secondary	96%	1%	4%	54%	39%
Others	96%	-	7%	43%	50%
P-value	0.680	0.196			
Currently Employed/Self Employed					
Yes	96%	1%	7%	50%	40%
No	97%	1%	3%	58%	37%
P-value	0.090	0.054			

Note: statistical significance is at 0.05, 0.01, and 0.001 levels.

Findings in Table 13 above show statistical significant difference in positive behavior change by urban-rural residence. More OSY in urban than rural areas reported positive behavior change as a result of their involvement in the project (98% vs. 95%, p-value = 0.047). And more OSY in urban than rural areas reported that the change in behavior was satisfactory/very satisfactory (98% vs. 92%, p-value = 0.043). These results are important for programming geared to maximize impact among sub-groups of a target population.

Objective 2: To Increase VCCT uptake among the people of Cross River and Rivers states.

This section is presented in two parts, (1) ISY and OSY counseling on HIV, and (2) PMTCT services including HCT of pregnant women, early infant diagnosis of HIV and monitoring, and antiretroviral treatment. This objective started with counseling on HIV but was broadened to incorporate testing of pregnant women and prevention of HIV transmission to infants.

Findings of this evaluation showed that more OSY (72%) than ISY (56%) reported receiving counseling on HIV from the project. The majority of ISY (84%), and OSY (96%) rated counseling services received as satisfactory/very satisfactory.

Table 14: Percentage distribution of ISY according to satisfaction rating on counseling on HIV received by selected basic characteristics

<i>Background characteristics</i>	<i>% Satisfaction ratings on counseling on HIV</i>			
	Not satisfactory/Don't know	Fairly satisfactory	Satisfactory	Very satisfactory
State				
Rivers	2%	8%	56%	34%
Cross River	12%	13%	35%	40%
P-value	0.000			
Sex				
Male	7%	8%	54%	31%
Female	4%	12%	39%	45%
P-value	0.042			
Age group (in years)				
14 or younger	4%	15%	45%	36%
15 to 18	7%	6%	48%	39%
19 or older	10%	3%	60%	27%
P-value	0.092			
Residence				
Rural	8%	8%	48%	36%
Urban	3%	10%	50%	36%
P-value	0.436			
Level of Education				
Primary	0	50%	0	50%
Junior Secondary	7%	13%	47%	33%
Senior Secondary	4%	8%	52%	36%
Others	16%	4%	32%	48%
P-value	0.093			

Table 14 showed that ISY's satisfaction on HIV counseling differed significantly by state and sex. More ISY in rivers than in cross river state were satisfied/very satisfied with HIV counseling services received (90% vs. 75%, p-value = 0.000). There was slight significant difference in the proportion of male (85%) vs. female (84%) ISY who reported involvement in the project's HIV counseling services.

Table 15: Percentage of out of-school respondents according to satisfaction on counseling on HIV received by selected basic characteristics

<i>Background Characteristics</i>	<i>Satisfaction Ratings on counseling on HIV</i>			
	Not Satisfactory	Fairly Satisfactory	Satisfactory	Very Satisfactory
State				
Rivers	2%	3%	49%	45%
Cross River	0	3%	60%	37%
P-value	0.082			
Sex				
Male	1%	4%	56%	39%
Female	3%	2%	55%	40%
P-value	0.495			
Age group (in years)				
14 or younger	0	0	71%	29%
15 to 18	0	0	72%	28%
19 to 24	0	2%	55%	42%
25 to 29	1%	8%	66%	25%
30 or older	4%	2%	44%	50%
P-value	0.017			
Residence				
Rural	1%	5%	55%	39%
Urban	2%	1%	56%	41%
P-value	0.188			
Level of Education				
None	1%	2%	56%	41%
Primary	3%	0	78%	19%
Junior Secondary	0	0	61%	39%
Senior Secondary	1%	5%	54%	40%
Others	5%	0	40%	55%
P-value	0.042			
Currently Employed/Self Employed				
Yes	4%	2%	48%	46%
No	0	4%	60%	36%
P-value	0.004			

Findings in Table 15 suggest that more OSY aged 18 or less than those aged 19 or older reported that they were satisfied/very satisfied with the HIV counseling services received (100% vs. 97% or less, p-value = 0.017). In general, more OSY with junior secondary or primary or none reported that they were satisfied/very satisfied about the HIV counseling services received from the project (97% or more vs. 95% or less, p-value = 0.042). And more unemployed OSY than those employed reported that they were satisfied/very satisfied with HIV counseling services received (96% vs. 94%, p-value = 0.004).

Overall Satisfaction of ISY & OSY on Information/Services

Table 16: Percentage distribution of In-School respondents according to overall satisfaction by selected basic characteristics

Background Characteristics	Overall Satisfaction			
	Not Satisfactory	Fairly Satisfactory	Satisfactory	Very Satisfactory
State				
Rivers	1%	3%	30%	65%
Cross River	1%	6%	36%	57%
P-value	0.093			
Sex				
Male	1%	5%	33%	61%
Female	2%	3%	33%	62%
P-value	0.326			
Age group (in years)				
14 or younger	0	5%	37%	58%
15 to 18	2%	3%	30%	64%
19 or older	1%	4%	33%	61%
P-value	0.032			
Residence				
Rural	2%	4%	34%	61%
Urban	1%	4%	31%	63%
P-value	0.512			
Level of Education				
Primary	0	0	57%	43%
Junior Secondary	0	4%	37%	58%
Senior Secondary	2%	4%	30%	65%
Others	3%	10%	33%	54%
P-value	0.087			

Note: statistical significance is at 0.05, 0.01, and 0.001 levels.

Table 16 shows results on overall satisfaction of ISY about information/services received were disaggregated by background characteristics and tested for statistical significance. Findings show significant difference in age by satisfaction rating. More ISY aged 14 or younger than those aged 15 or older rated the project information/services received as satisfactory/very satisfactory (95% vs. 94%, p-value = 0.032).

Table 17: Percentage distribution of Out-of-School respondents according to overall satisfaction by selected basic characteristics

Background Characteristics	Overall Satisfaction			
	Not Satisfactory	Fairly Satisfactory	Satisfactory	Very Satisfactory
State				
Rivers	0	2%	21%	77%
Cross River	1%	3%	40%	56%
P-value	0.000			
Sex				
Male	1%	2%	31%	65%
Female	0	2%	29%	69%
P-value	0.317			
Age group (in years)				
14 or younger	0	0	60%	40%
15 to 18	0	3	47%	50%
19 to 24	2%	1%	37%	60%
25 to 29	0	2%	24%	74%
30 or older	1%	2%	31%	66%
P-value	0.085			
Residence				
Rural	1%	2%	30%	67%
Urban	1%	1%	34%	64%
P-value	0.736			
Level of Education				
None	0	3%	36%	61%
Primary	2%	2%	31%	65%
Junior Secondary	0	4%	33%	63%
Senior Secondary	1%	1%	27%	71%
Others	2%	5%	27%	66%
P-value	0.485			
Currently Employed/Self Employed				
Yes	1%	2%	27%	70%
No	0	2%	33%	65%
P-value	0.320			

Note: statistical significance is at 0.05, 0.01, and 0.001 levels.

Finding in Table 17 above shows that more OSY in rivers than cross river rated overall performance of HARPIN as satisfactory/very satisfactory (98% vs. 96%, p-value = 0.032).

Pregnant Women and PMTCT

Table 18: Percentage distribution of women accessing HCT, ANC & Post-natal care services at health facility

<i>Types of Information Received</i>		
	<i>Yes (%)</i>	<i>Total (N)</i>
Received counseling on HIV	74%	480
Had HIV test	67%	480
Knows result of test	65%	480
HIV status ó Positive	8%	480
HIV status - Negative	92%	480
Labour, Delivery & Postnatal care		
Delivered baby in facility	31%	477
Knows HIV status of baby	25%	480
Child's HIV status ó Positive	7%	127
Child's HIV status ó Negative	93%	127

Table 18 shows that the majority of the women interviewed received counseling on HIV (74%), had HIV test (67%), know their test results (65%), and 8% were HIV positive. Thirty-one percent of the women delivered in the health facility where they were interviewed, and 25% know the HIV status of their baby. Of the women who knew the HIV status of their baby, 7% reported that their children was HIV positive, while 93% reported negative. Qualitative findings corroborate the positive project impact of babies' lives as the excerpt from a health provider below shows.

“It has really help because all the mothers that have HIV their babies turn out to be negative. There was a time a woman from UNICEF came to visit us and she was shocked with what she saw it was a day the women came for their antenatal and she was greatly pleased with what we are doing with the women.” (Health Provider, Cross River).

Further analysis of HIV status by background characteristics shows that more urban than rural women were HIV positive (9% vs. 6%), more of those aged 29 or less reported that they were positive than those aged 30 or older (7% or more vs. 4%), and more women who had secondary education (10%) compared to those with junior secondary or primary (both 8%) reported HIV positive. Also, more of unemployed women (8%) than those employed (7%) reported that they were HIV positive. Analysis of HIV status by background characteristics did not show any significance.

Table 19: Percentage distribution of respondents according to ratings of quality of services received through the project

Indicators of service	PMTCT Women				Total (N)
	Not satisfactory/don't know	Fairly Satisfactory	Satisfactory	Very satisfactory	
Rating on ANC information received from health facility	2%	5%	59%	34%	406
Rating on HIV counseling services received	0	7%	59%	34%	356
Rating on post natal care services received	0	5%	57%	38%	129
Rating on overall satisfaction on services received	1%	5%	47%	47%	414

Most PMTCT women interviewed rated the quality of services that they received high. Table 19 showed that the majority of women rated ANC information received from health facility as satisfactory/very satisfactory (over 93%), HIV counseling services satisfactory/very satisfactory (92%), and post natal care services (95%). And most women interviewed gave overall rating of information and services received as satisfied/very satisfied (94%).

Findings suggest that although most women reported that the quality of services received were satisfactory/very satisfactory, qualitative findings suggests variation across the health facilities used by the project. Findings suggest that quality of services may be related to distance, availability of drugs, and health provider's knowledge about the process of providing services as the excerpts below suggest.

It is very satisfactory, yes. .hmmmmm. First of all I will ask if she came for anti-natal and if she say yes, I will ask if she has registered with us. I will take her to ANC to register after that they will send her to me for counseling and testing, just pregnant. .if the person comes in for anti-natal I will sit her down and counsel her and test, we counsel everything about HIV and about the test and how she can be able to read the test on her own and if she is positive then the disclosure is her own view. When the patient accepts to be tested because some of them opt out after counseling then I will start the test. .yes, if she insisted you have to allow her but you still have to counsel her. They are treated just like any patient no discrimination. (Health Care Provider 1, Cross River State).

Hmm, actually one of the clients complained about poor services so we believe that we will live up to their expectation. Because there is no complain that they bring that we will not be able to handle it. .Even those across the river they formally when they did not send their drugs to them there. When the drugs come, everything will be ready for them to come and pick and go back. The only time they will not have access to it means if the stock here is no more. That is if they did not

Table 20: Percentage distribution of PMTCT women according to overall satisfaction by selected basic characteristics

<i>Background Characteristics</i>	<i>Overall Satisfaction</i>			
	Not Satisfactory	Fairly Satisfactory	Satisfactory	Very Satisfactory
Pregnancy Status				
Pregnant	1%	6%	53%	40%
Not-pregnant	1%	4%	41%	54%
P-value	0.071			
Marital Status				
Single	0	5%	53%	42%
Widowed/Divorced	0	0	53%	47%
Married	1%	5%	46%	48%
P-value	0.910			
Age group (in years)				
19 or younger	0	7%	36%	57%
20 to 24	1%	6%	49%	44%
25 to 29	1%	2%	48%	49%
30 or older	0	7%	50%	43%
P-value	0.681			
Residence				
Rural	1%	5%	52%	42%
Urban	0	5%	39%	56%
P-value	0.038			
Level of Education				
Primary	0	2%	50%	48%
Junior Secondary	1%	7%	42%	50%
Senior Secondary	0	13%	75%	12%
P-value	0.017			
Currently Employed/Self Employed				
Yes	0	3%	52%	45%
No	1%	7%	42%	50%
P-value	0.037			
Number of children alive				
None	6%	0	72%	22%
1 to 3	0	5%	48%	47%
4 & above	1%	8%	44%	47%
P-value	0.008			

Table 20 shows that PMTCT women’s overall rating of project performance varied significantly by residence, education, employment status, and number of children alive. More urban than rural women rated overall project performance as satisfactory/very satisfactory (95% vs. 95%, p-value = 0.038). More women who had primary education than those who had junior secondary or secondary education rated project as satisfactory/very satisfactory (98%, 92%, and 87% respectively, p-value = 0.017). Likewise, more employed/self employed PMTCT women than those unemployed reported project performance as satisfactory/very satisfactory (97% vs. 92%, p-value = 0.037). And slightly more women who had at least one child compared to those who had none reported project performance as satisfactory/very satisfactory (95% vs. 94%, p-value = 0.008).

Objective 3: To educate communities about HIV/AIDS transmission and reduce the stigma associated with HIV/AIDS

Some of the findings reported in objectives one and two above on ISY, OSY, and PMTCT ties into objective three in terms of education of community members on HIV/AIDS and reduction in associated stigma. Findings suggest that community leaders, religious leaders, school principals, teachers, and other key community stakeholders, who were the main focus of objective three were the gate keepers initially contacted to create enabling environment for project take off, and were also engrafted into the project implementation.

Community involvement and participation is a key component of HARPIN. Results of qualitative analysis suggest that the first step into a community is an organized meeting with the community head and other leaders to explain the aims and objectives of the project and solicit support, and cooperation. Once the community leaders have given their support, the project team then contact other gate keepers like principals, teachers in schools, religious leaders, health personnel who in most instances were later trained to become health moderators advocating the project.

Examples of direct quotes from key informant interviews with selected community leaders buttress community involvement approach adopted by the project.

“Oh, Oh. She (a HARPIN staff) use to call so many people here. And we use to gather here and hear about what she use to say. She started HIV, she started last year. So many of us know about this HIV, so many of us chiefs know about it.” **(Community Leader, Cross River)**

“We were five moderators and we trained 200 people here in this community. We go out and look for those that are reactive and take them as brothers. Is that I go round that’s why we have meetings once a month. I have this exercise book, this is the name of the people in the support group. I support them and I follow the reactive ones up so that I don’t default. I refer people. Many of them are happy to go for the test, I don’t force them” **(Health Moderator, PLWHA, Cross River)**

Participation of key stakeholders such as school principals, and teachers help to institutionalize the projects into the school system. Results of data analysis of key informant interviews shows that some schools through health clubs formed by the project organized regular debates, quiz, rallies, and campaigns on HIV and even incorporate related songs in morning devotions.

“Due to the nature of the school there is no ample time for social events and even sporting events but the group meets once in a week at scheduled time. There exist a health club it is known as PRO health club, they conduct debates, quiz, and some other time they go out on enlightenment rallies/campaigns and compose songs which they even recite in the morning devotions.” **(Vice-Principal, Port Harcourt).**

Findings of this evaluation suggest that community involvement needs to be managed carefully at the initial point of entry when trust is lowest, and myths and misinformation about HIV may be high. A case in point where initial entry was not successfully implemented was in a community rivers state. In this case, the community head gave approval but relationship with other key members of the community was not well managed. There seemed to be gaps in communication about project objectives, and perhaps, some agitation for monetary compensation. Below is excerpt from one participant in an FGD corroborating suggesting misgivings with HARPIN staff.

“They came and met the chief that they wanted to establish an organization in the community and they were given the go ahead to establish. They only told us they wanted to be like a sister organization to us, í í They didn’t tell us its a program to promote HIV/AIDS, they told us the objective of the organization is to promote HIV/AIDS awareness. Executives was set up both indigene and non-indigene, I was made the President of the organization. A program was done in conjunction with the two organizations and people came, we went to many places to do the program. At the end of the program, we all (Groups) met at the community town hall and a particular amount of money was suppose to be given to them (participant) but the participant felt the money given to them was not enough and there was disagreement. I was accused of collecting money from the HARPIN staff which I did not do such. So since I don’t want to spoil my image in the community, I resigned from being the President. PHI staff, I believe are into this for their own selfish interest example if there is a program now in this community for women, they wont tell us the men instead they will even go outside the community to do the program. If they call some women (indigene of the community) go and ask them if they know what the program is all about, its only few of them that will know the program. We the indigene to an extent have not really felt the program in our community. That was why we declined to continue.”
(Community leader, Port Harcourt).

In addition to involving key community stakeholders, PMTCT component of HARPIN used and strengthened existing PHC facility, and networked with TBAs in the community to mobilize eligible women to use the services offered. Working with TBAs have not been easy due to the fact that increasing delivery at health facilities may take away their traditional functions, but their relationship with the project is getting better by the day as the opinion culled from a key informant interviewee below suggest.

“What we do is that we meet with them monthly. We have this monthly TBA meetings in LGAs where we go and we partner with SFH. They support us with water guards and buckets so these are what we give to them during the meetings. We also give them tea breaks and just inform them on HIV prevention. It wasn’t easy initially but with time, they now began to see the importance of participating in this program and we make them see that is not as if we are stealing your clients from you we just want you to be safe.” **(HARPIN project field staff)**

Despite community participation successes described above, findings of this evaluation suggest that stigma and discrimination associated with HIV/AIDS is still substantial in most of the communities where project intervention took place. A basic indicator of stigma and discrimination is the proportions of a population who had HIV test. The proportion of HARPIN target sub-groups who have ever taken HIV test were relatively low (ISY = 10%, OSY = 52%, and PMTCT women (67%) compared to the level of programming efforts to reduce stigma and discrimination in the community. Other indications of stigma and discrimination observed during fieldwork and analysis of data were (1) difficulty in identifying and separating PMTCT women for KII during the fieldwork in cross river, and (2) the challenges expressed by some health providers in getting HIV positive women to disclose status to their spouse.

The following quote from a KII with a health provider, and a HARPIN staff buttresses the existence of stigma and discriminations in the intervention communities.

“We provide like the clients, that is the positive cases, we give them drugs, we care for them in any way that is, as in, encouraging them because of this stigmatization and the rest. Because some of them, when you test them and you tell them the result they’ll feel very bad, they’ll be crying, how will they do, so we try to encourage them to leave up to expectationí ..” **(Health Provider, Cross River)**

“í í We also try and follow-up, especially on the positive pregnant women to make sure that their babies have taken niverapine after 48 hours of delivery. But you know stigma is till an issue, so one other thing we might have to do is training on stigma reductioní ..” **(HARPIN**

Objective 4: To strengthen the capacity of PHI and its partners in carrying out HIV/AIDS prevention activities.

This section focuses on the people who actually implemented HARPIN including PHI staff and CBOs especially with respect to the training that they received during the life of HARPIN.

Basic Characteristics of HARPIN Field Staff

Nineteen staff responded to survey questions during the evaluation, and were fairly equally distributed between Rivers (47%), and Cross River (53%). There were more males (67%) than females (33%), with more aged 26 to 30 (44%), followed by those aged 31 or older (39%), and 25 or younger (17%). The majority lived in urban areas (95%), and had tertiary level education (83%). Of those who completed the survey questionnaires, 21% were from admin/finance, 63% from program, and 10% from M&E department. Most HARPIN staff had spent at least two years in the organization (76%), were mainly in sexual prevention (53%), or both sexual and PMTCT (42%).

Capacity Building of Project Staff

Capacity building was conducted at all levels throughout the life of the project. Findings from qualitative data showed that PHI had an approved training plan for COP 09 which was implemented in addition to on the job training, workshops and meetings. Quantitative findings showed that 58% of those who participated in the evaluation attended program management training, 93% in financial management, 90% in grants development and management, 63% in M&E, and 53% in peer education. Most (94%) were satisfied/very satisfied with the quality of the training received.

Specific trainings reported during group interviews and KII with sexual prevention staff are in-school and out-of-school program implementation, media materials development, CBO management, financial and management, systems training, EBP education training, and M&E management for results. Other trainings reported are on; basic data management, data reporting, and data quality to beef-up the M&E system of the project. Specific training reported by PMTCT staff includes full PMTCT packaged training including HCT, ARV, EID, and infant feeding. Similar to survey reports, qualitative findings suggest that most staff reported that exposure to trainings, workshops and professional meetings enhanced their performance on the job as excerpt from a KII below shows.

“I have received a lot of training. I had a lot of capacity before I came into HARPIN but I have been refreshed on some of this capacity like HCT, HARPIN has trained me on HCT, couple counseling, infant feeding, ARV, EID and quite a number of meetings and workshop. We have been going for that training in Jos. I think twice. The training has really improved my performance on the job because you know medical prevention is science based and science changes. Because of these trainings, I am always up to date as to what to offer in the facility, with the facility HCW as I mentor them, train them and supervise them. And during step down training it has really built my capacity, I transfer it to them on proper implementation of PMTCT services.” (HARPIN field staff)

Findings show that relevant trainings received by HARPIN staff were stepped down to the CBOs staff, peer educators, health moderators, and TBAs, as necessary. Key trainings received by CBOs staff included how to train in-school and out-of-school peer educators, training of trainers (TOT), HIV/AIDS and reproductive health issues, HIV counseling, sexually transmitted diseases (STIs), condom demonstrations, financial management, balanced ABC, and life building skills among others. Peer educators (both in-school and out-of-school) received training on HIV awareness and knowledge, peer education skills, and behavior change regarding reproductive health. The general consensus among CBOs staff and peer educators is that the trainings received enhanced their work performance. Excerpts from qualitative data below depict the types of training received by CBOs which they in turn step-down to peer educators.

“CBO1: we had received training on HIV/AIDS counseling, STI's, condom demonstration. CBO2: responded that there is one received on how to train in-school and out-of-school in short we have received a lot from them. CBO3: responded that a lot as CBO - Pro/health international has been training members, there is one we attended last month TOT, It means training of trainers. More other people are also going for financial training. Just last week, we received training as peer educators. Pro/health is putting a lot of effort to ensure that their CBO are trained on HIV/AIDS and reproductive health issues. Then they also trained the health moderators to go out and provide education on how HIV/AIDS can be prevented through balance ABC-Abstinence, be faithful and the use of condom to adult that within the age of twenty five to thirty five. (CBO1 to CBO3 were CBO members in a group discussion, River)

With respect to PMTCT program area, TBAs were exposed to trainings in the form of education on women's reproductive health, safe delivery, HIV/AIDS, and mobilization skills. Excerpt below from KII done with a TBA is quite interesting. Two phrases worth emphasizing because of the insights they provide are “I understand them now” implies no competition between my role and that of the PHC, and “I am taking their advice” means information from the trainings and meetings are useful for my work. Thus, corroborating the two concerns mentioned earlier about general resistance from TBAs due to perceived competition, and the series of trainings in the form of meetings that they are exposed.

“Okay TBAs, yes, yes we do. In fact I think about two months ago they attended a training there in the council. I think we have about five that's in this very particular village, we have about 5 or 6 of them and at times we call them for meeting even with the PMTCT.... they come, they have meeting together before HARPIN started their program we were having this kind of relationship with the TBAs but it was not strong like now that we use to go and see what they are doing It's because of the HARPIN and this program that is at hand. ”
(Health Provider, Cross River)

“I am a TBA in Calabar South. When the pregnant women come, I use to ask them whether they have registered in the hospital. If they say yes, they have to show me card. I use to ask them everything about them, about their husband, whether they have taken immunization. The project is good because I understand them now (which mean no competition). The thing I achieve from the project is that the project is very good, I am taking the advice (means information from the project during meetings) from them.”
(TBA, Cross River)

PROGRAM & MANAGEMENT ISSUES

Project Objectives & Strategies

The community engagement and participation in project implementation for both the sexual prevention and PMTCT program areas worked well except that set objectives in the cooperative agreement were perhaps, over ambitious in terms of scope, coverage and timing. The first objective of increase knowledge on HIV transmission was implemented among youth (ISY and OSY) in both Cross River and Rivers states, and was implemented only among pregnant women and TBAs in Cross River state. Available information showed that the project was not able to rapidly scale-up to 18 LGA (nine per state) in the two states in three years. Also, TBAs were not provided with free TBA delivery kits as incentive for participating in the project. Age range of OSY sub-group was unclear in the cooperative agreement but resolved in the one year extension proposal document.

On objective two, while the project was over ambitious in terms of coverage on HCT (former VCCT) among people in the two states, it provided more PMTCT services to pregnant women in Cross River state than was planned in the cooperative agreement. These differences in implementation was due partly to delay and shift in USAID funding focus resulting in change in emphasis and priorities from HCT to HIV counseling among people in the two states, and more PMTCT services (including HCT, ARV, EID, and IF) in only Cross River state.

Objective three geared to educate leaders and interest groups about HIV/AIDS transmission and reduce stigma associated with HIV/AIDS reached community leaders, key gate keepers and interest groups in communities with relevant activities. Evaluation findings did not show that project implementation deliberately targeted PLWHA although a few health moderators reported that they were HIV positive.

The findings of this evaluation showed that the fourth objective i.e. strengthening the capacity of PHI and its partners on HIV/AIDS programming was perhaps, better implemented of the four objectives. Findings suggest that PHI staff attended several trainings throughout the life of the project, and trainings were stepped-down in a hierarchical fashion from PHI staff to CBOs, and to health moderators/peer educators, and health provider to TBAs. Findings suggest that many key stakeholders i.e. principals, and teachers in schools, and matrons in health facilities were sensitized and trained to become champions of the project activities in their respective domains.

The one year realignment document was clear on targeted sub-groups and age range but was in general silent on the number of LGAs to cover or the timeliness of activities stated in the cooperative agreement. Also, the realignment document expanded on the PMTCT and PLWHA component of HARPIN, without clear evidence for the emphasis. Review of relevant documents showed that the objectives stated in the one year project realignment were different in target population and intent when compared to the original objectives stated in the cooperative agreement.

Strengths of Project Implementation

Key strengths of the project contributing to successes reported by project staff and other stakeholders are stated below.

- The PHI staff work together as a family which resulted in cohesion and oneness of purpose in achieving stated objectives.
- Project implementation was strengthened by PHI long standing experience and understanding of the difficult terrain in the Niger Delta. PHI is one of a few development organizations that could provide PMTCT services on river creeks including HIV testing on water.
- HARPIN had a unique opportunity to leveraging on the free health care services implemented by PHI in the two states, and other states in the Niger Delta. Leveraging implies tapping into a wealth of good will created by other PHI project.
- The approach of engaging community members in the implementation of project activities enabled them to understand the project intent and objectives at a faster pace. But most important, is that this increases ownership of the project, and thus sustainability.
- The PMTCT enrollment strategy of òin or opt outö helped to eliminate differences between number of pregnant women counseled for HIV and those who were tested. The number of women enrolling for PMTCT in the project sites was substantial due to the òhubsö and òspokesö referral system that enabled most women to received the services that they desire.
- Dedicated and committed PHI management leadership at the headquarters and field offices ensured that project objectives were achieved in a timely fashion. The management leadership is also evident in maintaining continuous political support at the state and LGAs levels.

Weaknesses of Project Implementation

- There were discrepancies between objectives planned in the cooperative agreement, and actual implementation with respect to geographical and content coverage which were not completely addressed in the one year extension and realignment.
- The project did not start with a strong human resource base. It relied mainly on volunteers to implement a technical project that needs considerable experience and finesse. The human resource was strengthened a little late in the project life with gaps evident in key human resource i.e. communication specialist, M&E specialist, and proposal development specialist.

Project Management Issues

Below are key management issues that may have contributed in one way or the other to the implementation of HARPIN.

Administration & Finance

- The structure of PHI with headquarters located in Jos and a regional office in Port-Harcourt worked well in general, but there were instances that some administrative bottlenecks were created in taking actions on some project activities. Findings of this evaluation suggest that getting approval on certain issues especially those related to procurements may have been delayed than necessary especially for the Calabar field office that had to go through the regional office to get approval. It may be worthwhile to vest more decision making powers on field management staff to eliminate potential bottlenecks in the future.
- The administrative aspects of the project have also gone through transitions. As of early last year, the organogram and reporting guideline were not clearly defined. Likewise, the majority of staff worked without clear job descriptions which imply duplications of efforts in some cases, and conflicts among staff in the performance of their job. This situation has changed now with the development of job descriptions for every staff and line of reporting clearly defined.
- One area where capacities of project staff have been built over the years is in financial management. The standard set by the USAID on financial principles and accounting procedures were difficult to follow at the beginning but now staff of the finance department are able to produce standard financial reports as at when due. Staff use USAID comprehensive financial accounting manual and have been audited by external auditors from USAID twice without problems.

Project Monitoring and Evaluation (M&E)

- Findings of this evaluation suggest that there was no clear M&E system until sometime last year when few staff with skills and expertise were employed. Prior to the M&E staff employment, it was difficult to link and track information on a data sheet to the beneficiaries, but this has been rectified to a large extent, and considerable gaps in service statistics data collection eliminated.
- Outcomes of this evaluation show that the project now has tools designed to capture each project activity. For example on PMTCT, there are several registers each on an area of service— HCT, EID, ARV, delivery, monthly summary forms etc. Also, weak MIS of the past has been improved to meet standard national requirements. M&E staff ensures timely and accurate data collection of PMTCT statistics by having monthly meetings with the health providers in which information in their registers are reviewed and collated. Also, M&E staff conduct monitoring of the 34 PMTCT sites on a weekly basis using a roster that ensure that all sites are visited at equal interval.

- In an attempt to provide standard M&E system, the department now has a total of 12 M&E tools (for both sexual prevention and PMTCT) and use EPI Data, and DHIS for data entry, and SPSS for data analysis.
- In addition, the current changes were made possible by competent and dedicated M&E team who have been conducting series of trainings in-house, have individually initiated and produced items to enhance the system some of which are; HARPIN MIS, HARPIN Strategic Information system, and data flow chart.

Working with the CBOs

The project worked with six CBOs, three in Rivers and three in Cross River states mostly on prevention activities that involved ISY, OSY, and advocacy and engagement with community leaders and key opinion leaders on HIV/AIDS issues.

- One of the key successes of the project is the creation of truly indigenous local CBOs that relate well with community dynamics to achieve results. A unique aspect of this effort is that the CBOs were formerly OSY who after graduating from the project were encouraged to form their own CBOs. The key functions of the CBOs were mainly advocacy with community leaders, and training of ISY peer educators, and OSY health moderators.
- Findings of this evaluation showed that the CBOs formally attended TOT training on ISY peer education, and OSY health moderation. The CBOs in turn step-down training to several peer educators in school, and health moderators in-charge-of educating OSY and other community stakeholders. The CBOs received training on financial management but were not empowered to demonstrate the skills learnt and gain experience by running their own accounting system using the project funds. Findings showed that in most cases, HARPIN staff handled financial transactions by themselves.
- The CBOs supervised and monitored the capacity building efforts of the peer educators, and health moderators directly. Also, they were involved in the collection and reporting of M&E data on project activities including service statistics, and participated in quiz, drama, and community participatory drama used to create awareness about HIV/AIDS in their community. CBOs M&E skills were built by being responsible for the distribution and collating of basic M&E forms for ISY and OSY i.e. consent form, in-take form, and MIS form.

Linkages with Government Agencies & Other Stakeholders

A key aspect of the project implementation is collaboration with government agencies working on HIV/AIDS in the states.

- Results suggest that HARPIN staff worked well with key government agencies in the two states including but not limited to; MoH, MoE, SACA, SASCAP, LACA, and LGA chairman and other officials at the community level. Findings based on key informant interviews in Cross River state showed that HARPIN staff were involved in ongoing UNICEF program and state PMTCT committee meeting including support with logistical arrangements.

- Findings showed that HARPIN staff engaged in advocacy to improve infrastructures in the community when necessary. For example HARPIN staff in Cross River state advocated for the renovation of PHCs in the state. Aspects of collaboration include adoption of sexual prevention and PMTCT tools obtained from SASCAP, and SACA. The next level of collaboration that may need attention is fostering direct linkages between government agencies and the CBOs and to leverage funds for planned activities.

Field Staff Welfare

The evaluation examined field staff welfare which is crucial to project implementation and job performance. Findings on key areas of concern are provided below.

- Early years of the project was marked by high turnover of staff majority of who were volunteers moving to take-up positions in more competitive organizations. However, results of this evaluation suggest that staff salaries and other conditions of service have now improved, and the project has recently attracted more qualified staff into key positions.
- Findings suggest that more retention of qualified staff than before is a good indication of better conditions of service which should be coupled with staff motivation in the form of job specific training, promotion, health insurance, and security assurance for difficult to reach areas.
- Findings showed that most project volunteers worked under hard environmental conditions with little or no motivation in the form of stipend and health insurance or security. Volunteers' terms of reference may need to be reviewed to provide better working environment for them.

Sustainability and Future Directions

This evaluation examined key components of HARPIN that contribute to sustainability in the future. Some of the key findings are presented below.

- The creation of local based CBOs, three in Rivers state, and three in Cross River is an important move towards sustainability. The uniqueness of the CBOs is that they were formed by community members who participated in the OSY program. As of the time of this evaluation, the six CBOs have been duly registered and have participated in services of training and activities.
- Another indicator of sustainability is the involvement of community stakeholders in project activities, some of which are already good ambassadors of the project. Also, the project is supported by MoH, MoE, and LGA officials and they attend most project activities. In order to ensure continuous stream of funds for implementation, it may be necessary to elicit financial buy-ins from these government agencies and community stakeholders to ensure that implementation continues in the future.
- The project use of existing facilities and structures is another move towards sustainability. For sexual prevention, the focus is existing schools in the community, and for PMTCT the focus is existing PHCs. The project strengthens existing structures through capacity building of staff, and provision of needed materials for project implementation. Findings of this evaluation showed that in most schools visited, the project activities have been

integrated into daily activities in the form of drama, quiz and even at daily devotion. The extent of integration of project activities was demonstrated by a school in Rivers state which planned HIV/AIDS rally outside the school premises (including printing a T-shirt with HIV messages) to mark end of session. Also, there are examples of PHCs involved in the project to provide PMTCT services in consonance with their daily routine services.

Challenges & Constraints

The evaluation team examined key challenges that may have impinged on the implementation of the project. Key challenges faced are highlighted below.

- Findings of this evaluation showed instances where prompt decisions on certain project activities may have delayed due to the time it takes to get response from the head office in Jos. Delay in responding to certain requests may be due to the fact of not being on ground to fully appreciate the situation in the field. Aside, decision making channel from field office (in the case of Calabar) to regional office in Port-Harcourt and then to the head office in Jos may result in delay. The decision making channel may have affected some activities more than others, for example those on finances and procurement may have had the most impact.
- The project has contributed to providing PMTCT services to pregnant women in River state with 34 PHCs involved in the project. Findings suggest that the PMTCT sites may not be evenly distributed across the state especially in difficult terrain where services may be mostly needed. Also, some of the health facilities lacked qualified personnel and materials i.e. HIV test kits, drugs to operate effectively and provide quality services.
- Findings showed that the project used considerable number of volunteers who were not commensurately compensated, and were exposed to security risks on constant bases. In order to get maximum contribution for volunteers, their compensation package may need to be reviewed.
- Results of the evaluation suggest that inflexible financial system may have affected programming especially with respect to unexpected expenses. There were situations that required spending outside fixed budgeted but this was not permitted although it would have had beneficial effect on project outcomes.
- This evaluation showed that CBOs formation at the community level was unique, but where in dire need of financial support to secure office space, and pay for basic facilities and running cost. Findings of this evaluation did not show that the CBOs had any direct funding linkages with HAPRIN, and this may have had adverse effects on them.
- HARPIN work in difficult environment and have managed to gain experience and survive challenges met on a daily basis. Findings suggest that logistics for the challenging terrain i.e. creeks, and swampy water ways were not adequately catered for.

Two approaches that qualify as best practices in HARPIN are; (1) use of existing community structures and (2) community PMTCT which are actually under the same broad approach i.e. community participation.

- Findings of this evaluation showed that the use of existing structures in terms of physical and human resources worked well in helping the project gain entrance and acceptance in the communities. Use of community structures implies use of human and material resources available in the community at the time of project intervention. This approach was demonstrated in the use of school buildings, teachers, principals, and youths as peer educators in the ISY program, and OSY as health moderators, some of whom transitioned to form and manage local CBOs.
- Community PMTCT is also premised on using existing PHC facilities, health providers, and TBAs to provide needed services. The advantage of these approaches are similar; (1) people who know the culture, and understand the people provide the services, (2) existing physical structures may be improved in the process, and (3) self empowerment and ownership becomes easy to achieve with direct personal involvement.

Unexpected Outcomes of Implementation

Key unexpected outcomes mentioned during the evaluation are:

- HARPIN implementation produced unexpected outcomes one of which is a chieftaincy title given by a community leader to a program officer in Cross River state after tireless efforts brought the community to fully embrace the project and its activities.
- It is interesting to note that in general, pregnant women preferred to patronize TBAs than the PHC facilities because they are more trustworthy and less complicated in their procedures. With this realization, program strategies had to be reviewed to accommodate TBAs traditional functions and to rather emphasize building their capacity through continuous engagement at meetings and workshops.

Overall Project Performance

This evaluation findings showed that HARPIN has improved its implementation processes in the past three years, starting from teething age to being able to hold its own among USAID committee of IPs in Nigeria. Perhaps, the PMTCT program is the most successful, due to innovative programming using community PMTCT with tangible results i.e. the number of pregnant women who attended ANC and were tested, and the number of DBS negative, considering the short period of its implementation.

Evidence suggest that the ISY program may be the next successful because of the level of HARPIN activities integration into schools daily activities, and the observed positive change in the pupils sexual behavior. Also, it seems that the schools may be able to sustain the project activity for a longer time if funding stops.

The OSY component responded more positively than ISY with respect to behavior change but the change is more likely to skew towards use of condoms rather than abstinence. In addition, the CBOs which in most cases were offshoot of the OSY are yet to operate independently.

Overall, HARPIN may be rated between fair and satisfactory, leaning more towards satisfactory with considerable room for improvement in the future. Aside programming outcomes, aspects of the overall performance involves operational issues highlighted above that need to be addressed and improved upon.

LESSONS LEARNT

Key lessons learnt from this evaluation are listed below.

- An intervention can receive overwhelming acceptance and support if introduced in such a way that it involves the people right from the beginning and gets their direct participation. Except in few situations, community members embraced all aspects of HARPIN including the ISY, OSY, and the PMTCT components, and became ambassadors on their own account.
- The fact that people recognize that you want to help them does not remove the fact that they would like to be compensated as well. Also, once the practice is to provide incentives, it may become an important factor in future negotiation.
- It is interesting to note that community structures and agencies have inexhaustible inertia to propel its own survival once the initial force is applied. An example is the way some OSY (some of which may not have had clear goal in life before the project intervention) transition to health moderators, of which some became CBOs founder. The potential of this group may be explored further through capacity building and funding for direct project implementation.

CONCLUSIONS

HARPIN is a three-year project implemented by PHI through funding from PEPFAR/USAID with the overall objective of providing HIV/AIDS prevention activities in cross river and rivers states.

The main objective of this evaluation is to assess project achievements, challenges and constraints, lessons learnt and recommendations that will inform future project implementation. It employed participatory approach using ex-post study design involving both quantitative and qualitative methods.

Key findings of this evaluation are presented below.

More of ISY were females (51%), lived in rural areas (59%), and were public school students (79%). The majority of OSY was males (57%), lived in the rural areas (71%), had at least junior secondary education (59%). Most PMTCT women who participated in this evaluation had junior secondary or lower (98%), and were from the rural areas (68%).

Findings of this evaluation showed that the project met and surpassed USAID targets for sexual prevention in COP 08, and COP 09 and statistics excluding fourth quarter showed that it was close to meeting set target for COP 10. Likewise, the project met PMTCT targets for COP 09 and was close to reaching that for COP 10 as at the time of evaluation. Most important, the project was successful in averting HIV transmission to the majority of newly born infants who were exposed to the EID.

Objective I:

- Results of this evaluation showed that the majority of ISY (over 66%) were exposed to HIV/AIDs, adolescent reproductive health and rights, and per education information, and were satisfied/very satisfied with the information that they received.
- Likewise, the majority of OSY (over 91%) reported receiving information HIV/AIDs, care and support for PLWHA, adolescent reproductive health and rights, and condom messaging, most of them were satisfied/very satisfied with the information.
- In general more OSY than ISY reported that they were exposed to HIV/AIDs and reproductive health and rights information/services before and after the project intervention activities. The difference may be due to the ability of OSY who are of older ages to recollect part activities.
- Both ISY and OSY reported positive change in behavior as a result of exposure to HARPIN intervention. Qualitative findings showed that positive change in behavior were with respect to abstinence, reduced in number of sexual partners, condom use, non use of sharp objects and self discipline and self esteem.
- There was significant difference in ISY positive behavior change by state and residence, and significant difference in satisfactory/very satisfactory rating in behavior change by sex and level of education. In order to have more success with this sub-group, future programming may need to consider state, residence, sex, and education.
- OSY reported significant difference in positive behavior change by residence and significant difference in satisfactory/very satisfactory rating by levels of education. Future

programming need to consider residence and education in designing customized programs and activities to meet their specific situations.

Objective II:

- More OSY (72%) than ISY (56%) received counseling on HIV. And the majority of both OSY and ISY were satisfied/very satisfied with the counseling service received and this differed by state and sex, for ISY and by age and education and employment status for OSY. These results implies that state and sex are key factors that need to be included in programming for ISY and age, education and employment status should be considered on HIV counseling activities for OSY.
- Findings showed that the majority of PMTCT women who participated in this evaluation reported receiving HIV counseling (74%) had the test (67%) and the majority (65%) know their results, and a few (8%) tested positive. Also, the majority rated counseling and other services received as satisfactory/very satisfactory (over 90%). Findings suggest statistical difference in overall satisfaction of pregnant women in PMTCT information/services received by residence, education, employment status, and number of living children. Also, qualitative data analyses suggest variation in quality of PMTCT services and facilities by residence and geographical locations across PHC sites involved in the project.

Objective III:

- Findings of thus evaluation showed that community leaders were well informed about HIV/AIDS and other project activities and some of them actively participated in its implementation.
- Also, the use of health providers and TBA for PMTCT programming worked well, but it may be necessary to review TBAs functions in future programming to make them more integrated into the project.
- Despite the advances made in improving on HIV/AIDS awareness and knowledge, stigma and discrimination is still evident. This is evident from the proportion reporting for HIV test which is still low across age groups. This is a major challenge that needs to be tackle in future programming.

Objective IV:

- Evaluation results showed that the capacity of HARPIN staff were strengthened through formal trainings, in-house training, on the job training, participation in conferences and relevant training were stepped down to CBOs, peer educators, health moderators. And of those who participated in the trainings, the majority were satisfied/very satisfied with the capacity building efforts.
- Also, for the PMTCT component both HARPIN staff and health providers reported receiving step down trainings in key areas of their work.

Program and Management Issues

- In general this evaluation suggests overambitious programming in terms of coverage and content of HARPIN. For example, the six LGA covered in the period of implementation was not close to 18 LGA included in the cooperative agreement, and TBAs were not provided delivery kits, nor was there a deliberate programming focused on PLWHA.

- The one year realignment document tended to review and provided clarity on aspects of the cooperative agreement i.e. it fine-tuned objective two, clarified age groupings and distinctions across target categories. However, the realignment document still left out clarifications on coverage and certain deliverables in the cooperative agreement.
- Key strength of HARPIN programming include cohesion from seeing self as working in a family, PHI long standing experience in the region, use of existing community structures, and good leveraging on other PHI projects i.e. free health services.
- Key challenges in programming include variation in PMTCT facilities and personnel across PHCs in Cross-river states, delay in decision on certain project activities from headquarters, lack of funding for CBOs and difficult project terrain.

Overall Performance

- Overall the project performance may be rated as near satisfactory but definitely not fair. PMTCT seem to come first in ranking performance followed by ISY program and OSY is third.

RECOMMENDATIONS

Key recommendations based on the findings of this evaluation are presented below.

- The sexual prevention program succeeded in providing information and improved knowledge about HIV/AIDS and reproductive health of both ISY and OSY in the intervention communities. Future programming should factor in background characteristics while designing specific activities to activities to meet their needs. Overwhelming, respondents and interested stakeholders suggested that future programming should scale-up to reach other communities and states in the area.
- Despite efforts to educate community members about HIV/AIDS, findings suggest that stigma and discrimination about the disease is still prevalent in the communities. This is evident from the low turnout for testing, and the reluctance of some pregnant women to disclose that status to their spouse. Future programming need to address stigma and discrimination. This is where formative research will be necessary to examine community specific socio-cultural factors reinforcing stigma and discrimination.
- The majority of women who participated in PMTCT were satisfied with the services. And there was significant difference in overall satisfaction of the women by residence, education, employment status, and number of living children. Future programming needs to factor these background characteristics into activities designed to meet their specific needs. An important finding of this evaluation is that the PMTCT component was effective in reducing HIV transmission from mother to infant among those who participated in the project.
- Findings of this evaluation suggest that TBAs are generally more preferred to PHC staff because of their òuncomplicated and simpleö procedures. Efforts should be made to review the role of TBAs to make them part and parcel of the project. This will enable the project to get deeper into the grassroots and enlist more pregnant women for PMTCT. Also, getting more TBAs involved will make it possible to subject them to better standard and control as well. It is important to ensure even distribution and consistent supply of PMTCT materials and facilities i.e. HIV test kits should be provided free if possible, and other materials provided where they are needed mostly in the creeks and swampy waterways.
- Use of existing community structures in implementing projects is quite unique and responsive to program impact, but may not produce the same results depending on modalities for its introduction in a given community. The use of existing community structures approach (including humans, and materials endowment) should be introduced alongside initial trust building initiatives which may not necessarily translate to monetary exchange. Initial trust building initiative could be valuable information on other needs in the community. Any misstep or miscommunication about initial trust may elicit unwarranted hostility as reported in one community during this evaluation.
- Findings of this evaluation suggest that quality of PMTCT service and acceptance may be enhanced if services are comprehensive to include; a little focus on the mother's treatment, malaria treatment, STI management, and cancer screening. Also, the project should have linkages with other USAID IPs to enable the women tap into other services than are not available in HARPIN.

- HARPIN was over ambitious in stating the scope and coverage of objectives and implementation especially in the first three objectives in the cooperative agreement. And the realignment document did not fill all the gaps. However, efforts should be made in future programming to scale-up to include the remaining 12 of the 18 LGAs originally planned in the cooperative agreement.
- HARPIN key strength is its experience and long-standing services in a difficult terrain that many would rather not venture. While the project has demonstrated success in changing behavior towards HIV/AIDS, it seems that there are challenges in sustaining interest of the beneficiaries without relying on incentives. A statement paraphrased from a key informant interview buttressed this point “without refreshments they would not come to listen to us.” A true and perhaps, lasting change in attitudes and behavior should be accompanied by other benefits that ensure voluntary compliance. Future programming needs to engage this dialectic and perhaps, find alternatives that will reduce the interest of beneficiaries on incentives. Long term benefits will be the surest way to program sustainability in the long-run.
- HARPIN has built strong linkages with government agencies and other stakeholders. Efforts should be focused on continuously fostering and building on the relationship. Building on the relationship will require doing what was not done before, i.e. sharing of project reports, and other key documents. Most important, this relationship should lead to financial buy-ins by the government organs at the three tiers for project sustainability in the future.
- The project has been able to retain more qualified staff than before. However, efforts should be put into reviewing staff condition of service to include health insurance, staff security of staff while canvassing dangerous terrain, and more attention to volunteer benefits.
- Also, HARPIN management should examine ways and means of reducing lag time in decision making especially on project activities that are perceived by field staff as needing urgent financial attention, including procurement issues, and endeavor to bring in additional expertise in key areas of project implementation.

APPENDIX ONE: LIST OF DOCUMENTS REVIEWED

- HARPIN, Abstinence Basic Facts: How Toí í (Reviewed in August, 2011 during End of Project Evaluation)
- Alexander Ijeomah, Program Design And Implementation Plan For Balanced ABC-In-school Program. July 2011
- Amobi Onovo, Progress So Far (M&E Evaluation). July 2011
- Cooperative Agreement No. 620-A-00-08-00132-00, òHIV/AIDS Reduction Program in the Niger Deltaö (Reviewed in July, 2011 during End of Project Evaluation)
- HARPIN, HARPIN Abstinence and Be Faithful Manual. January 2009
- HARPIN, Basic Facts on Condoms, You need to Know Series (Reviewed in August, 2011 during End of Project Evaluation)
- HARPIN, Basic Facts on STIs: You Need to Know Series I (Reviewed in August, 2011 during End of Project Evaluation)
- HARPIN, First Quarter 2009 Program Report presented to the Executive Director, PHI. May 2008
- HARPIN, Fourth Quarter 2008 Program Report presented to the Coordinator, Rivers State Aids Control Program (Reviewed in August, 2011 during End of Project Evaluation)
- HARPIN, HARPIN Strategic Information Management Guide (HSIMG) (Reviewed in August, 2011 during End of Project Evaluation)
- HARPIN, In-school Balanced ABC Data, Cross River State (Reviewed in August, 2011 during End of Project Evaluation)
- HARPIN, In-School Peer Education Training Workshop manual: Abstinence, June 2011
- HARPIN, In-School Peer Education Training Workshop manual: Adolescent Reproductive Health Situation in Nigeria, June 2011
- HARPIN, In-School Peer Education Training Workshop manual: Adolescent Sexual Behavior, June, 2011
- HARPIN, In-School Peer Education Training Workshop manual: Anatomy and Physiology of Male and Female Reproductive System, June 2011
- HARPIN, In-School Peer Education Training Workshop manual: Assertiveness, June 2011
- HARPIN, In-School Peer Education Training Workshop manual: ARH issues 1: Introduction to Puberty & Adolescence, June 2011
- ARH issues 4: Teenage pregnancy and its effect on boys and girls, June 2011
- HARPIN, In-School Peer Education Training Workshop manual: Drug Abuse, June 2011
- HARPIN, In-School Peer Education Training Workshop manual: Gender Issues in Reproductive Health and HIV & AIDS, June 2011
- HARPIN, In-School Peer Education Training Workshop manual: Goal Setting, June 2011
- HARPIN, In-School Peer Education Training Workshop manual: HIV & AIDS, June 2011
- HARPIN, In-School Peer Education Training Workshop manual: HIV and AIDS Situation In Nigeria, June 2011
- HARPIN, In-School Peer Education Training Workshop manual: Introduction To Communication Skills, June 2011
- HARPIN, In-School Peer Education Training Workshop manual: Decision Making, June 2011
- HARPIN, In-School Peer Education Training Workshop manual: Introduction to Life Building Skills, June 2011
- HARPIN, In-School Peer Education Training Workshop manual: Negotiation Skills, June 2011

- HARPIN, In-School Peer Education Training Workshop manual: NPP & MPPI Approach, June 2011
- HARPIN, In-School Peer Education Training Workshop manual: Overview Of Life Building Skills, June 2011
- HARPIN, In-School Peer Education Training Workshop manual: Ovulation, Fertilization/Pregnancy and Menstruation, June 2011
- HARPIN, In-School Peer Education Training Workshop manual: Refusal Skills, June 2011
- HARPIN, In-School Peer Education Training Workshop manual: Relationship and Friendship: (Family and within Society), June 2011
- HARPIN, In-School Peer Education Training Workshop manual: STIs Prevention & Management, June 2011
- HARPIN, In-School Peer Education Training Workshop manual: Substance and Drug Abuse
- HARPIN, In-School Peer Education Training Workshop manual: The concept of Peer Education, June 2011
- HARPIN, In-School Peer Education Training Workshop manual: Value And Value Clarification, June 2011
- HARPIN, List of HARPIN Balanced ABC-Out of School intervention sites, Rivers State (Reviewed in August, 2011 during End of Project Evaluation)
- HARPIN, List of HARPIN intervention schools in Ikwerre, Obio/Akpor and Khana LGA
- HARPIN, List of Schools in Rivers (Reviewed in August, 2011 during End of Project Evaluation)
- HARPIN, Quarterly Progress Report, Fiscal Year 2010, COP 10. January 1 ó March, 2010
- HARPIN, Quarterly Progress Report, October ó December 2009. January 2010
- HARPIN, Quarterly Progress Report, January ó March 2010. April 2010
- HARPIN, Quarterly Progress Report July 2010 ó September 2010. October 2010
- HARPIN, Quarterly Progress Report, Fiscal Year 2010, COP 10, October 1 ó December 31, 2010
- HARPIN, Quarterly Progress Report, Fiscal Year 2011, COP 10, January 1 to March, 2011
- HARPIN, Reference Guide for Condoms and Other Prevention-Small Group Discussions (Reviewed in August, 2011 during End of Project Evaluation)
- HARPIN, Sample Management Information System (MIS) Form for Peer Education and Small Group Discussion (Reviewed in August, 2011 during End of Project Evaluation)
- HARPIN, Sample PITT Form. (Reviewed in August, 2011 during End of Project Evaluation)
- HARPIN, Sample PMTCT Monthly Summary Form. (Reviewed in August, 2011 during End of Project Evaluation)
- HARPIN, Second Quarter 2009 Program Report presented to the Finance and Administration Officer (Reviewed in August, 2011 during End of Project Evaluation)
- HARPIN, Training Workshop manuals: Advocacy for Comprehensive ABC (Balanced ABC) (Reviewed in August, 2011 during End of Project Evaluation)
- HARPIN, Training Workshop manuals: Condom Methodology And Logistics (Reviewed in August, 2011 during End of Project Evaluation)
- HARPIN, Training Workshop manuals: Condom Use (Reviewed in August, 2011 during End of Project Evaluation)
- HARPIN, Training Workshop manuals: HIV/AIDS Prevention Modalities In The Workplace (Reviewed in August, 2011 during End of Project Evaluation)

- HARPIN, Training Workshop manuals: Introduction to Sexually Transmitted Infections (Reviewed in August, 2011 during End of Project Evaluation)
- HARPIN, Training Workshop manuals: Issues in HIV and AIDS Counseling & Condoms issues plus Condom Demonstration (Reviewed in August, 2011 during End of Project Evaluation)
- HARPIN, Training Workshop manuals: Key Gender Concepts, July, 2011.
- HARPIN, Training Workshop manuals: Monitoring and Evaluation, June, 2011
- HARPIN, Training Workshop manuals: Overview of HCT, TB & STI Correlation (Reviewed in August, 2011 during End of Project Evaluation)
- HARPIN, Training Workshop manuals: Record Keeping And Report Writing, June, 2011
- HARPIN, Training Workshop manuals: SMART Objectives/Results for Communication (Reviewed in August, 2011 during End of Project Evaluation)
- HARPIN, Training Workshop manuals The Role Play HIV/STI Identification And Counseling
- HARPIN, Training Workshop manuals: Update On Key Health Sector Response To HIV/AIDS At National Level (Reviewed in August, 2011 during End of Project Evaluation)
- Offonime Effiong, Program Design And Implementation Plan For Balanced ABC óOut-of-School Program. July 2011
- Pro-Health International, Proposal for One Year Extension of the HIV/AIDS Reduction Program in the Niger Delta (HARPIN) Program. Program Description, May 2011
- Pro-Health International, Fiscal Year 2011, COP 10, October 1 ó December 31, 2010: Quarterly Progress Report Submitted to USAID Nigeria. January 2011
- Pro-Health International, Fiscal Year 2011, COP 10, January 1 ó March 31, 2010: Quarterly Progress Report Submitted to USAID Nigeria. April 2011

APPENDIX TWO: LIST OF PEOPLE CONTACTED

Pro-Health Staff Headquarters, Jos Plateau State

Dr. Iko Ibanga	Executive Director
Pastor (Mrs.) Esther Ibanga	Director of Finance
Dr. Gabriel Toma	Director of Programs
Emmanuel J. Udofia	Director of Administration
Gabriel Ugoji	Senior Account Officer

Pro-Health Staff, Rivers State

Mr. Chris Ogedengbe	Program Manager
Pastor Bimbo Adams	Finance Manager
Alexander Ijeoma	Sexual Prevention Advisor
Akin Olugbenga	Finance Officer
Robert Patricia	Human Resources Officer
Ofonime Effiong	SBC Officer
Adeleke Adetunji	SBC Officer
Emmanuel Pimonki	Logistics Officer
Green Tumini Edith	Data Officer
Christiana Edet	Front Desk Officer
Elizabeth Christopher	Office Assistant
Okparah Nwabunwanne	Volunteer
Jane Inyang	Volunteer
Elizabeth T.Kune	Volunteer
Azubuike Juliet N.C	Volunteer
Mercy Tende	Volunteer
Ibe Julius	Driver

Pro-Health Staff, Cross River State

Adekugbe Olayinka	Deputy Program Manager
Ogban E.Omoronyia	PMTCT Advisor
Akibu Tosin	Sexual Prevention Advisor
Andrew A. Onovo	Monitoring/Evaluation Officer
Amaka Ofem	Prevention of Mother to Child Treatment Officer
Ikwuta Ada	Finance Officer
Akpu Blessing Oko	SBC Officer
Leah Umeokeke	SBC Officer
Peace Bartholomew Ekeng	Volunteer

USAID-Nigeria Staff, Abuja

Pamela Gado	HIV/VCT Manager /AOTR
Tessy Ononye-Philips	Program Assistant/Formal AOTR
Isa Ioyrtim	Medical Transmission Prevention Manager/Alternate AOTR
Kalada Green	Senior Prevention Advisor/Unit Lead
McPaul Okoye	Senior Laboratory/VCT Manager
Duke Ogbokor	Health Management Information System Manager
Akin Atobatele	Monitoring & Evaluation Manager
Dolapo Ogundehin	PMTCT Program Manager

Sola Onifade
Abu Ugbede-Ojo
Abiye Kalaiwo

Orphan & Vulnerable Children Manager
Logistics Manager
Sexual Transmission Prevention Manager

Consultants/Evaluators

Rivers

Muyiwa Oladosun
Babajide Akinpelu
Saudat Sanni
Emmanuel Oladosu

Lead Consultant
Field Supervisor
Field Supervisor
Field Supervisor

Cross River

Muyiwa Oladosun
Charles Ayo Toriola
Ifeyinwa Ononye
Femi Oladosu
Patience Bioye

Lead Consultant
Consultant
Field Supervisor
Field Supervisor
Field Supervisor

SACA/LACA/MOH/AND MOE OFFICERS

Rivers State

Mrs. Joy Nwamaka
Dr. Nasiga Francis
Mrs. Ogbuji Victoria

Ministry of Education
State Action Committee on AIDS
Local Government Action Committee on AIDS, Ikwerre

Cross River State

Mrs. Minka Takon
Mrs. Regina Odey
Mrs. Rosemary Offiong

Ministry Of Education
Ministry Of Health
Local Government Action Committee on AIDS, Akamkpa

PRIMARY HEALTH CENTERS (PHC) HEALTH CARE PROVIDERS

Cross River State

Elizabeth E. Eteng
Mary B. Ekeng
Ekaette B Inyang
Mrs. Asari Eniang Effiong
Mrs. Agan .U. Udiba
Regina .E. Ogburang
Udeme A. Essien
Bennet Ukpabio

Matron, PHC Aningheje, Akamkpa
NdCHEW, PHC Aningheje, Akamkpa
Community Health Officer, PHC Aningheje, Akamkpa
Laboratory Scientist, PHC Ekpo-Abasi, Calabar South
Laboratory Technician PHC Akpet I, Biase
Principal CHEW, PHC Uyanga, Akamkpa
Director, HCT Centre, Odukpani
M& E Officer, HCT Centre, Odukpani

COMMUNITY LEADERS

Rivers State

Aluu Community, Khana
Chief Simon Icheboule
Chief Ruben Isi

Community Leader
Community Leader

Emmanuel Chibuzor	Community Leader
Jacob Nnamdi	Community Leader
Akobundu Mark	Community Leader
Akandu C. Justice	Community Leader

Cross Rivers

HRH Onun Otu	Community Head (Echu Igriga), Adim Community, Biase
Chief Eto Ikama	Community Leader, Ikami Community, Uyanga, Akamkpa
Munene Effiong Okokon Mbukpa	Community Head, (Eta Odionka Ebuka VII), Calabar south

SCHOOL PRINCIPALS

Rivers State

Mr. Ugoneme Jerin L	Principal, Government Comprehensive High School Taaba, Khana
Mrs. Boma Jaja	Principal, Emarid College Igwuruta/Eneka, Ikwere
Sir Chief M.J. Oha	Principal, Anglican Secondary School, Isiokpo, Ikwere
Mr. John Zachaeus	Vice Principal, Rivpoly Comprehensive Secondary School, Khana
Sir Lucky Ernest Baridam	Principal, Community Secondary School Kpean, Khana
Mr. Felix Gbara	Principal, Bane Comprehensive College Bane, Khana

Cross Rivers

Mrs. Nsa Esu	Principal, Science School, Mayne Avenue, Calabar South
Mrs. Elizabeth Archibong	Principal, Government Secondary School Atu, Calabar South
Mrs. Helen Ekpat	Vice Principal, Nigerian Navy Secondary School Akpabuyo, Calabar South
Dr. Mrs Ina	Vice Principal, Community Secondary School Adim, Biase
Mr. Ekpo Ekpo Obo	Principal, Government Secondary School Uyanga, Akamkpa
Mrs. Immaculata Mbem	Principal, Pinn Margerate School, Calabar south

COMMUNITY BASED ORGANIZATION

Rivers State

Youth Caring For Health (YCH), Khana LGA

Numbara Baridapdro	President
Yigah Faah	General Secretary
Nekabari Banikpe	Treasurer
Deekie S.Nyiradee	Member
Bright Nwikipugi	Member
Nwibana John Lekara	Member
Alap Lekara	Member

Rumudumaya Health Organization, Obio-Akpor LGA

Barisi Kanee	President
Abah Onoja Gabriel	Secretary General
Nwoko Uchechi	Member

HEALTH MODERATORS

Rivers State

Bori Community, Khana LGA

Paul Apanya	Health Moderator
Niabani John	Health Moderator
Pastor Agnes Døebee	Health Moderator
Patience Ideede	Health Moderator
Joseph Jim Meekor	Health Moderator
Bernard Nmeakor	Health Moderator
Dum Jack	Health Moderator

Obi-Akpor LGA

Emmanuel Clifford	Health Moderator
Boma I. Wakama	Health Moderator
Samuel Nkpee	Health Moderator
Christy Harrison	Health Moderator
Izuogu Rita C.	Health Moderator
Susan Don-Pedro	Health Moderator
Josephine Echie	Health Moderator
Donald Ikwun Omang	Health Moderator

Cross Rivers

Ikami Community, Uyanga, Akamkpa

Blessing Victor Asuquo	Health Moderator
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Anantigha Community, Calabar South

Esenyie Victor Dick	Health Moderator
Okereke Patience Azeng	Health Moderator
Owan Mary Nda	Health Moderator
Okala Onyemaechi Kelvin	Health Moderator
Ubi Jesam Eteng	Health Moderator
Effiong Eyo Okon	Health Moderator
Tom Bassey Stephen	Health Moderator

IN-SCHOOL YOUTHS & PEER EDUCATORS

Rivers State

Community Comprehensive Secondary School, Rumukouruchi, Obi-Akpor

Elizabeth Izidor	Peer Educator
Uduak John	Peer Educator
Obiyo Uchechi	Peer Educator

Government Comprehensive High School Taaba, Khana

Gentle Vincent	Peer Educator /FGD Participant
Edoo Bridget	Peer Educator /FGD Participant
Bantor Kunce	Peer Educator /FGD Participant
Zorly Faith	Peer Educator /FGD Participant

Precious Iheanyi	Peer Educator /FGD Participant
Confidence Mbaedee	Peer Educator /FGD Participant
Stanly Elijah	Peer Educator /FGD Participant
Mission Godgift	Peer Educator /FGD Participant
Elizabeth Izidor	Peer Educator /FGD Participant
Uduak John	Peer Educator /FGD Participant
Obiyo Uchechi	Peer Educator /FGD Participant

Cross-River

Government Technical College Mayne Avenue, Calabar South

Marshal Nsikan Inuen	FGD Participant
Ekwere Hannah Ebuk	FGD Participant
Elisha Akan Umanah	FGD Participant
Abigail Effiong Etim	FGD Participant
Winifred Joseph Ogar	FGD Participant
Mary Essien Ekpeyong	FGD Participant

Community Secondary School Adim, Biase

Ofem Egwu Etan	Peer Educator /FGD Participant
Gift Echu Ekpeni	Peer Educator /FGD Participant
Owenone Ernest Ilem	Peer Educator /FGD Participant
Uno Efut Ejogobe	Peer Educator /FGD Participant
Odum Ezak Akari	Peer Educator /FGD Participant
Joy Egwu Egong	Peer Educator /FGD Participant
Hilary Ajah Ekpang	Peer Educator /FGD Participant
Susan James Ben	Peer Educator /FGD Participant

Government Secondary School Atu, Calabar South

Akaniyene Peter Tom	FGD Participant
Angelina Effiong Anthony	FGD Participant
Ada Inyang Kalo	FGD Participant
Iseral Asuquo	FGD Participant
Rose Okon Edet	FGD Participant
Uduak Benson	FGD Participant
Magreat Archibong	FGD Participant
Irene Bassey Etim	FGD Participant
Joy Emmanuel	FGD Participant

OUT- OF SCHOOL YOUTHS

Rivers State

Bori- Looyoo Community, Khana

Glays Baleera	FGD Participant
Mercy Yaakpaa	FGD Participant
Barisi Gberazia	FGD Participant
Doris Mpeba	FGD Participant
Baridakara Kenneth	FGD Participant
Bariledum Suakpo	FGD Participant
Waamene Nsagha	FGD Participant
Choice Bariaaba	FGD Participant

Cross River

Adim Community, Biase

Emmanuel John Owai	FGD Participant
Wisdom Nelson Ekpe	FGD Participant
Benjamin Eni Eyong	FGD Participant
Abel Owai Eyak	FGD Participant
Prince Pius Okon	FGD Participant
Fade Uno Ekpe	FGD Participant

Abredang Community, Biase

Ulong Ukam	FGD Participant
Ukam Ulong Ajah	FGD Participant
Ilokam Ukam Uno	FGD Participant
James Ukam	FGD Participant
Oguolo Uwgbor	FGD Participant
William Oban	FGD Participant

APPENDIX THREE: EVALUATION SCOPE OF WORK

1. BACKGROUND

HIV/AIDS Reduction Program in the Niger Delta (HARPIN) is a PEPFAR/USAID-funded Project designed to support the Federal Government of Nigeria's (FGoN) response to the expanding HIV epidemic in the country. Pro-Health International (PHI) is a Nigerian, faith-based, non-profit organization involved in HIV/AIDS prevention. In response to the APS No. 620-06-002 dated April 13, 2006, PHI, proposed a project to provide HIV/AIDS prevention activities in Cross-River and Rivers States by addressing elements 1 and 2 of the USAID APS as follows:

1. Strengthening NGO capacity to respond to HIV/AIDS in their communities; and
2. Preventing HIV transmission, especially among youth, couples, and pregnant women.

The project covers seven local government areas in Rivers and Cross-River States. USAID Nigeria awarded Cooperative Agreement No. 620-A-00-08-00132-00, on HARPIN to PHI in March 2008 and the three year project was initially planned to start in April 2008 to end in March 2011. The implementation eventually commenced in August 2008 and the project was extended to August 2011.

As with all other PEPFAR initiatives, the goal of HARPIN is to reduce the spread of new HIV infections in Rivers and Cross-River states over a period of three years. Thus, the project contributes towards achieving USAID/Nigeria's Strategic Objective (SO) 14 - reduced impact of HIV/AIDS in Rivers and Cross-River states, through:

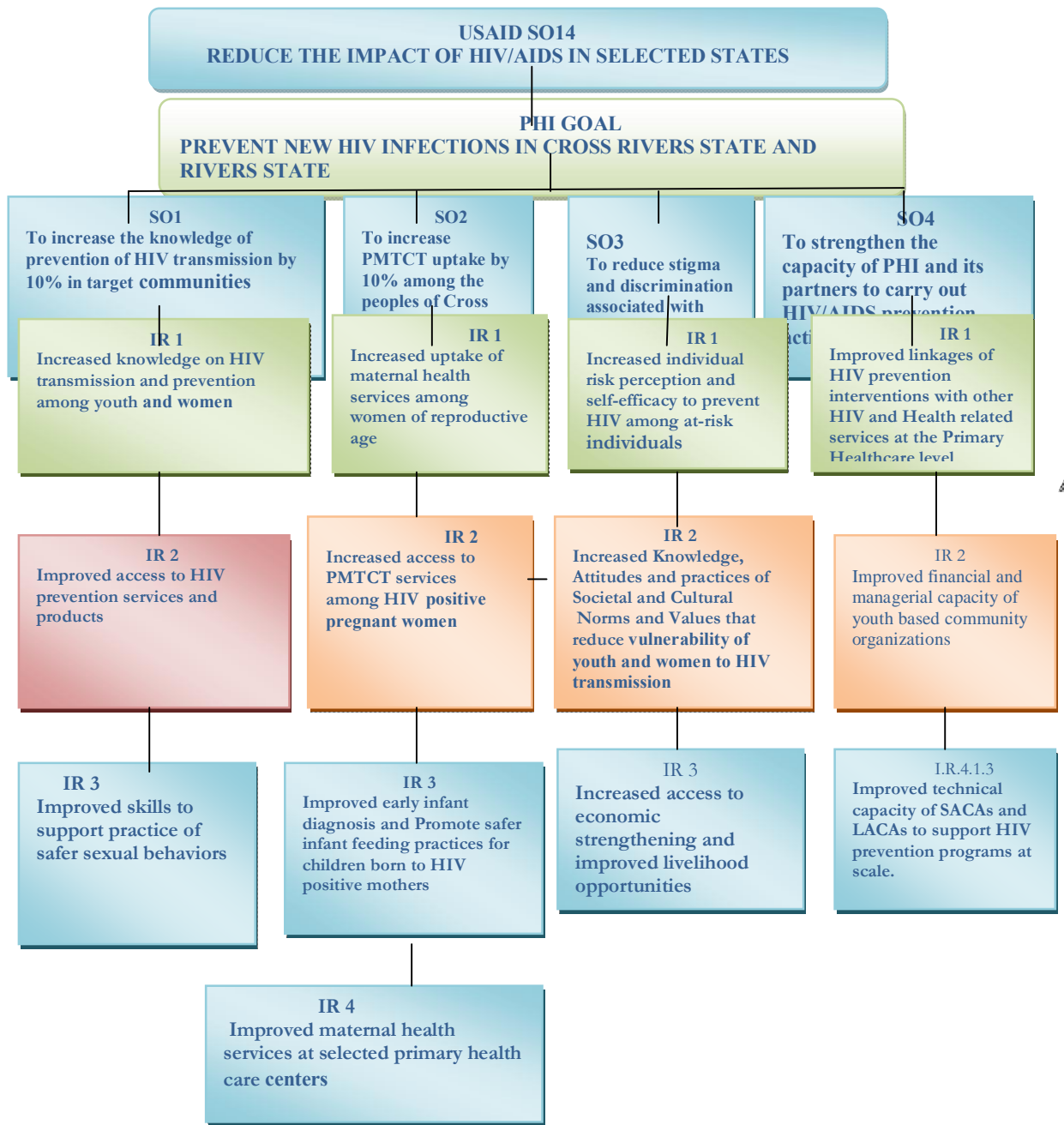
IR 14.1: Increased knowledge on HIV transmission and prevention among youth and women

IR 14.2: Increased uptake of maternal health services among women of reproductive age

IR 14.3: Increased individual risk perception and self-efficacy to prevent HIV among at-risk individuals

IR 14.4: Improved linkages of HIV prevention interventions with other HIV and Health related services at the Primary Healthcare level

HARPIN is strategically designed to address the drivers and predisposing factors of new HIV infection among high risk and vulnerable populations. In the last three years PHI/HARPIN has uniquely devised strategies to ensure community ownership and sustainability of all its interventions.



The objectives of the program are:

1. To increase the knowledge of prevention of HIV transmission by 10% among selected populations in target communities.
2. To increase PMTCT uptake by 10% among pregnant women in the selected communities in Cross-River and Rivers states over a 3 year period.
3. To increase knowledge on stigma and discrimination associated with HIV/AIDS by 10% among selected populations in target communities in Cross-River and Rivers state.
4. To build the financial and management systems capacity of PHI and its partners to provide more effective HIV/AIDS programming.

After successful implementation of the program for first two years, PHI re-negotiated for a program realignment and modification. In January 2011, a major program and budget modification was completed to implement a new phase of HARPIN through August 2011. This amendment took into cognizance the drivers of the epidemic in the Niger Delta region. The revised program description was drafted to reflect the socio-cultural norms and practices that increase vulnerability to HIV infections.

The program has the following two main components:

- Sexual Prevention
- Prevention of Mother to Child.

The sexual prevention components targets youths between the ages of the 15-24 and other at-risk population with behavior change messages. This program focuses on Abstinence, Being Faithful and Condom messaging, STIs referral and counseling for vulnerable population. The sexual prevention component uses the peer led approach as a fulcrum for implementing the minimum prevention package of Intervention.

One of the primary targets of HARPIN's sexual prevention interventions is in-school youth between the ages of 15-24 years for which a peer led approach is used as a fulcrum using a non-curriculum based approach. In the last two years HARPIN/PHI has worked in eighty one (81) schools, training over 3000 peer educators, who in turn reached over 30,000 youths with HIV/AIDS prevention messages. In order to promote and create an environment conducive for sustainable behaviour change, HARPIN provides supports in formation and sustenance of school health clubs (HIGH FLYER CLUB). On a quarterly basis funds are allocated to school health clubs for behaviour maintenance activities (games, quiz, competitions, health talks, valentine special, etc). Since inception of HARPIN till date over 81 health clubs have benefitted from the HIGH FLYER CLUB INITIATIVE.

The aim of the PMTCT is to prevent the trans-generational spread of HIV by targeting pregnant women with HCT, ARV, IF, and FP. HARPIN provides quality healthcare services in line with the government of Nigeria's stated objectives of improved quality of care at the primary level, especially provision of universal access to prevention of mother-to-child transmission services. HARPIN provides minimum package PMTCT, which ranges from counseling and testing for pregnant women, ARV prophylaxis to prevent MTCT, counseling and support for safe infant feeding practices, Family planning counseling/referral.

The PMTCT Program has conducted HCT for 6000 pregnant women, trained over 120 health care workers on PMTCT service delivery, improves accessibility to ARV prophylaxis among eligible clients and increased the coverage of PMTCT services by 39% in target community.

2. STRATEGY/APPROACH OF THE PROJECT

PHIØ strategy uses three prong approaches which are:

(a) Working in partnership with other local organizations

(b) Adopting cross-cutting approaches aimed at building local ownership, addressing gender inequalities, scaling-up, and building local capacity to continue and sustain activities after the project has been concluded.

(c) Implementing behaviour change communication (BCC) activities. The sexual prevention carries out its intervention by using the three minimum packages of HIV/AIDS prevention hinged on health communication behaviour change strategy. The focus of the sexual prevention interventions is to promote behavior change among at-risk and vulnerable populations. The minimum packages adopted are **Peer-led approach (peer education)** which will be the first prong of this approach will target the individuals primarily to increase knowledge as well as target the individual with the objective of increasing knowledge to a point of concern while concurrently providing the right motivational packages and behavior change messages. This approach will be used for this age group in both in-school and out-of-school communities. Specifically for the Out of school community **Condom messaging and demonstration as a community outreach approach** is adopted as the second prong while **Community dialogue meeting and formation and support of Community Based organizations** serves as the third prong as this will target socio cultural and socio occupational milieu of the target individual with the aim of addressing specific drivers of the epidemic. For the in-school community in addition to peer education, **Small group discussion** and **Formation and support of Health club** are implemented.

(d) The HARPIN program works with Primary Health Care Centers (PHC) in mostly Rural and Urban areas. The HARPIN PMTCT program is implemented in four local government areas (Odukpani, Akampa, Calabar South and Biase) in Cross River State. Currently the program operates in 30 sites scattered across the four local government areas. HARPIN PMTCT program will emphasize PMTCT at the Primary and Secondary levels of healthcare delivery in efforts to ensure that PMTCT services are more accessible to the average rural pregnant woman. This Community PMTCT component will receive greater emphasis to drive increased uptake of PMTCT services in poorly attended Primary Healthcare Facilities in the Niger Delta.

3. OBJECTIVE OF THE FINAL EVALUATION

The purpose of this assignment is to undertake a final assessment of the performance of this program (HIV/AIDS Reduction Program in the Niger Delta) relative to the project design as contained in the original project document and critically analyzing the achievements, outcomes and the lessons learned in the process of executing the project. Thus the objective is to assess achievements, lessons learned and challenges of HIV/AIDS reduction Program in the Niger Delta in a manner conducive to the implementation of the resulting recommendations and action plan.

The evaluation will assess project achievements relative to the plan presented in the project proposal as well as other positive and negative consequences identified by the stakeholders. The evaluation will cover, but will not be limited to, the project plan as presented in the proposal. The evaluation process will also attempt to capture the unintended or unforeseen effects, both good and bad, of project activities which may be of great importance.

The evaluation will place greater emphasis on the outcomes, of project implementation, and determine whether the project was implemented according to plan. The evaluation will also undertake a full assessment of the multiple factors that contribute to the successful program

implementation and actualization. It will serve also as a gateway to obtaining community perspective on the program out-comes.

The final evaluation will also review the extent to which project activities were implemented in all the program areas, and number of target population reached within the project time-frame. This final evaluation will be used to elicit information on the gaps between program design and delivery, critically accessing the measure to which project implementer have maintained fidelity implementation plan

The final evaluation will be a collaborative effort among all stakeholder groups. In this collaborative plan, the core evaluation team will facilitate a process through which stakeholders will assess the successes and failures of the project and determine future actions.

The final evaluation will be conducted by an external evaluator who will work with PHI team on the plan, carry out the fieldwork and produce the report of the evaluation. The consultant(s) will organize the core evaluation team that will drive the process, generate the report and present the report to PHI and USAID.

Specific Objectives: The specific objectives of the evaluation are to evaluate the outcomes/results of this program in terms of:

- Changes in Knowledge regarding HIV/AIDS and sexual health among vulnerable youths in the project areas.
- Reducing risky sexual behavior among the target groups: in-school and out-school youth
- Addressing demands for confidential HCT services through referral.
- Increasing the usage of HCT services among pregnant women
- Improving the accessibility to ARV among HIV positive pregnant women
- Promoting safer infant feeding practices among HIV positive mothers
- Improving maternal health services among women of reproductive age
 - Building local capacity and coping strategies and implementing as well as replicating sustainable community based HIV/AIDS prevention.

The final evaluation is divided into two parts: project implementation and PHI internal project management. Each of the two parts will address the following core areas:

i. Project implementation issues

The evaluation will assess the achievements and challenges arising from the implementation activities, which have taken place to prevent new HIV infections among in-school, out-of-school youths and the prevention of HIV infections among people living with HIV/AIDS. The evaluation will examine how the prevention of mother to child has prevented new born babies from contacting the infections.

ii. Internal project Management

The second part will examine the internal project management. In this respect, the final evaluation will carry out assessment of PHI's internal management of the HIV prevention project on AB, balanced ABC and the PMTCT in Rivers and Cross-River states.

1. EVALUATION QUESTIONS

The final evaluation will reveal if the objectives of the project were achieved and will elicit the lessons learned in the process of implementing the project such that the project will facilitate improvement and sustainability of future projects in Niger Delta. Specifically evaluation will answer the following questions:

To what extent did the HARPIN project achieve its objective of reducing HIV infections in the Niger Delta?

To what extent has the knowledge of prevention of HIV transmission increased among in-school and out-of-school youths in target communities of Rivers and Cross-Rivers states

1 Was HARPIN able to reduce the risky behaviour of in-school and out-of-school youths in the project locations of Rivers and Cross River states?

What were the external factors that affected the implementation of the project?

To what extent did the capacity building efforts of HARPIN contribute to the Community-based organizations' overall performance in the delivery of HIV/AIDS prevention services in the selected communities of the project states?

To what extent did the project improve accessibility to ARVs among HIV positive pregnant women in the selected communities?

In what ways could the accessibility of ARV be improved up and made sustainable in the region?

What was the level of coverage of PMTCT delivery points as compared with the program plan?

What factors should be put in place to scale up future PMTCT programming in the Niger Delta?

What were the lessons learned in the planning process and in implementing of the project that would guide in the improvement of future interventions in HIV/AIDS prevention in the Niger Delta?

To what extent are program accomplishments sustainable and replicable in the target communities?

Were project target beneficiaries fully served by this activity?

To what extent are program accomplishments sustainable and replicable in the target communities?

How effective were the project's selected interventions and implementation strategies in reducing HIV transmission among target populations?

How could the management elements be improved in the future

Sources of information to answer the questions

Relevant information for answering the questions above will be obtained from the Sample Survey, Key Informant interviews, Focus Group Discussions among the different respondents given in section 5 below. Some of the relevant information for answering the questions will also be obtained from the review of project documents.

EVALUATION METHODS

The methodology will focus on obtaining information, opinion, qualitative and quantitative data from target population. These will also include the preparation of appropriate questionnaire that will enable the team gather all the information required from all the parties involved and related

to the activity. The methodology will comprise a mix of tools appropriate to the evaluation's research questions.

The final evaluation will be conducted in the in the following stages:

Stage 1: Review of Existing Documentation

Stage 2: Refinement of Review Methods

Stage 3: Data Collection

Stage 4: Write Evaluation Report

Stage 1: Review of Existing Documentation

The evaluation team will conduct a thorough review of existing data and information from the project documents. In addition, the team leader (external consultant) may decide to consult additional documentation from other sources. Finally, the team leader will outline preliminary field visit plans.

Stage 2: Refinement of Review Methods

HARPIN activities are heavily weighted toward reaching in-school and out-of-school through peer education methodology, community outreach activities, and capacity building activities for field staff in order to increase their effectiveness in project implementation that avert new HIV infections. Also in PMTCT program, sensitization of the general and the target population and continuous support and training of the health personnel are among the major activities. In order to determine whether knowledge has been built and, more importantly, that this increased knowledge is being used on a routine basis by the trained staff and impacting program activities, the team will need to combine both quantitative and qualitative approaches to data collection. Rather than stating the exact mix in this scope of work, we feel that it is crucial for the consultant/team leader to be instrumental in the method selection process.

Stage 3: Data Collection

In assessment of program indicators, qualitative methods will be used to gather useful information consequently, the following data collection methods will be utilized and respective instruments will be used:

- **Sample survey** ó Structured Questionnaire
- **Focus group discussions (FGD)** ó FGD Guidelines
- **Key informant interviews (KII)** - KII Guidelines
- **Document review** - List of documents
- **Observation** - List of Project Sites
- Random spot checks - visits to field offices and target population Clinics/Homes/Fields.

Quantitative Data – Sample survey

The quantitative data will be collected by using Structured Questionnaires and data will be collected from in-school youth in the participating schools. The list of the schools in each of the selected LGAs will form the sampling frame and each school will constitute a cluster of students and consequently **Cluster System** will be used in the sampling. The first level of sampling will be the schools and the second level is will be students thus the system is **Multiple Cluster Sampling**.

Qualitative Data – FGD and KII

The qualitative data will be collected using the FGD and KII methods from the following the stipulated personnel:

Key Informant Interviews/In-depth Interviews

Funding Agency – USAID

- Team Leader, USAID Prevention Technical Working Group
- Agreement Officer Technical Representative
- USAID Accountant responsible for the project
- A member of the USAID PTWG

Government of Nigeria

- Two officials of State Agency for the Control of HIV/AIDS (SACA)
- An official of LGA Agency for the Control of HIV/AIDS (LACA) in each of the LGAs selected for the project.

PHI Head Office in Jos

Executive Director, Director of Programmes, Director of Administration and Program Accountant

PHI Field Offices – Port Harcourt and Calabar

Program Manager, Deputy Program Manager, Program accountant, Program Officers and Strategic Behaviour Communication Officers (SBCOs)

Project sites – Rivers and Cross-River state

Principals of participating schools, Officials of the Ministries Health and Education and Health workers in the participating PHCs

Focus Group Discussions

Target groups of In-school and out-of-school youth, pregnant women, and Members of the targeted communities

The consultant will develop tools (Questionnaire, FGD and KIII guidelines) for the collection of data from the articulated personnel given above. These tools will be pretested in neutral areas to avoid bias responses during the actual interviews.

Analysis Plan The information collected will be analyzed by the Evaluation Team to identify correlation and establish the major trends and issues articulated in the evaluation questions.

The data from the completed questions will be edited, coded and entered into computer with Epi-Data computer program and be exported to SPSS for data cleaning, processing and analysis. The data will be exported to MS Excel for generating tables, charts and graphs.

The data will be disaggregated by gender, age, ethnicity to identify how program impact differs across groups. The notes obtained from the focus group discussion and interview will be revised, deciphered, edited and transcribed into Microsoft word. The responses will be categorized by gender, age, occupation, socio-economic class and community. The responses will be coded and arranged into categories, patterns, themes, and issues that emerged during interviews and focused group discussion.

Important themes identified from the transcribed information using quasi quantitative method which allow calculating the frequency of participants with particular beliefs, attitudes, views, knowledge, and perceptions of the participants. All findings will be disaggregated by state, LGA, sex and age.

Stage 4: Write Evaluation Report

Upon completion of the field data collection, the team leader will draft the evaluation report with conclusions and recommendations. The team leader will hold a meeting with PHI to present findings, lessons learned, and recommendations.

The evaluation team will also review the following written materials related to the project:

1. Realigned Cooperative agreements.
2. Work-plan for the previous years
3. Quarterly Reports
4. Interviews with Beneficiaries
5. Performance monitoring Plan
6. Field Monitoring Reports

7. Monitoring and evaluation guideline
8. Data Management Chart
9. HARPIN/PHI database

Existing data, reports and formats will be used as the sources of information for the evaluation to the extent possible to determine if our strategy could lead to achievement of stated targets, and whether the project is reaching its target groups and to what extent?

Much of the information that will be needed for the final evaluation is easily accessible from routine reports. Additional qualitative information may be collected from the project stakeholders. PHI staff will provide detailed information on the program.

1. PERFORMANCE INFORMATION

HARPIN has a well established Monitoring and Evaluation unit and it is manned by an M&E officer. The officer maintains the database on the project and will provide the evaluation team with the monitoring reports and necessary service data for the project.

The quarterly reports contain information on Performance Monitoring Plan (PMP) which will show the trend in covering the project targets on different project indicators. The result framework is presented in the page below.

2. PERFORMANCE PERIOD

Table 1 **Timeline for the Final Evaluation**

S/N	ACTIVITY	TIMELINE	WHOSE RESPONSIBILITY
1	Approval of the SOW of the evaluation	July 1	PHI, USAID
2	Publication of expression of interest (EoI)	July 4 -11	PHI
4	Selection of the external consultant	July 12	PHI
5	Seeking the approval of consultant from USAID	July 13	USAID
6	Commencement of the evaluation	July 18	Consultant
7	Planning of the evaluation	July 18-20	Consultant
8	Document review and Fieldwork of the evaluation	July 21- 28	Consultant. PHI to provide relevant information
9	Data analysis and report generation	July 29 - Aug. 2	Consultant
7	Preliminary discussion of the draft of the evaluation with PHI	Aug. 4	Consultant
8	Presentation of the draft to USAID	Aug. 8	Consultant
9	Correction of the draft	Aug. 9	Consultant
10	Presentation of the final report to PHI	Aug. 11	Consultant
11	Submission of final report to USAID	Aug. 12	PHI
12	Dissemination of the evaluation report to the stakeholders	Aug. 15	PHI, Consultant

The evaluation will begin with the approval of the SOW by USAID on or before August 1, 2011 and will require 45 days of effort. The details of the timeline of the final evaluation are given in Tale 1 above. The final report is expected to be submitted to USAID on August 12, 2011.

3. SCHEDULING AND LOGISTICS

The evaluation team will be responsible for arranging air travel and accommodation. The logistics/administrative assistant of PHI in the field office (Port Harcourt) will arrange field visits, local travel, hotels and appointment with stakeholders. HARPIN/USAID personnel will be made available to the team for consultation regarding sources and technical issues, before and during the evaluation process.

PHI will be responsible for arranging the dissemination workshop and for producing the copies of the final report.

9 REQUIREMENTS FOR REPORTING AND DISSEMINATION

The major findings from the evaluation will be presented in a draft report and the draft report should show the following:

CONTACT INFORMATION

Mr. Chris Olusola Ogedengbe, Program Manager of HARPIN, and Dr. Yinka Adekugbe, Deputy Program Manager, are the points of contact for this assignment.

ILLUSTRATIVE REPORT OUTLINE

Cover page (Title of the study, the date of the study, recipient's name, name(s) of the evaluation team.

Preface or Acknowledgements

List of Acronyms

Lists of Charts, Tables or Figures [Only required in long reports that use these extensively]

Executive Summary [Stand-Alone, 1-3 pages summary of report. This section may not contain any material not found in the main part of the report]

Main Part of the Report

- i. **Introduction/Background and Purpose:** [overview of the final evaluation. Covers the purpose and intended audiences for the final evaluation and the key questions as identified in the SOW]
- ii. **Study Approach and Method:** [Brief summary. Additional information, including instruments should be presented in an Annex].
- iii. **Findings:** [This section, organized in whatever way the team wishes, must present the basic answers to the key evaluation questions, i.e., the empirical facts and other types of evidence the study team collected including the assumptions].
- iv. **Conclusions:** [This section should present the team's interpretations or judgments about its findings.
- v. **Recommendations:** [This section should make it clear what actions should be taken as a result of the study]
- vi. **Lessons Learned:** [In this section, the team should present any information that would be useful to people who are designing/manning similar or related new or on-going programs in Uganda or elsewhere. Other lessons the team derives from the study should also be presented here.]

The consultant will have a meeting with PHI officials where the preliminary findings and recommendations of the evaluation will be discussed. The consultant will prepare a PowerPoint presentation which will be presented to USAID and discussed. Thereafter he/she will also make the presentation when discussing the findings with PHI and presenting the final report at the dissemination workshop.

Dissemination of the report

The final report of the evaluation will be disseminated to stakeholders at a location acceptable to USAID. About 50 participants comprising officials from USAID, GoN, Representatives of Governments of Rivers and Cross River, Health workers from the participating PHCs, community leaders and village heads of the communities where the project was carried will be invited to dissemination workshop.

Five hundred (500) copies of the final report will be produced for the dissemination and for the resource unit of PHI.

The findings from the evaluation will be shared in the website of PHI and will be available to be published by the funding agency (USAID).

1. TEAM COMPOSITION

EVALUATION TEAM COMPOSITION AND LEVEL OF EFFORT

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

1. Team Leader: The Team Leader will provide leadership for the team, finalize the evaluation methodology design to be shared with USAID Nigeria for their feedback and comments, coordinate activities, arrange periodic team meetings, consolidate individual input from team members and coordinate the process of assembling the final findings and recommendations into a high quality document. S/he will be responsible for writing the final report and leading the preparation and presentation of key findings and recommendations to USAID Nigeria, HARPIN, and other stakeholders, as appropriate. S/he will also lead in providing recommendation for future directions. (LOE 45 days).

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

2. Team Members: The additional five-to-six team members will assist in the design of evaluation instruments (Questionnaire, KII Guidelines and FGD Guidelines) and will be responsible for reviewing the progress in accomplishing the evaluation's planned results and outcomes per their assigned roles and responsibilities. The team members will be responsible for drafting portions of the evaluation report and debriefing. (2 Team Members = LOE 50 days; 2 USAID Team Members = LOE 22 days; 1-2 GoN staff members = LOE 22 days).

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

- a. Individual(s) with an in-depth understanding of HIV/AIDS prevention, care and treatment programs and services in a public health context in an international setting.
- b. Individual(s) with program monitoring and evaluation experiences.
- c. Individual(s) with an in-depth understanding of USAID and PEPFAR procedures and reporting frameworks.

The external consultant will be selected through a published newspaper advertisement of Expression of Interest and the most qualified candidate, using the criteria stated above, will be appointed to carry out the evaluation.

APPENDIX FOUR A: LIST OF QUANTITATIVE INSTRUMENTS

HARPIN End of Project Evaluation: Questionnaire for ISY

HARPIN End of Project Evaluation: Questionnaire for OSY

HARPIN End of Project Evaluation: Questionnaire for PMTCT Beneficiaries

HARPIN End of Project Evaluation: Questionnaire for HARPIN/PHI Staff

APPENDIX FOUR B: LIST OF QUALITATIVE INSTRUMENTS

HARPIN End of Project Evaluation: FGD Question Guide for ISY
HARPIN End of Project Evaluation: FGD Question for Peer Educators
HARPIN End of Project Evaluation: FGD Question Guide for OSY
HARPIN End of Project Evaluation: FGD Question Guide for Health Moderators
HARPIN End of Project Evaluation: Interview Guide for CBO
HARPIN End of Project Evaluation: FGD Question Guide for PMTCT Beneficiaries (women)
HARPIN End of Project Evaluation: Interview Guide for School Principals
HARPIN End of Project Evaluation: Interview Guide for Health Providers
HARPIN End of Project Evaluation: Interview Guide for TBAs
HARPIN End of Project Evaluation: Interview Guide for PHI/HARPIN Staff
HARPIN End of Project Evaluation: Interview Guide for USAID Staff
HARPIN End of Project Evaluation: Interview Guide for MDAs and others

Evaluation Team Visit Summary

Project Manager	Mr. Chris Olusola Ogedengbe
Program	Sexual Prevention
Beneficiaries	In-School Youths (10-14years), Out of School Youth (14 years and above)
Key Partner	Global Health Network Against HIV/AIDS, Rumuodumaya Health Organization, Youth Caring for Health
State	Rivers
LGA	Ikwerre, Obio-Akpor and Khana
Dates	August 2008 ó August 2011

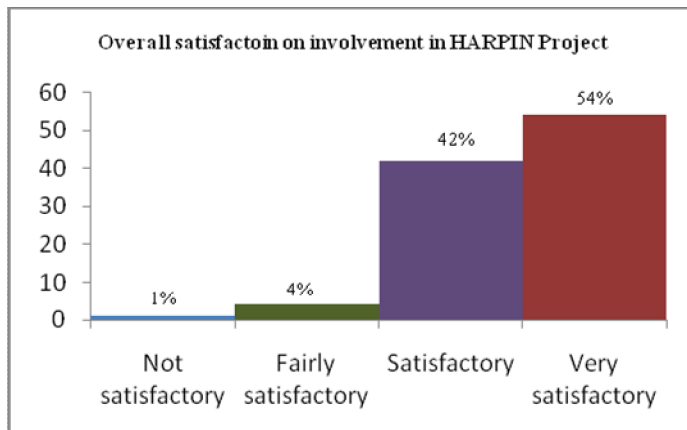
The evaluation Team A comprising of Muyiwa Oladosun, Akinpelu Babajide, Emmanuel Oladosu and Saudat Sanni met with the project staff at the Port Harcourt project office where an overview of the project, including program implementation progress was presented to the team of evaluators. Thereafter, data collectors were recruited and trained; and a pilot test of the data collection tools was conducted at Oginigbe Comprehensive Secondary School, Oginigbe, Obio-Akpor preceding actual data collection. The team administered questionnaires across 26 ISY and OSY sites. Qualitative information was also elicited from the project staff and stakeholders involved in the program.

Program Description

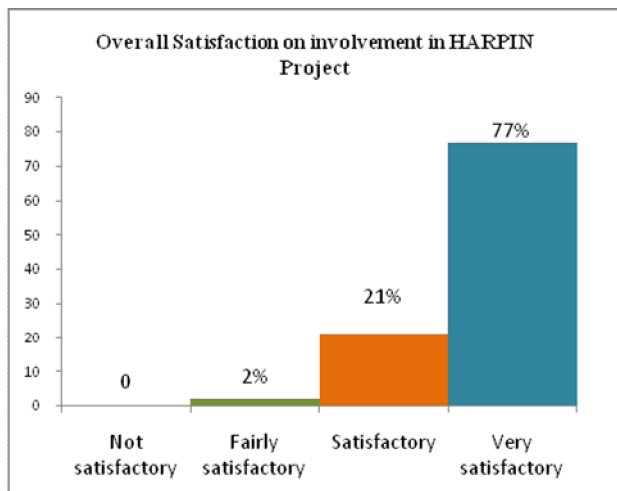
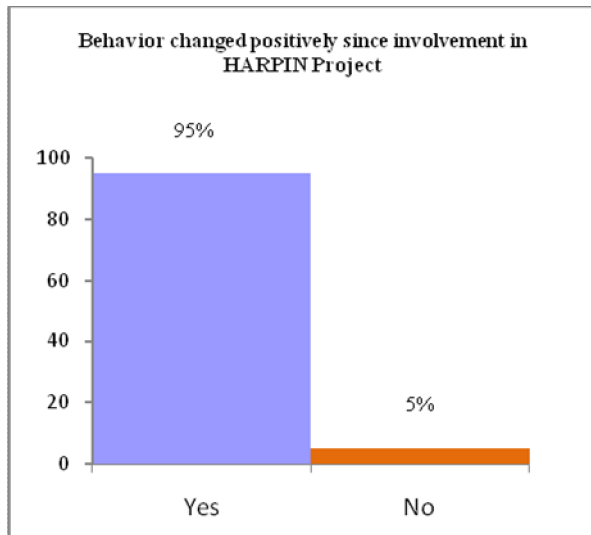
HIV/AIDS Reduction Program in the Niger Delta (HARPIN) is a three year PEPFAR/USAID-funded project aimed at providing HIV/AIDS prevention activities in Cross River and Rivers States. The project is implemented by Pro-Health International (PHI) and was scheduled for implementation between April 2008 and March 2011. It eventually commenced in August 2008, after the first roll out, it was extended to August 2011. HARPIN project is implemented in one program area-Sexual Prevention, in Rivers state covering three LGAs (Ikwerre, Obio-Akpor and Khana).

The figures below illustrate positive behavior change and overall satisfaction in both In-School and Out of School Youths sexual prevention program.

In-School-Youth



Out-of-School Youth



Key Achievements

- The HARPIN project has been able to increase HIV/AIDS awareness, consistent use of condom and HIV testing among OSY
- The program has been able to evolve a peer group into a Community Based Organization (Youth Caring for Health) and their capacity has been built as a result of their involvement with the program
- The program has been able to significantly change the behavior of youths reached positively with sexual prevention messaging.
- The organization has helped in the capacity development of all those that are actively involved in the program (Staff, Community based organizations) through trainings.
- The HARPIN project has been able to gain acceptance during the implementation of the program through its advocacy and community involvement for sustainability.

The tables below show the rating of the quality of information received/services received

Table 1: Percentage distribution of In-school youths according to ratings on quality of information/services received

Indicators	Satisfaction Ratings				Total (N)
	Not satisfactory	Fairly satisfactory	Satisfactory	Very satisfactory	
<i>Information received about HIV/AIDS</i>	3%	7%	47%	42%	657
<i>Behavior Change</i>	3%	6%	49%	42%	624
<i>HCT Services Received</i>	1%	8%	57%	34%	155
<i>Overall Satisfaction</i>	1%	4%	42%	54%	581

Table 2: Percentage distribution of Out of school youths according to ratings on quality of information/services received

Indicators	Satisfaction Ratings				Total (N)
	Not satisfactory	Fairly satisfactory	Satisfactory	Very satisfactory	
<i>Information received about HIV/AIDS</i>	1%	5%	52%	42%	369
<i>Behavior Change</i>	13%	6%	51%	41%	360
<i>HCT Services Received</i>	3%	3%	49%	45%	137
<i>Overall Satisfaction</i>	0%	2%	21%	77%	247

Challenges

- There is a need for more time to be allotted to the program in schools involved in the project so as to increase participation of ISY.
- More training and re-training is necessary to emphasis AB messaging of sexual prevention amongst ISY already reached by the program.
- Financial aids was needed by the CBOs to help sustain their involvement in the program.

- Logistics was an issue because of the difficult terrain and distance between the communities especially in Khana LGA so as to reach more communities in the LGA.

Key Lessons Learnt

- The involvement of community leaders/stakeholders in the program helped its acceptance and the creation of awareness within the community.
- The target population required a lot of incentives before they got involved in the program especially with respect to OSY.

Sustainability

- Pro Health International is trying to assess funds from the NDDC and various stakeholders in the Niger Delta Region. This should continue and even scale up in the state and in the region.
- The partnering and training of CBOs will help in the continued delivery of the project's services in the community for a long while.
- Building of the capacity of both the HARPIN staff and CBOs would help strengthen the two thematic areas of the project. That is prevention of new infections and behavior change.

Conclusions and Recommendations

- Effective communication with field offices and PHI in Jos to ensure efficient delivery of services.
- Staff welfare should be looked into to reduce attrition of Staff.
- The M&E structure of the program should be developed.

APPENDIX FIVE B: SUMMARY REPORT - CROSS RIVER STATE

Deputy Program Manager	Dr. Yinka Adekugbe
Program Areas	Sexual Prevention and Prevention of Mother To Child Transmission (PMTCT)
Beneficiaries	Out of School & In-School Youths, and HIV positive Pregnant women
Partners	Biase Public Health Initiative, Clear-Image Youth, Akamkpa, HIV/AIDS Enlightenment, Idang
LGA	Calabar South, Odukpani, Akamkpa, and Biase
Date	August 2008 ó August 2011

Evaluation Team Summary Visit

The evaluation Team B of Dr Muyiwa Oladosun, Charles Toriola, Femi Oladosu, Patience Bioye, and Ifeyinwa Ononye travelled to the Cross Rivers field office and met with the program staff, led by, Dr Yinka Adekugbe. The team visited in-school, out-of-school and PMTCT sites in 4 local government areas. Questionnaires were administered and group discussions were conducted for project beneficiaries and project staff. Some key program stakeholders in the state were equally interviewed.

Program Description

HARPIN is implemented under two program areas in Cross River state, Sexual Prevention and PMTCT. The Sexual prevention targeted in-school and out-of-school community with Balanced ABC intervention. PMTCT on the other hand was initiated in February, 2009 and became fully operational in March, 2010. PMTCT interventions include HIV Counseling and Testing, ARV prophylaxis, Early Infant Diagnosis, and Infant Feeding.

The following are illustrations suggesting achievements.

Changes in Behavior with Respect to Sexual Health

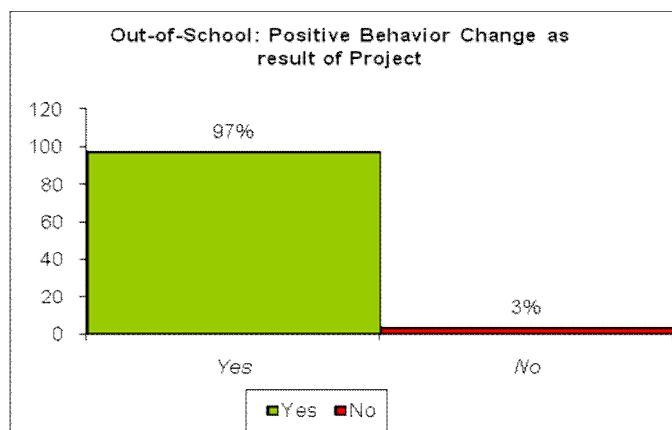
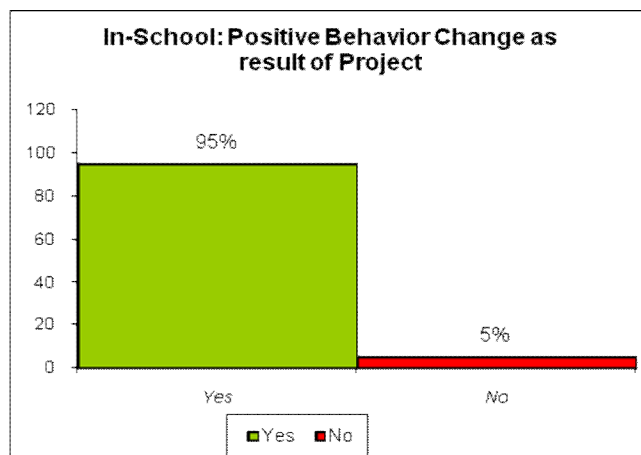


Table 1: Percentage distribution of in-school youth according to ratings of quality of services received during the project life

Indicators of Services	In-School Youths			
	Not satisfactory/don't know	Fairly satisfactory	Satisfactory	Very Satisfactory
Information received about HIV/AIDS	3%	8%	42%	47%
Behavior Change	1%	5%	47%	48%
HCT Information	9%	12%	41%	39%
Overall Satisfaction	1%	5%	37%	57%

Table 2: Percentage distribution of out of school youth according to ratings of services received during the project life

Indicators of Services	Out of School Youths			
	Not satisfactory/don't know	Fairly satisfactory	Satisfactory	Very Satisfactory
Information received about HIV/AIDS	1%	4%	58%	34%
Behavior Change	1%	5%	56%	38%
HCT Services Received	1%	3%	60%	37%
Overall Satisfaction	1%	3%	40%	56%

Achievements

- The program was able to effect positive behavior change in the target population through increased awareness of HIV/AIDS and reproductive health rights and the use of condom.
- Findings show that overwhelming number of in-school (97%) and out of school youths (95%) reported positive change in behavior as a result of the program intervention.
- The program had good community entry and stakeholder engagement.

- Legal registration of the program's CBOs with the Ministry of Youth and Sport and SACA.
- There was increased uptake of PMTCT services and prevention of mother to child transmission of HIV. An appreciable number of negative babies' delivery was recorded.

Strengths

- Stakeholders' support facilitated the implementation of the HARPIN program in Cross River state.

Sustainability

- The program intends to embark on an extensive collaboration with their political and traditional stakeholders and the community to generate a PMTCT fund. The fund would be fixed with the hope of generating enough income that would be split into two parts; a part for program planning and the other would be reinvested into the bank.

Challenges

- The river and swampy nature and distance between communities in the state hindered coverage and implementation of the program's interventions.
- Inadequate client-provider relationship in the health facilities prevented increased accessibility to PMTCT services.
- Financial dependence of the field office on the regional office stalled the implementation of some interventions.

Recommendation

- Future programming should take into cognizance the topography of the region, with logistics for accessing difficult terrain.
- Field offices should have some level of financial independence.