

# Strengthening district health sector responses to HIV/AIDS in Sub-Saharan Africa

An evaluation of the WHO/OPEC Fund Multi-country Initiative on HIV/AIDS



July 2006

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## Acronyms and abbreviations

AFRO	WHO Regional Office for Africa
AIDS	Acquired Immunodeficiency Syndrome
ANC	ante-natal care
ART	Antiretroviral Treatment / Therapy
ARV	Anti retroviral Drugs
CBO	community based organization(s)
CMSR	Centro Mondialita Sviluppo Reciproco
CNCS	Conselho Nacional de Combate ao HIV/SIDA (Mozambique)
CUAMM	Collegio Universitario Aspiranti Media Missionari
DPS	Provincial Directorates of Health (Mozambique)
FBO	faith-based organization(s)
HAI	Health Action International
HBC	Home-based Care
HIV	Human Immunodeficiency Virus
HQ	WHO headquarters
HSD	Health Sub-District (Uganda)
IEC	Information, education and communication
MTCT	mother-to-child transmission
NAP	National AIDS programme
NASCOP	National AIDS Control Programme
NGO	nongovernmental organization
NSP	national strategic plan
OI	Opportunistic Infections
OPEC	Organization of Petroleum Exporting Countries
PEPFAR	President's Emergency Plan for AIDS Relief
PLWHA	people living with HIV/AIDS
PMTCT	prevention of mother-to-child transmission
RCA	Central African Republic
STI	sexually transmitted infection
UNAIDS	joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	voluntary counseling and testing
WFP	World Food Programme
WHO	World Health Organization
ZACP	Zanzibar AIDS Control programme

## Table of contents

Foreword to the Report	6
Executive summary	7
I. Introduction to the Report	12
II. Monitoring and evaluating the progress of the Initiative	15
III. Findings and Lessons Learned	17
IV. Addressing common obstacles to implementation and scaling up	29
VI. Conclusions and recommendations	35
VII. The way forward	36
VIII. Final budget, financial status as of 31 May 2006	37
Annex 1: Findings by country	38
Burkina Faso	39
Burundi	40
Central African Republic	41
Ethiopia	42
Kenya	43
Malawi	44
Mozambique	45
Rwanda	46
Tanzania	47
Togo	48
Uganda	49
Zambia	50
Annex 2: Key questions addressed by the final evaluation	51

Sub-Saharan Africa is by far the worst HIV-affected region in the world, home to more than two-thirds of the 40 million people currently living with HIV. In the absence of massively expanded prevention, treatment and care efforts, the AIDS death toll is expected to continue to rise.

In June 2002, the Director of WHO and the Director General of the OPEC Fund for International Development signed an agreement whereby WHO supported an US\$8.11 million initiative in 12 African countries to combat HIV/AIDS. Under this WHO/OPEC Multi-country HIV/AIDS Initiative, countries implemented specific activities in rural underserved districts, across seven programmatic areas. These areas covered a wide range of interventions, including services for voluntary counseling and testing, the prevention of mother-to-child transmission of HIV, the provision of care and support to those infected and affected by the disease, case management of sexually transmitted infections, information, education and communication about HIV/AIDS, the continued supply of safe blood, and finally the monitoring and surveillance of the epidemic.

It should be remembered that when the WHO/OPEC Initiative commenced, the Global Fund was not yet fully resourced, many HIV/AIDS interventions were still at project level in urban areas, and antiretrovirals were not yet available; also, medicines to treat opportunistic infections and many normative tools such as guidelines and treatment protocols were not adapted to local requirements. Since then, significant progress has occurred, and many global and bilateral partnerships are now improving the ability of countries to respond to HIV/AIDS. But at the time, the WHO/OPEC agreement was an innovative mechanism focusing on strengthening the health sector response to HIV/AIDS at the district level.

Each national project was an integral part of the National strategic plan against HIV/AIDS. WHO reviewed workplans and provided technical support to finalize the workplans. WHO also provided technical support to countries during implementation and conducted monitoring visits to improve quality and assist in problem solving. WHO also tried to facilitate exchanges of best practices and to enhance a common monitoring and evaluation framework.

As the Initiative nears its conclusion, the 12 countries have undertaken an evaluation to review the accomplishments, obstacles, and lessons learned during implementation of the Initiative. Since several of these projects are still under way, information on their effectiveness is not yet available. This evaluation report summarizes the results of twelve country assessments of the Initiative's efforts to achieve three objectives: to fill gaps at the normative level by finalizing or updating policies and standard guidelines for appropriate interventions; to build national and local level capacity, including both human and systems build-up; and to scale up key interventions, through integrated, primarily district-based efforts.

The report highlights the areas where this ambitious programme of scaling up HIV prevention and care in health facilities and in communities in African rural districts has made a difference. The evaluation found that after two years of implementation many projects -- not all of them and not in all countries -- have succeeded in either developing new HIV/AIDS activities or expanding them at district level, despite a range of obstacles. The Multi-country Initiative also significantly contributed to building local capacity by training staff, securing commodity supplies and improving the health infrastructure. The major challenges, however, remain the enhancement and sustaining of the achievements. The experience gained and lessons learned shall be applied to scaling up the implementation of similar programs around the world.

### Background

The WHO/OPEC Fund Initiative on HIV/AIDS was launched in 2003 in twelve African countries (Burkina Faso, Burundi, Central African Republic, Ethiopia, Kenya, Malawi, Mozambique, Rwanda, Togo, Uganda, Tanzania, and Zambia) in order to:

- strengthen the response of the health sector, both in the prevention of HIV transmission and through enhanced support and care for the persons living with HIV/AIDS, and
- increase the availability and access to services for populations living in rural districts.

Based on their national priorities, the participating countries implemented a set of interventions in seven technical areas, including voluntary counseling and testing (VCT), prevention of mother to child transmission (PMTCT), STI management, care and support, blood safety, monitoring and surveillance, and HIV prevention.

WHO reviewed workplans and provided technical support to finalize workplans. WHO also provided technical support to countries during implementation and conducted monitoring visits to ensure quality and assist in problem solving. As the Initiative nears its conclusion, the countries have undertaken an evaluation to review the accomplishments, obstacles, and Lessons Learned during implementation of the Initiative. Since several of these projects are still under way, information on their effectiveness is not yet available. The scope of this evaluation examines how the Initiative has contributed to:

- filling gaps at the normative level;
- building national and local level capacity; and
- scaling up key interventions.

### Results

The WHO/OPEC Fund Initiative project deliberately undertook to develop partnerships with States in conflict, facing insecurity and political instability, including Burundi, Rwanda, the Central African Republic, Uganda, and Ethiopia. In addition, remote rural districts were selected for implementation of the Initiative. The WHO/OPEC Fund Initiative should take some credit for this hard choice, as there have been some successes in these typically underserved locales. Indeed, the evaluation found that after two years of implementation many projects have made a difference at the district level.

However, there were also initial difficulties. The capacity of WHO to coordinate implementation of activities in seven technical areas in 12 countries was overestimated. Major delays occurred at various levels in recruiting staff at headquarters, the WHO Regional Office for Africa and in countries; in planning and developing district operational plans, in involving community organizations, and in the reporting system, which in turn delayed the disbursement of funds on the schedule previously agreed.

1. Progress accomplished in finalizing or updating policies and standard guidelines, and in promoting their use.

In all countries, the Initiative has improved the dissemination process and use of guides at the district level. In half of the country projects, the Initiative has played a significant role in developing or refining guidelines and tools.

2. Progress in building capacity of people and health systems.

The Initiative has helped considerably the building of service delivery capacity in all selected sites, through staff orientation and training and through renovations of existing facilities. Because of the selected model of implementation -- an integrated and district based approach, supporting the health sector -- ownership was easily realized at district level in every project but one. The evaluation found that in half of the countries, training was restricted to health care providers in the selected government structures, ignoring civil society and community workers; in addition, training often focused only on technical areas, ignoring management, supervision and monitoring issues. In half of the countries, the training was not phased in to complement the implementation of planned services, due to delays in the provision of guidelines, drugs or equipment.

### 3. Progress in scaling up key interventions

#### 3.1 Voluntary Counseling and Testing (VCT)

Six countries out of nine accomplished significant scaling up in VCT. In those countries, there was a rapid increase of clients from one year to another, showing that the demand for services was high and that the quality of services was acceptable. In total, between 55,000 and 70,000 people have been counselled and tested as a result of the Initiative.

#### 3.2 Prevention of mother-to-child transmission

In four of six countries, the scaling up of counseling and testing of pregnant women in the selected districts was significant and contributed to paving the way for other initiatives. In total, as a direct or indirect result of the Initiative, approximately 65,000 pregnant women have been counselled in the last 2 years. However, the systematic prevention of mother-to-child transmission, involving the provisioning of HIV positive mothers with ART, was not always achieved. Among those HIV seropositive mothers, between 50% (Uganda) and 90% (Kenya, in one site) received Nevirapine.

In addition, most projects did not provide comprehensive quality PMTCT services, such as nutritional or food support and/or systematic referral to psycho-social services. In four countries out of eight, the Initiative has significantly boosted the scaling up of care and support programme activities, and contributed to the enrolment of 67,000 people living with HIV/AIDS.

#### 3.3 Care and support scaling up

Eight countries developed important programme activities in care and support through training health workers in clinical management of opportunistic infections and improving availability of drugs, as well as by strengthening existing home-based care programmes with increased capacity, including provision of drug kits and linking home-based care to ART. In four countries out of eight, the Initiative has significantly boosted the scaling up of care and support programme activities and contributed to the enrolment of 67,000 people living with HIV/AIDS.

#### 3.4 STI management

Several thousand STI patients have benefited from improved STI management; more than five hundred health workers have been trained in the syndromic approach, and drug availability has improved. While STI activities have often resulted in expanded access to services, they were not planned as comprehensive interventions where HIV prevention, care and treatment are integrated.

#### 3.5 Activities targeting young people

Programmes were developed in Burkina Faso among young military recruits and in Ethiopia with youth friendly services. Since these are innovative processes, the results are yet to be supported by specific studies. These activities are promising but there was no evidence that the WHO/OPEC Fund Initiative has had a comparative advantage in dealing with young people or made a difference in implementing activities for young people.

#### 3.6 HIV surveillance and improved programme monitoring

The activities in HIV surveillance were achieved but have not proved helpful to governments and partners seeking to become more strategic and selective.

#### 3.7 Blood safety

The specific programme carried out in Central African Republic accomplished the target activities. As a result, at the national blood transfusion Centre in Bangui, the seropositivity rate among blood units has fallen from 11% in 2000 to 5% in 2004; this is due to good organization of voluntary blood donations.



#### 4. Common obstacles in implementation and scaling-up

As stated before, project implementation was delayed. For future programme activities, it is critical to address constraints and obstacles. Following the finalization of Action Plans at the central level, activity implementation at district level was delayed because districts needed more time to elaborate their operational plans, including funding requests. As a result, submission of activity reports was also delayed. Bureaucratic procedures for disbursing WHO funding and the lack of a development account at local level were strong impediments. However, the Initiative was unique and innovative developing alternative routings for funding, thus avoiding bureaucratic delays. Initially, coordination between levels of the health system was generally weak and consequently affected management of the project at the district level; however, service delivery statistics indicates that coordination improved steadily over the Initiative. Most country projects initially did not have monitoring and evaluation plans. There was a high turnover of staff in most project sites, not only at district level but also at the MoH's and the WHO offices.

#### 5. Key Lessons Learned and best practices

5.1 The most successful projects in achieving scaling up were those with strong community mobilization from the start of the implementation phase, and where concerted efforts in time and money were deliberately mobilized for this purpose.

5.2 Where partnerships were actively foreseen and networks formally established with a variety of partners, programme implementation was the most successful and long-term sustainability can be achieved.

5.3 Using lay counsellors, community workers, support groups of HIV sero-positive pregnant and post-partum women improves not only PMTCT and VCT services uptake and quality but also ownership and involvement of the community.

5.4 Few projects have outsourced key functions. Where outsourcing has occurred, it has accelerated implementation of the activities and improved their quality, proving that broader partnerships are essential elements for scaling up.

5.5 In some countries, the large number of actors engaged in implementation makes difficult the direct attribution of successes or outcomes to the WHO/OPEC Fund Initiative's projects. However, by acting collectively the local actors often managed to improve programme impact.

5.6 Basket funding at district level facilitates money and commodity flow. In **Ethiopia, Kenya and Burkina Faso**, there were attempts to use the total budget for HIV/AIDS at district level as a common basket to fund activities. This flexibility in inter-budgetary reallocation of funds, as dictated by the needs on the ground, was reported to be an important factor in enhancing the implementation. The WHO/OPEC Fund Initiative has supported the basket funding approach by allowing flexibility in the decision-making process, for example, by allowing managers to transfer funds between budget lines as dictated by local needs.

5.7 Programme sustainability is more likely to occur in successful programmes. According to the assessments in countries, a third of the projects in countries have already received assurance of partners' support at local level or at central level or both. Usually, those projects that are financially supported or integrated into routine activities were the most successful in terms of scaling up.

5.8 By pooling resources together at district and provincial level, some programmes were able to create synergy and compensate for limited human resources capability.

## 6. Conclusions and recommendations

The WHO/OPEC Fund Initiative should take credit for having initiated an ambitious programme of scaling up HIV prevention and care in health facilities and in communities in African rural districts. Indeed, the evaluation found that after two years of implementation many projects have made an observable difference at district level despite the range of obstacles.

6.1 To be effective, especially at district level, WHO needs to strengthen its system of procurement: simplified but standardized procurement and delivery of supplies should be sought to deliver set programme products and thus achieve a greater and more timely impact.

6.2 WHO should develop a simple and functional system for funds transfer among the different hierarchies of the local institutions and a special reporting mechanism within the existing information system that could facilitate the implementation and monitoring of outlined activities.

6.3 WHO should assist countries in developing comprehensive projects in technical areas where the Organization has clear recognized expertise and can mobilize partnerships.

6.4 Countries should develop programme activities that are more strategic; projects should include clear behavioural outcomes, not just increased access to services; and HIV prevention should be integrated as a key component of any health care activity.

6.5 By linking programmes such as the WHO/OPEC Fund Initiative to other global initiatives including 3 x 5, and “Three Ones” principle, WHO should ensure better integration that in turn, should lead to increased sustainability.

6.6 The specificity of WHO/OPEC Fund design, with its emphasis on the district level, calls for increased supervision from the central level and strong monitoring and evaluation systems, as compared to other projects.

## 7. The way forward

The WHO/OPEC Fund Initiative was innovative and pioneered some of the current global developments in HIV response, such as the 3 by 5 Initiative and Universal Access to HIV prevention, care and treatment.

There is now an increased recognition that coverage needs to be expanded by decentralizing HIV prevention and treatment access to first-level primary care providers (in both the public and private sectors). The WHO/OPEC Fund Initiative has started to meet these new challenges, recognizing that rural district sites are more vulnerable to underlying weaknesses in health systems.

Based on the experience accumulated in the last 3 years, it is recommended that the WHO/OPEC Fund Initiative extend its support to districts in three inter-related technical areas where much more scale up can be achieved and where additional catalytic support can make a strong difference: VCT programmes, PMTCT programmes, and home-based care.

Detailed recommendations on how to dramatically improve the scale-up of services in these three areas are available in evaluation reports, including the recommendation to share achievements, knowledge and lessons learned with newly-participating countries. Priorities in programming should also address the crisis in human resources for health, including through innovative approaches such as regional training initiatives and public-private ventures, as highlighted in this report and as recommended by the 3 x 5 evaluation.

Sub-Saharan Africa has been the region hardest hit by the HIV/AIDS epidemic to date. An estimated 25.8 million individuals - more than 60 per cent of all people living with HIV/AIDS - are concentrated in that region. The epidemic's effects are felt in all aspects of life, from higher mortality rates to decreased life expectancy to the slowdown in economic growth.

### **The WHO/OPEC Fund Multi-country Initiative on HIV/AIDS**

It was within this context of a development and humanitarian crisis that a multi-country Initiative was conceived, meeting the need to support the scaling up of HIV prevention and care in the most affected countries. Following preliminary discussions between the OPEC Fund for International Development and WHO in October 2001, and in consultation with the WHO's Africa Regional Office (AFRO), a call for HIV prevention and care programme proposals was issued to the Sub-Saharan countries. Through the provision of support to countries, the Initiative was expected to:



- increase the level of funding available to fill gaps in National Strategic Plans and to scale-up activities, as well as to strengthen and complement partnerships with other stakeholders, including the World Bank, the Global Fund, other UN Agencies, bilateral donors and NGOs;
- strengthen the response of the health sector, both in the prevention of HIV transmission and through enhanced support and care for persons living with HIV/AIDS, thereby mitigating the epidemic's impact; and
- increase the availability and access to services for populations living in rural districts.

After an initial response by countries and following discussions with the OPEC Fund, twelve countries were identified -- Burkina Faso, Burundi, Central African Republic, Ethiopia, Kenya, Malawi, Mozambique, Rwanda, Tanzania, Togo, Uganda and Zambia. Each country chose and defined its respective targeted interventions within a matrix of seven programmatic areas.

WHO and the OPEC Fund signed a Memorandum of Agreement in June 2002 to implement the WHO/OPEC Fund Multi-country Initiative on HIV/AIDS for a period of 18 months with a grant from the Fund of US\$ 8.11 million. The period of the Initiative was initially planned for 18 months, from July 2002 to December 2003, but was later extended to December 2005. Most countries began implementation between early and mid 2003, while a few began in 2004. More than US\$6 million was available for projects in districts which represent 74%; the rest was spent on supervision, technical support and administration. The total budget for each country varied from US\$400,000 to US\$680,000, depending on the scope of their planned programme activities. Procurement of commodities and supplies for services delivery was by far the most important item in the budget, accounting for 40% of spending, followed by training (26%), improvement of infrastructures (22%) and various (12%). Evaluation data show that the absorption of funds by the Initiative participants was comparatively better than other programmes.

## Goals of the Initiative

**Strengthen national and district level responses to HIV/AIDS**

## Objectives of the Initiative

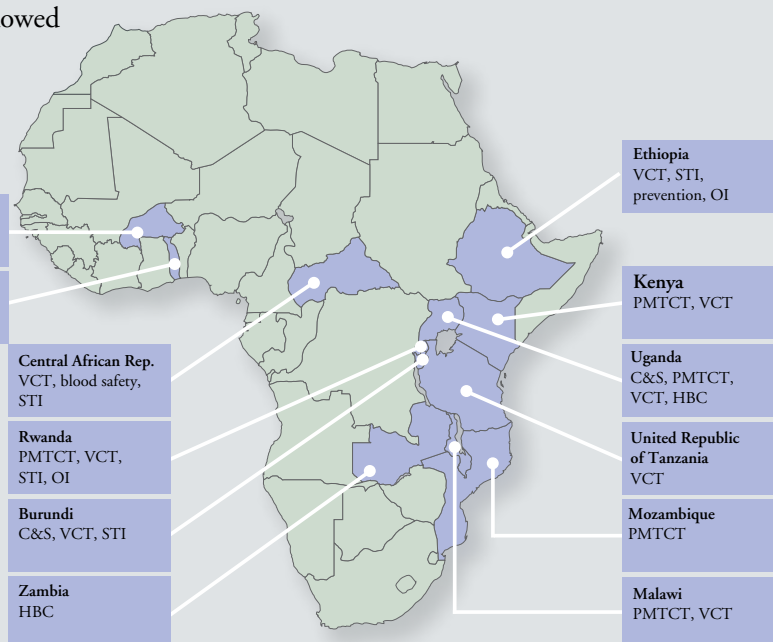
<b>Fill normative gaps</b>	Many countries need to finalize or update policies and standard guidelines for appropriate interventions. Normative work, therefore, was a crucial step in the national response, in order to ensure that scaling up of interventions were within national strategies and standards.
<b>Build capacity</b>	Capacity-building concerns covered both human and systems build-up, such as training of staff, the development of appropriate management and supervision tools, securing commodity supplies, and improvements in health sector infrastructure.
<b>Scale up key interventions</b>	Countries have defined intervention areas in their National Strategic Plans (NSPs). The Initiative has support the scaling up of prioritized activities through integrated, primarily district-based efforts by offering quality services and making drugs available to communities.

### Engagement of twelve Sub-Saharan African countries

The countries selected reflected the geographical and epidemiological diversities prevailing across the region. Western Africa (2 countries), Eastern Africa (3 countries), Central Africa (3 countries) and Southern Africa (4 countries) are represented; five countries are Francophone, one is Lusophone and the remainder Anglophone. All but one are in the bottom one-third of the UNDP Human Development Index ranking, and all have low GDP per capita. Adult HIV prevalence ranges from 5 per cent in Togo to nearly 20 per cent in Zambia. Eight countries are among the hardest hit by the HIV/AIDS epidemic, with prevalence levels over 10 percent. Six countries -- Burkina Faso, Burundi, Mozambique, Rwanda, Tanzania and Uganda -- were also involved in the WHO/Italian Initiative and the partnership with the OPEC Fund allowed them to further scaling up their activities.

### Seven Programmatic Areas

WHO Country Representatives were in close contact with national and district authorities to identify priority programmatic areas from which the Initiative would build. The activities were derived from the national priorities outlined in the HIV/AIDS National Strategic Plans in each country. Geographic areas of focus for implementation were identified, based on existing coverage and local priorities; the Initiative intentionally targeted under-served and hardship districts with few or no other participating partners.



The seven programme areas include:

- The establishment of youth-friendly services and IEC activities;
- The expansion of voluntary counseling and testing services;
- The prevention of HIV transmission from infected mothers to their infants;
- The prevention and control of sexually transmitted infections;
- The increased availability of care and support services, including treatment of opportunistic infection, both at the clinical and the community level;
- The critical and continuous availability of safe blood supply, combined with the provision of universal precautions;
- Continued surveillance and monitoring of HIV infection

The implementation of interventions followed an integrated and district-based approach, in which the health sector supported to scale up the capacities to deliver packages of services to beneficiary populations. Priority interventions and geographic areas of implementation are summarized below.

Country	Number of areas selected	VCT	PMTCT	STI	Care & support	Youth programmes	Blood safety	Surveillance monitoring & evaluation
Burkina Faso	5 regions	•			•	•		•
Burundi	7 provinces	•		•	•			
Central African Republic	3 regions	•		•			•	
Ethiopia	6 districts	•		•	•	•		•
Kenya	5 districts	•	•					
Malawi	1 district	•	•					
Mozambique	7 districts		•					
Rwanda	3 districts	•	•	•	•			
Togo	6 sites		•	•	•			•
Uganda	11 districts & more	•	•		•			•
United Rep. of Tanzania	8 districts in 3 regions	•			•			
Zambia	3 districts				•			

*Table 1: Summary of key interventions by country*

**Institutional arrangement**

The priority interventions were derived from the national priorities outlined in the latest National Strategic Plans in each country. Geographic areas of focus for implementation were identified, based on existing coverage and local priorities.

WHO guaranteed the overall co-ordination of the Initiative by:

- maintaining the overall liaison between the OPEC Fund and the governments of participating countries;
- co-ordinating and monitoring the implementation of different phases of the Initiative;
- providing input to all steps of the Initiative, maintaining technical oversight to guarantee programmatic quality throughout the intervention areas;
- ensuring co-ordination between the different actors, including government institutions and other stakeholders;
- facilitating cross-country sharing of experiences and dissemination of results; and
- providing both technical and financial feedback to the OPEC Fund.

## II. Monitoring and evaluating the progress of the Initiative

### 1. Progress Monitoring

In October 2002, as a first step toward supporting countries in implementing the Initiative, WHO/AFRO and WHO/HQ organized a planning workshop with all participating countries. The product of the workshop was draft national plans for achieving the project's objectives. WHO also fielded consultants and staff to further support the roll out of the national plan through the development of district-based operational plans. The grant arrangement specified that monitoring and evaluation activities would be undertaken periodically, that progress in implementation would be measured at the end of the grant period, along with its outputs and outcomes. Quarterly progress reports were sent to WHO/AFRO and WHO/HQ. A mid-term review was also conducted. Despite technical support visits, some countries were not able to implement their plans at required rates. Absorption rates for funding range from 45% to 99%. As the project was a multi-country project, all countries needed to reach the same level of absorption to have their grants replenished. This delay by some countries has negatively impacted the roll out of planned activities.

Major delays in implementation occurred in:

- recruiting staff at headquarters, the WHO Regional Office for Africa and in countries;
- delays in planning and developing district operational plans,
- delays in involving community leaders; and
- delays in the reporting system, which in turn delayed the disbursement of funds on the schedule previously agreed.

In order to accelerate the implementation of the Initiative and to undertake the final evaluation, WHO/AFRO and WHO/HQ conducted a three-day workshop in Dar es Salaam, Tanzania in May 2004. During the workshop, the countries addressed specific implementation blockages and determined changes in approaches as well as agreeing on the methodology, indicators and tools in preparation for a final evaluation.



*Meeting in Dar es Salaam, May 2004, to accelerate implementation of the Initiative.*

### 2. Evaluation objectives and scope

The specific objectives of the final evaluation were to assess progress towards achievement of the Initiative's three broader goals, by reporting on the baseline and progress (See Annex 2):

- filling gaps at the normative level in their national response to HIV/AIDS;
- building national and local level capacity by training health workers and rehabilitating infrastructure to make them more effective for service delivery;
- scaling up key interventions by offering quality services and making drugs available to communities.

It was agreed that the formative evaluation should track inputs, processes and outputs against work plans through records and reports. *Input* comprises the financial, material and human resources invested in the programme. *Processes* includes the types of activities the programme delivered, such as training. *Outputs* refer to the deliverables from processes, such as the number of persons trained or the number of clients receiving services. *Outcomes* mean the intermediate effects of programme efforts that are in accordance with programme objectives, such as behavioural or health changes. Unfortunately, most outcomes were impossible to measure because of the lack of baseline data and the lack of appropriate surveys or studies. Quality of services delivered was difficult to assess but most evaluation reports tried to capture this dimension through key interviews at sites and through comparison of services to quality standards.

### 3. Data collection and analysis

The final evaluation was the product of 12 country specific internal evaluations and external evaluations in three of the twelve countries. The country specific assessments were conducted in each of the 12 countries with the help of an independent Internal Consultant In Rwanda, Burundi and Kenya, external assessments were conducted by a team comprising an independent External Consultant (Team leader), the Internal consultant, a member/s of the Ministry of Health, the focal point in the WHO Country office and the district coordinator officer and his/her team. The external evaluation was brief, 9 to 12 days. Data used included baseline data, documentation of processes, quarterly reports, special studies and data from national health information systems. Techniques such as data triangulation, literature review, desk studies, interviews, field investigations/ observations and group interviews were used.

The teams reviewed and analysed their baseline data, monitoring data and documented the inputs, processes and outputs for each activity. The teams also reviewed district plans, records of furniture and other supplies and records of training activities. The teams visited selected or all sites and conducted key informant interviews with stakeholders. Some teams conducted facility surveys to determine the scope and quality of services. In Burundi for instance, client interviews confirmed that the existence of the project served to reduce stigma within the surrounding areas. Twelve internal reports were developed as well as three external evaluation reports conducted separately in Burundi, Kenya and Rwanda. These three countries were selected based upon their ability to further inform evaluation objectives in specific areas of interest.

This report synthesizes the content, i.e. cross-cutting findings, best practices, lessons learned, conclusions and recommendations from the 12 internal and 3 external evaluations carried out in the countries. (Annex 1 presents a summary of country specific internal reports.)



### III. Findings and Lessons Learned

#### Goal 1: Accomplishments in finalizing or updating policies and standard guidelines, and in promoting their use

#### Comment

In all countries, the Initiative has improved the dissemination process and use of guides at the district level. In half of the country projects, the Initiative has played a significant role in developing or refining guidelines and tools.

In half of the projects (Table 2), this role has been modest, with reproduction and minimal distribution of existing guides and promotion of their use during training. This was not a surprise because the targets were often more to disseminate policies than develop new ones. In some countries, the Initiative has really triggered the development of new policies.

In Malawi for example, a total of 16 normative tools was developed and 13 of them disseminated through the Initiative. These included a 2-year national VCT scale-up plan and VCT site assessment tool. The project started at a time when the Ministry of Health was planning to roll out VCT and PMTCT services to be funded by the Global Fund. At the beginning of the project only draft guidelines for VCT, VCT training curriculums and PMTCT draft guidelines existed. The implementation of the project catalysed the finalization of some of the guidelines as they were required for the implementation of the project. The guidelines have since been disseminated to all sites providing VCT and PMTCT services in Zomba district.

In Ethiopia, two national guidelines, *STIs management guidelines* and *VCT guidelines*, were updated and revised, with the revisions supported directly by the Initiative.

In Zambia, a standardized training manual was developed for the first time and used nationally. Furthermore, a Community Health Management Information System was developed, which will be linked to the new national M&E framework.



Clinic staff training in PMTCT.



Revised/updated guidelines for Kenya.



Improving recordskeeping in Uganda.

	Development of guidelines or tools	Dissemination of guidelines/tools	Use of guidelines or tools
Burkina Faso		✓	✓
Burundi		✓	✓
Centrafrique		✓	✓
Ethiopia	•	•	•
Kenya		✓	✓
Malawi	•	•	•
Mozambique	•	•	•
Rwanda	✓		✓
Tanzania		✓	✓
Togo	•	•	•
Uganda	•	•	•
Zambia	•	•	•

Table 2: Accomplishments in updating policies and standard guidelines, and in promoting their dissemination and use. [Key: • = significant; ✓ = moderate; blank = not significant]

### III. Findings and Lessons Learned, continued

#### Goal 2: Accomplishments in building capacity of people and health systems

##### Comment

The Initiative has contributed significantly to the building of service delivery capacity in all selected sites through staff orientation and training and renovations of existing facilities.

Training of health personnel was a strong component of the interventions in all sites (Table 3). A few countries such as Zambia have planned reiterative training of health personnel. However, in most sites training was a one-off activity, with minimal or no supervision mechanisms organized. In seven countries, the Initiative has significantly contributed to the building or the renovation of health facilities. In addition, in eight countries, health facilities were provided with equipment such as computers and vehicles. Drugs and medical supplies were provided to all sites.

	Training	Building/renovation	Infrastructure equipment	commodities
Burkina Faso	•		✓	✓
Burundi	•		✓	•
Centrafrique	•	•	•	•
Ethiopia	•	•	•	•
Kenya	•	•	•	•
Malawi	•	•	•	•
Mozambique	•	•	•	•
Rwanda	•	✓	✓	✓
Tanzania	•	•	•	•
Togo	•	•	•	•
Uganda	•			•
Zambia	•		•	•

Table 3: Accomplishments in capacity building.

[Key: • = significant; ✓ = moderate; blank = not significant]

##### Comment

Because of the selected model of implementation -- an integrated and district-based approach, supporting the health sector -- in all projects but one, ownership was easily realized at district level.

The integration of project activities within existing health care delivery systems has clearly helped build the capacity of the health system. By not employing separate project staff both at national and district level, and by using empowered local staff as the main providers of the services, ownership and sustainability of the activities have been created.

In **Ethiopia** for example, all regions reported that they played the role as owner and provided leadership during the course of the project life. “The project is owned by the Regional Health Bureau and the actual services are run by the health facilities coordinated and supported by the District Health Officer. The project has truly filled the gaps, both financially and technically, we had. Therefore, there is no question of the ownership of the project.”

In **Kenya**, sensitization meetings facilitated joint planning between NASCOP and the District Health Management team members during which priorities and modalities of operation were set. District teams took the lead while NASCOP and WHO Kenya provided technical oversight, resource allocation and coordination from the Centre.

Training activities often targeted only health personnel in public institutions, ignoring civil society and community workers; in addition, training was often focused on technical areas, not management, supervision and monitoring issues.

In half of the countries, training was limited to health care providers in the selected government structures. **Kenya, Togo, Malawi, Uganda, Tanzania, Ethiopia, and Zambia** extended training beyond the public sector by including a variety of civil society actors such as lay counsellors, local NGOs, home-based care providers and private practitioners. In Mozambique, training was organized for all health staff at all levels in the two provinces where the Initiative was implemented. In the four HBC programmes, the training was organized by the NGOs.

Several countries have identified institutional capacity-building and improved coordination as priority interventions; however, it has been difficult to find documented evidence of success in these areas. Because capacity building was limited to service providers only, the supportive management environment needed to ensure sustained and institutionalized implementation was not sufficiently present. The buy-in and support of the health system management and supervisory levels and mechanisms, including skills in monitoring and evaluation, were not built into the training components. With some exceptions, training activities focused only on technical and clinical issues. As a result, in many sites supervision mechanisms for quality control and as follow-up of adherence to training are not in place.

In half of the countries, the training was not phased in to complement the implementation of planned services, due to delays in the provision of guidelines, drugs or equipment.

The Initiative faced delays in funding disbursements, consequently delaying implementation and service uptake. Training activities were often conducted several months before activities could take place. Staff turnover and lack of training follow-up were impediments to effective service delivery.

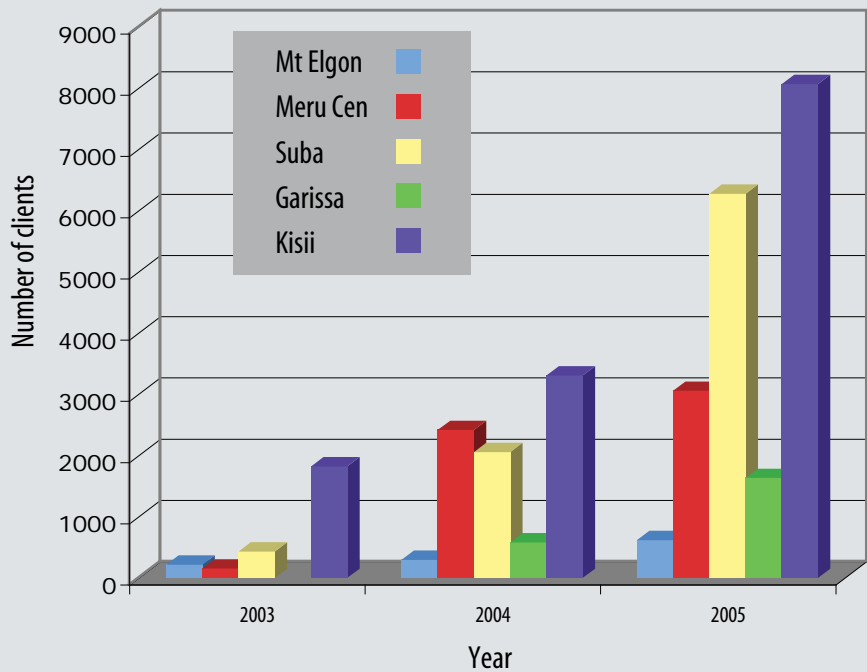
*Goal 3: Progress in scaling up key interventions*

3.1 Voluntary counseling and testing (VCT)

The expansion of VCT activities was an important aspect of the Initiative. Nine countries of 12 selected this activity as a priority at district level.

Six countries of nine accomplished significant scaling up. In those countries, there was an increase of clients from one year to another, showing that the demand for services was high and that the quality of services was acceptable. In total, between 55,000 and 70,000 people have been counselled and tested as a result of the Initiative. More than 80 centres were renovated or built.

Kenya and Malawi were countries where a rapid scaling up of VCT attendance was observed although the contribution of the Initiative was more synergetic than direct.



*Figure 1: Yearly increase in number of VCT clients in the five districts of the Initiative in Kenya (2003-2005).*

Take the example of the five districts selected for the project in Kenya (Figure 1). In 2005, 19,700 people accessed VCT service in the 5 districts and approximately 31,000 over the entire project period. This represents a significant scale up, given that these districts had near or non-existent capacity to provide this service at baseline. The increase cannot be directly attributed to the Initiative, but the assessment found that the Initiative contributed to attracting other partners. A similar situation occurred in Malawi (Figure 2, facing page).

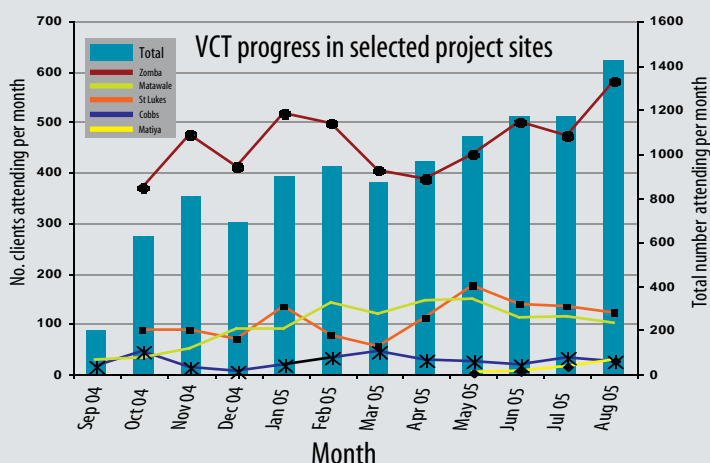


Figure 2: VCT attendance Sept. 2004 to Aug. 2005 in selected project sites. Malawi

In Malawi, when the Initiative commenced only two facilities were providing VCT services. The monthly progress in selected sites in the three months before the evaluation and for all sites is shown in Figure 2. Some centres are performing more than others. As of August 2005, about 50% of all health facilities in the districts were providing VCT services and 65% of these had been set up or supported by the Initiative. This means that the increase in VCT attendees is not due only to the Initiative activities. About 16% of the 15 - 49 year old population in the Initiative's catchment areas accessed the services. On average, 32% of the clients were HIV positive and were referred to post-test care services. Strong community mobilizations in both Kenya and Malawi were determinative in successful and rapid scale up.

However, the observed increase in numbers of attendees does not necessarily give the exact measure of the progress. In countries such as Tanzania, Burkina Faso and Central African Republic, VCT activities were only able to attract 1000 clients, but there were less than a hundred two years ago. This first increase is probably the most difficult.

Countries	N° of new VCT centres	N° of VCT centres strengthened	N° of counsellors trained, including trainers of trainers, and supervisors
<b>Burkina</b>	4		45
Burundi		7	135
CAR	3	1	90
<b>Ethiopia</b>	3	4	15
<b>Kenya</b>	4	1	51
<b>Malawi</b>	11		70
<b>Rwanda</b>	2	1	35
<b>Tanzania</b>		36	48
Uganda	10		120

Table 4: Number of new or improved VCT centres and counsellors trained. Countries in bold demonstrated significant scaling up (more than 200% increase over 3 years).

As a result of implementing HBC activities, Zambia noted an increased demand for counseling and testing among bed-ridden HBC clients. This resulted in the addition of community and home-based counseling, testing and linking to ART services. The Initiative complemented 3x5 activities and presaged the strategies of Universal Access to prevention, care and treatment.

3.2 Prevention of mother-to-child transmission

Comment

In four out of six countries, the scaling up of counseling and testing of pregnant women in the selected districts was significant and contributed to pave the way for other initiatives.

Countries	N° of new centres	N° of centres strengthened	N° of people trained, incl trainers of trainers, and supervisors
<b>Kenya*</b>	1	4	104
Malawi		4	20
<b>Mozambique*</b>	1	7	292
<b>Rwanda*</b>		3	35
<b>Togo*</b>	2	3	31
Uganda	1	1	25

Table 5: Number of new or improved centres and number of health workers trained. Countries in bold demonstrated significant scaling up (more than 200% increase over 3 years).

In total, as a direct or indirect result of the Initiative, around 65,000 pregnant women have been counselled in the last 2 years, and nearly 30 centres have been renovated or developed.

In Kenya over the project period, more than 40,000 mothers were offered PMTCT and 28,000 (70%) took the HIV test in 63 sites (only five are directly supported by the Initiative) of the five Districts. (Figure 3)

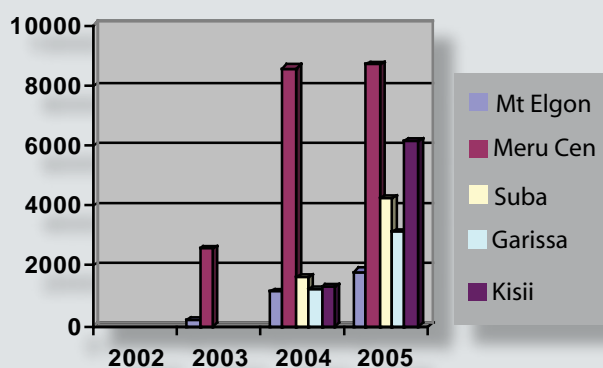


Figure 3: Increase in utilization of PMTCT services in five districts in Kenya (2002-2005).

In Mozambique, in 2004, more than 11,000 pregnant women were counselled and 95% of them were tested for HIV. 16% were HIV seropositive. Similar attendance was registered in 2005. The Initiative has established partnerships with civil society through support groups of seropositive pregnant and post-partum women, community groups and activists, further to linking with other NGOs, small community-based organizations, associations and churches. The Initiative has contributed to providing quality standard services, and can be considered the national model for the district level.

#### Comment

*The systematic prevention of mother to child transmission, involving the provision of HIV positive mothers with ART, was not always achieved. Among those HIV seropositive, between 50% (Uganda) and 90% (Kenya, in one site) received Nevirapine.*

The ultimate goal of scaling up PMTCT activities is to reduce mother to child transmission. However, it is clear from country reports that although some success has been achieved in terms of scaling up counseling and testing of pregnant mothers, far less progress has been realized in *systematically* providing HIV positive mothers with single doses of Nevirapine. Although it is understood that in most projects Nevirapine was supposed to be provided by other partners such as UNICEF or UNFPA, it is felt that this is ultimately the responsibility of the PMTCT programme to achieve prevention of mother to child transmission

#### Comment

*Most projects did not provide comprehensive quality PMTCT services, including systematic referral to psycho-social services and/or nutritional or food support.*

Components such as prevention of HIV infection for all women, prevention of unintended pregnancy in HIV-infected women, support for alternative to breastfeeding, systematic referral to psycho-social support were not fully endorsed as part of the initial design of the intervention. This was supposed to be complemented by partners, whether UN organizations or NGOs. In most projects, the follow up of children and mothers is still weak and community response about PMTCT services (including access to male partners and community support) remains a challenge.

### 3.3 Care and support scaling up

Eight countries developed important programme activities in care and support, by training health workers in clinical management of OI and improving availability of drugs, and also by strengthening existing home-based care programmes with increased capacity including drug kits. (Table 6, following page ).

#### Comment

*In four countries out of eight, the Initiative has significantly boosted the scaling up of care and support programme activities, and contributed to the enrolment of 67,000 people living with HIV/AIDS.*



*HBC kits in Kenya.*

In two projects -- **Burkina Faso** and **Togo** -- the increased availability of ART has triggered the swift delivery of ART, in addition to treating opportunistic infections. In **Uganda**, activities were reprogrammed to focus on the training of health personnel in ART delivery.

However, at least 65% of this figure is due to the Uganda programme, where the Initiative contributed to the training of health workers at the national level. In the other countries with ART treatment programmes, progress was modest; programmes were clinical pilot activities with limited focus. In the absence of national treatment scale-up plans, the activities should be seen as first steps paving the way for future expansion.

Countries	Type of intervention	Provision of drugs or kits	N° of patients	N° of people trained, including trainers of trainers, and supervisors
Burkina	Opportunistic infections, ART	drugs	115	18
Ethiopia	Opportunistic infections	drugs	Not available	81
Rwanda	Opportunistic infections	drugs	Not available	67
Togo	opportunistic infections, ART	drugs	593	49
Uganda	Home based care	Printing of 200 HBC tools	x	x
<b>Burundi</b>	Home-based care	281 kits	9370	x
<b>Tanzania</b>	Home-based care	24 kits	4475	116
<b>Zambia</b>	Home-based care	4570 kits	8000	96
<b>Uganda</b>	ART training	x	51 ART sites providing ART 45,133 clients	31 national facilitators 79 expert clients 283 health workers

Table 6: Care and support activities implemented, number of patients and people trained. Countries in bold demonstrated significant scaling up of care and support.

In **Zambia**, the client kit project for home-based care led to an increased number of HBC sites (from six to 16). Partnerships and linkages between government and NGOs have been enhanced in three districts.

In **Tanzania**, the Initiative is implemented by NGOs in collaboration with district health services. Five ARV sites have been established and two more are expected to be initiated in the year to come in project implementing districts. Promotion of VCT and HBC services was an important component of the Initiative. IEC materials and communication strategies were elaborated. In total, 55,000 leaflets, more than 2,000 posters, 20,000 magazines, 110 radio spots, 1,400 T-shirts, 74 drama shows and 37 billboards have been developed.



In Uganda, the WHO/OPEC Fund Initiative did not implement activities in home-based care, except for the printing of HBC guidelines. The funds were re-allocated to support the countrywide training of health workers in comprehensive HIV care, including ART. As shown in Table 7, the achievements in training and the increase in the number of patients on ART are impressive. The WHO/OPEC Fund Initiative contributed with many other actors in this national effort. Health workers were also trained in rapid HIV testing in order to link HBC to ART. These findings again indicate the complementary impact of the Initiative on the 3x5 activities, particularly in accelerating Universal Access to prevention, care and treatment.

District	HW trained in comprehensive HIV care + ART & IMAI		Facilitators trained in comprehensive HIV care + ART		Expert Client Trainers trained		Health facilities accredited and providing ART		Clients on ART	
	B/line	Current	B/line	Current	B/line	Current	B/line	Current	B/line	Current
1. Arua	0	16	0	3	0	4	0	4	400	2200
2. Gulu	0	16	0	1	0	4	0	3	280	1491
3. Hoima	0	18	0	4	0	5	0	2	0	297
4. Iganga	0	19	0	1	0	4	0	1	0	122
5. Kampala	0	75	0	16	0	20	0	31	10,160	39,271
6. Kitgum	0	16	0	0	0	4	0	2	0	82
7. Lira	0	16	0	0	0	4	0	1	0	690
8. Masindi	0	56	0	2	0	20	0	2	0	156
9. Mpigi	0	20	0	0	0	7	0	2	0	92
10. Pader	0	16	0	0	0	4	0	2	0	86
11. Soroti	0	15	0	4	0	3	0	1	40	646
<b>TOTAL</b>	<b>0</b>	<b>283</b>	<b>0</b>	<b>31</b>	<b>0</b>	<b>79</b>	<b>0</b>	<b>51</b>	<b>10,880</b>	<b>45,133</b>

Table 7: Changes in Comprehensive HIV Care and ART by District. Uganda.

### 3.4 Sexually transmitted infections

Five countries conducted activities to strengthen the diagnosis and treatment of STI and increase the provision of appropriate drugs for syndromic treatment. (Table 8)

#### Comment

Reports show that several thousand STI patients have benefited from improved STI management; that more than five hundred health workers have been trained in the syndromic approach; and improved drug availability and access as a result of the provision of free drugs.

Countries	N° of health workers trained	Provision of medical supplies: drugs and tests	Intervention in communities
Burundi	210	x	
CAR	77	x	
Ethiopia	164	x	Training of pharmacists, private doctors and drug vendors
Rwanda	50	x	
Togo	59	x	

Table 8: Activities implemented to manage sexually transmitted infections.

Ethiopia is the only country where there was evidence of increased attendance of STI clinics (see figure 4). It is also the only project where training activities included the private sector -- private health facilities and drug retailers -- and where links were established with NGOs to ensure the continuity of STI drug supply. There was also the explicit aim of using STI services as an entry point to VCT and other prevention services; promotion of behavioural change, including the provision of condoms, was a key component of training, although the impact of such interventions was not measured.

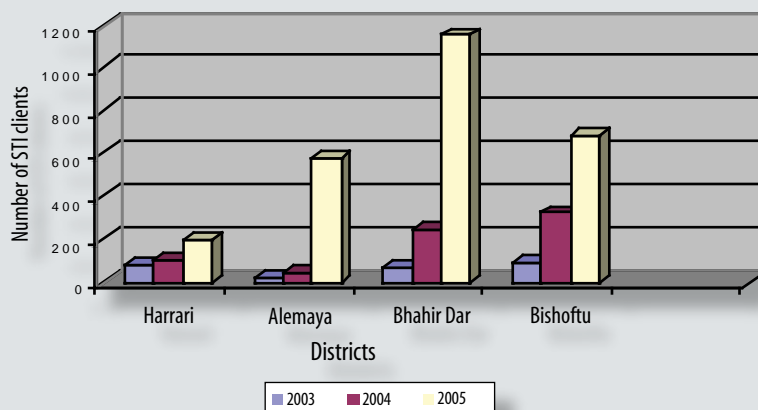


Figure 4: Yearly increase in number of STI patients in the four districts of the Initiative in Ethiopia (2003-2005)

Comment

While STI activities have often resulted in expanded access to services, they were not planned as comprehensive interventions where HIV prevention, care and treatment are integrated. However, in some countries, STI provided an opportunity for counseling in VCT services. This synergy is significant.

In four countries, the promotion of a syndromic approach to treat STI was not integrated into a broader public health approach that would have included community sensitization, condom promotion and training of health workers in counseling. The training was more technically and clinically oriented. Only Ethiopia has expanded its training beyond the public sector by including pharmacists and private practitioners. The comprehensive training has included partner notification, condom advice, management and reporting.

In countries such as Rwanda and Burundi, the provision of free drugs for STIs in specific sites has no clear rationale, was not part of the national policy and was not sustainable. In the other sites, free STI drugs were supposed to be given only to PLWHAs but the assessments have not permitted a validation of this approach.

### 3.5 Activities targeting young people

These programme interventions were carried out in two countries.

In **Ethiopia**, the concept of youth friendly centres was developed for the first time. Two centres were established (one is still under construction) and some promising pilot activities have begun: 160 peer educators and 40 health workers were trained in reproductive health for young people and 100 anti-Aids health clubs for in-school students and out-of-school youth were established. However, there is no evidence of gender sensitivity in training and of change in knowledge or behaviour.

In **Burkina Faso**, communication programmes to increase safer behaviour, including condom distribution, were implemented in the army setting and, after two years, the programme has reached about 3,000 young military recruits. Time and resources did not allow further study.

The assessments in these two countries did not permit assessment of quality, the impact on behavioural change, or the sustainability of these programmes, still in their early phases.

#### Comment

*There was no evidence that the WHO/ OPEC Fund Initiative has had a comparative advantage or made a difference in implementing activities for young people. Follow-up research is warranted.*

### 3.6 HIV surveillance and improved programme monitoring

In Uganda, the planned activities in HIV surveillance were undertaken by other partners before the implementation of the Initiative. In **Burkina Faso**, three new sentinel sites for HIV surveillance were established and are functioning. In **Togo**, HIV tests and equipment were provided to 16 sentinel sites. In **Ethiopia**, the focus was more on programme monitoring: 22 health workers were trained on basic computer skills and 13 computers and printers were provided. Communication and coordination between the different levels of the health system has improved through information exchange and feedback. Implementing districts were able to locally process their data using computers, printers, photocopiers, fax machines and other equipment funded by the Initiative.

The activities in HIV surveillance were satisfactorily achieved, but have not proved to help government and partners to be more strategic and selective.

### 3.7 Blood safety

In Central African Republic, through Initiative support, one blood transfusion Centre has been developed and four blood banks have been organized at district level; the health personnel have been trained in blood safety systems. At the national blood transfusion centre in Bangui, the HIV seropositivity rate among blood units has fallen from 11% in 2000 to 5% in 2004; this success is the result of the organization of voluntary blood donations, education and counseling of donors, and the enrolment of blood donors in associations.

## IV. Addressing common obstacles to implementation and scaling up

The reasons given by countries for the selection of particular rural districts varied; the primary reason was lack or deficiency of services for the communities selected, together with the perception of high risk behaviour in the particular geographical zone.

For example, in **Malawi**, the project focused on VCT and PMTCT in 11 health facilities in Zomba district, one of the 27 districts in Malawi. Zomba district was chosen because it has a disproportionately large number of major institutions which attract a transitory population of at-risk adults. At the start of the project, VCT services were only available at two sites but were limited in scope. PMTCT services were not available in any form in the district.

All evaluation reports have highlighted a series of obstacles and difficulties in implementation. The most common are summarized below in Table 9.

	Delayed procedures for WHO funding	Delayed procedures for procurements	Staff workload, staff turnover	Stock out of commodities	Lack of coordination	Lack of supervision and monitoring
Burkina Faso	✓	✓		✓	✓	
Burundi	✓	✓	✓	✓	✓	✓
Centrafrique	✓	✓		✓	✓	
Ethiopia	✓	✓		✓		✓
Kenya	✓		✓	✓		✓
Malawi	✓	✓	✓	✓		✓
Mozambique	✓		✓		✓	
Rwanda	✓			✓	✓	✓
Tanzania	✓	✓	✓	✓		
Togo	✓	✓				
Uganda	✓		✓	✓		✓
Zambia	✓	✓	✓	✓	✓	✓

*Table 9: Most common obstacles quoted by country evaluation reports. ✓ = mentioned in the Evaluation Report as a significant impediment to implementation and scaling up.*

The Initiative encountered the following difficulties:

- project implementation was delayed. Following the finalization of plans of action at the central level, the start of activity implementation at district level was delayed, as districts needed more time to elaborate their operational plans, including funding requests. As a result, submission of activity reports was also delayed.
- bureaucratic procedures involved in expending WHO funding and the lack of a development account at local level were strong impediments.

Reported one country:

*“The funds were controlled centrally and the disbursement to the district level did not take place in a timely manner, hence a number of delays were experienced.” (Malawi).*

Funding for the Initiative was distributed by rounds and planning was expected to cover the funding available for the period of implementation. Delays in submitting procurement requests by country offices as well as rigidity in WHO procurement procedures, have contributed to overall delays and to the low absorptive capacity of the countries in the use of their funds. Delays in delivering orders arise from errors in allotment numbers provided by countries or from lack of provision into allotments.

- some countries have tended to order excessive drug and reagent supplies, triggering a time-consuming re-review of orders. Delays in other activities such as printing and delivery of education materials, production of guidelines and tools, and stock outs of supplies also affected the quality of services supported by the Initiative.
- coordination between levels of the health system was generally weak and consequently affected management of the project at the district level. The capacity of MoH and WHO to conduct regular supervision and monitoring was weak, due to competing engagements, and other broad responsibilities of staff; consequently, supervision was hardly carried out in many sites.
- most countries did not have monitoring and evaluation plans at project inception. In countries where national M&E systems exist, linkage with the project indicators was absent, except in Ethiopia and Tanzania.
- there was a high turnover of staff in most project sites, not only at district level but also at the MoHs and the WHO office, which has had a negative impact on the programme implementation, direction and quality of delivery.

Despite these difficulties, it is surprising that most countries were able to achieve their target activities. The next section highlights the lessons learned in overcoming these impediments.

### Lesson Learned No. 1:

**The most successful projects were those with community mobilization from the start of the implementation phase, and where concerted efforts in time and money were deliberately mobilized for this purpose.**

In **Malawi**, to achieve continuum of care, support groups were established and supported, referral systems strengthened and a catalogue of available services developed in some of the VCT sites. The communities in the project area have been sensitized through a series of open days, sensitization meetings and provision of IEC materials. Community ownership and involvement has been achieved through use of lay counsellors and their involvement in community sensitization, and post-test care services through local community based organizations. The increased demand for services is reflected in the number of clients accessing the services.

In **Mozambique**, support groups of HIV seropositive pregnant and post-partum women represent the main partnership with civil society. These groups usually meet separately for pregnant and post-partum women at the PMTCT site. In 2004, there were 435 seropositive pregnant women participating in groups and 208 participating in post-partum groups. Beyond the usual counseling on infant feeding and caring practices provided to these women, they receive a monthly food basket provided by the World Food Program. Since the provision of food to the Positive Mothers' Groups began in mid-2004, a significant increase in the number of participants was observed. This plays an important role on the acceptability of PMTCT on the part of pregnant women.

### Lesson Learned No. 2:

**Where partnerships were actively foreseen and networks formally established with a variety of partners, programme implementation was the most successful and the potential for sustainability is high.**

In **Kenya**, four out of five districts were able to create networks among 5 to 8 development partners addressing areas relevant to WHO/OPEC Fund Initiative, i.e., capacity building/training, PMTCT, VCT, ART and community mobilization. Joint planning activities at district level contributed significantly to the project sustainability.

In **Mozambique**, the success of the partnerships as a model for implementing PMTCT activities at the rural level has represented a practical demonstration of its feasibility. The first experiences have attracted more funding from several sources (PEPFAR, USAID, UNICEF, World Bank, Bill Clinton Foundation, Bill Gates Foundation, Columbia University, and the CNCS), bringing about an increase in the number of PMTCT sites that is now under way.

### Lesson Learned No. 3:

Using lay counselors, community workers, support groups of HIV sero-positive pregnant and post-partum women improves not only PMTCT and VCT services uptake and quality but also ownership and involvement of the community. In Zambia, the use of community-based lay counselors increased access to ART for PLWHA in home-based care settings.

In Malawi, Kenya, Mozambique and Zambia, the WHO/OPEC Fund Initiative activities have successfully trained and organized different kinds of community workers and involved them early in the programme implementation process. This has contributed to community sensitization, motivation, increased service seeking behavior and an associated increase in utilization of the services.

### Community member participation works

(Mozambique) **Mozambique** provides convincing evidence of the role that community members can play. Health Alliance International (HAI), the NGO responsible of the programme implementation, works through community groups to support people who are living with AIDS as well as to mobilize individuals to get tested and access health services. Two grassroots groups, supported by HAI, are actively providing crucial home-based care in the communities where they work.

HAI activists make home visits to help clients and their families with palliative care and to provide support for adherence to medicines. Activists provide counseling and information about HIV care and prevention, as well as referrals to HIV/AIDS Day Hospitals and health centers, for more extensive clinical care.

Another aspect of HAI's community work is linking with other NGOs, small community-based organizations, associations and churches to educate their members, volunteers and outreach activists about HIV/AIDS, malaria, maternal and child health, and health system services that are available for people living with HIV/AIDS.

One theatre group supported by HAI was instrumental in promoting VCT services for young people, pregnant women and the general population in all districts where HAI works. HAI has also supported an additional 12 associations in HIV education and prevention activities in the communities, either for targeted events such as municipal festivals, or on an on-going basis for outreach and mobilization activities.

**Lesson Learned No. 4:**

**Few projects have outsourced key functions. Where this has been done, it has accelerated implementation of the activities and their quality, proving that broader partnerships are essential elements for scaling up.**

In **Malawi**, the District Health Office Management Team, supported by an international NGO, Diginitas International, had overall managerial responsibility of the project at the district level while the HIV/AIDS unit of the Ministry of Health had oversight and supervisory responsibility for the project.

In **Mozambique**, Health Alliance International (HAI), a United States-based NGO, was the main implementer of the PMTCT activities, working in close collaboration with the Provincial Directorates of Health. As a result, availability of commodities and supplies for PMTCT constitutes a real model. Not a single OPEC Fund site has ever had stock outs of materials from HIV tests and preventive ARVs (Nevirapine and Zidovudine), to gloves, lancets or any other basics. Stocks are managed effectively and the response from the provincial level to the service delivery level is very effective.

In **Tanzania**, two NGOs in two regions were selected to implement the VCT and home-based care activities, in collaboration with regional and council health management teams. This factor was determinative in scaling up the activities.

In **Zambia**, HBC activities were conducted by partner NGOs who provided regular reports to the DHMTs.

**Lesson Learned No. 5:**

**In some countries, the large number of actors engaged in implementation made difficult the direct attribution of successes or outcomes to the WHO/OPEC Fund Initiative. However, by acting collectively, the local actors often managed to improve programme impact.**

In **Kenya, Burundi, Uganda, Malawi and Togo**, the multiplicity of partners and donors supporting the same programmes at district levels makes it difficult for the evaluation to associate service utilization and delivery improvements to specific programmes. Coordination was challenging, but the large number of actors also creates synergy, complementarities and mutual support.

In **Tanzania**, for example, the Initiative has built partnerships with other implementers. The procurement of kits for HIV testing and home-based care services were made available to the OPEC Fund Initiative sites through different partners within districts; drugs and supplies are shared between the providers to serve those in need within the districts, regardless of the donor sources.



▶ **Lesson Learned No. 6:**

**Basket funding at district level facilitates money and commodity flow**

In theory, basket funding modalities at district level should improve “resource access to base.” In **Ethiopia, Kenya and Burkina Faso**, there were attempts to use the total budget for HIV/AIDS at district level as a common basket to fund activities. This flexibility in inter-budgetary reallocation of funds, as dictated by the needs on the ground is reported to be an important factor enhancing the implementation. The WHO/OPEC Fund Initiative has contributed to this basket funding by allowing flexibility in the decision-making process, allowing managers to transfer funds between budget lines as dictated by local needs. Other options should be explored, such as delegated cooperation where one donor or agency manages the funds on behalf of the other, and/or joint financing. In **Zambia**, funding was decentralized; the three DHMTs were funded and they sub-granted local partners.

▶ **Lesson Learned No. 7:**

**Programme sustainability is more likely to occur in successful programmes.**

According to the assessments in countries, a third of the projects in countries have already received assurance of partners’ support, at local level or at central level or both. Usually, those projects that are supported were the most successful in terms of scaling up.

In **Tanzania**, the support provided by the WHO/OPEC Fund Initiative has generated strong momentum for the success of the care and treatment programme for PLWHAs. Five ARV sites have been established and two more are expected to be initiated in the year to come in project implementing districts. Another third of projects has received guarantee of partial support: not all the activities will be sustained but only some of them. Another third of the projects have not received formal guarantees of support and may continue at current levels without further support or development.

▶ **Lesson Learned No. 8:**

**By pooling resources at district and provincial level, some programmes were able to create synergy and compensate for limited human resources capability.**

The health sector, either at the district or at the health facility levels, is confronted with limited human resource capacities. Some countries, such as **Kenya and Rwanda**, were able to build on existing capacities to develop linkages in training, planning, resource mobilization and monitoring strategies. In **Zambia**, the strategy of creating a cadre of resource persons and using them in another district was commendable. Combining provincial and district training allowed for quality training and good use of resources. In **Ethiopia**, supervision was carried out at the same time for VCT, care and support and STI activities.

## VI. Conclusions and recommendations

The WHO/OPEC Fund Initiative deliberately initiated partnerships with States in conflict, facing insecurity and/or political instability, such as Burundi, Rwanda, Central African Republic, Uganda and Ethiopia. In addition, remote rural districts were selected for the implementation of the Initiative. The WHO/OPEC Fund Initiative should take credit for this courageous choice. Indeed, the evaluation found that after two years of implementation many projects have made a difference at district level despite the range of obstacles.

It was clear from the start that by selecting remote and underserved rural districts, the Initiative would encounter logistical difficulties, in communications, transport and supervision. Some of these obstacles, which substantially affected rapid and efficient scaling up, could not be sufficiently addressed by WHO. Technical support provided by AFRO, for example, could not compensate for these structural administrative constraints.

### ▶ Conclusion/recommendation 1:

There is a need for WHO to review its administrative arrangements. To be effective, especially at district level, WHO needs to strengthen its system of procurement: simplified but standardized procurement and delivery of supplies should be sought to deliver set programme products and produce a greater impact.

### ▶ Conclusion/recommendation 2:

WHO should develop a simple and functional system of funds transfer among the different hierarchies of the local institutions and develop a special reporting mechanism within the existing information system that facilitates implementation and monitoring of outlined activities.

Project preparation with districts which normally might have taken one or two years was considerably shortened. The evaluation found that, in half of the countries, HIV programme effectiveness and strategic priorities were inadequate. Some country projects have consisted of simply providing training and commodities to rural districts without a comprehensive approach that would have required more efforts on HIV prevention and on community mobilization. Many activities were planned in terms of outputs, such as 'number of kits' or 'personnel trained,' and not in terms of outcomes and results. In addition, issues of sustainability of Initiative outcomes were not clearly articulated in many project plans.

The rapid preparation of some national projects, without in-depth strategic consultations at local and central level, sometimes translated into a patchwork of activities without coherence. At least five countries embarked on four different projects in different districts. **These country projects were less successful in achieving all their objectives than countries focusing on one or two technical areas in the same districts.**

### ▶ **Conclusion/recommendation 3:**

WHO should assist countries to develop projects that are more strategic and more selective, in technical areas where the organization has clear expertise and can mobilize partners.

### ▶ **Conclusion/recommendation 4:**

Countries should develop programme activities that are more specific; projects should include clear and measurable behavioral outcomes, not just increased access to services. HIV prevention and community mobilization should be integrated as a key component of any health care activities.

This project was unique in ensuring support to the key inter-linked aspects of service improvement: normative, capacity building and scale-up. This was a beneficial deviation from the common practice of donors or partners supporting training without paying attention to the infrastructure, equipment and supplies needed to fully apply the knowledge and skills. The evaluation strongly supports this integrated approach and commends its effectiveness. However, the issue of sustainability of the activities was not sufficiently addressed in the design of a majority of projects.

### ▶ **Conclusion/recommendation 5:**

By linking programmes such as the WHO/OPEC Fund Initiative to other global initiatives including 3 x 5 and “Three Ones” principle, WHO would ensure better integration that in turn would lead to greater sustainability.

Most of the interventions selected by countries to be implemented at district level were quite complex, requiring expertise in prevention and care, laboratories and/or clinical skills. Supervision and regular monitoring is known to be generally helpful in maintaining the performance of health workers. It is probably the only way to ensure that standards set in guidelines and imparted to staff during training are maintained.

### ▶ **Conclusion/recommendation 6:**

The specificity of WHO/OPEC design – with emphasis on the district level – should call for increased supervision from the central level and strong monitoring and evaluation systems over other projects.

The WHO/OPEC Fund Initiative was innovative and pioneered some of the current global developments in the HIV response, such as the 3 x 5 Initiative and the Universal Access to HIV prevention, care and treatment. There is an increased recognition that coverage needs to be expanded by decentralizing HIV prevention and treatment access to first-level primary care providers (in both the public and private sectors). The WHO/OPEC Fund Initiative has started to meet these new challenges as rural district sites are more vulnerable to the underlying weaknesses of health systems.

Based on the experience accumulated in the last 3 years, it is recommended that the WHO/OPEC Fund Initiative extend its support to districts in three inter-related technical areas where much more scale up can be achieved and where additional catalytic support can make a strong difference and lead towards Universal Access.

#### **VCT and PMTCT programmes and home-based care**

Detailed recommendations on how to dramatically improve the scale-up of services in these three areas are available in evaluation reports.



*Service delivery in Uganda.*

PMTCT is currently among the main entry points to HIV prevention, care and treatment services for pregnant women, mothers, their children and families. To effectively contribute to achieving the goal of universal access, the focus will be on accelerating scaling up of a standard of care for MTCT prevention within the health sector. This standard package will include the routine offering of HIV testing and counselling in ANC settings, primary prevention services for women tested negative, universal precautions, ART and ARV prophylaxis, safer obstetric practices, and infant feeding counselling and support.

Priorities in programme development and implementation should also address the crisis in human resources for health, integrated service delivery, community involvement in care and support of PLWHA. The national PMTCT scale up should be supported in countries which built on existing projects and initiatives. Innovative approaches should be encouraged such as regional training initiatives and public-private ventures, as highlighted in this report and as recommended by the 3 x 5 evaluation report.

This would call for improving coordination with the other multilateral and bilateral agencies to align the different sources of support for health systems strengthening and to plan technical assistance within national health sector priorities for further scaling-up towards Universal Access.

WHO can make better use of its advantageous position with the MoHs to play a more active role in helping to establish better information and coordination mechanisms.

**VIII. Final budget, financial status as of 31 May 2006**

Description	Planned budget	Obligated
<b>Phase 1: Finalization of country workplans</b>		
1.1 Organize Planning Workshop	121,000	120,000
1.2 Support workplan development, including regional consultants	69,000	75,000
1.3 Organize technical review meeting	30,000	30,000
1.4 Documentation and dissemination	25,000	25,000
<b>Sub-total phase 1</b>	<b>245,000</b>	<b>250,000</b>
<b>Phase 2: Support to implementation and monitoring</b>		
2.1 Country activities, including seed funding	6,102,000	5,446,090
2.2 Technical support and supervision to countries	314,000	237,880
2.3 Midterm review	300,000	73,647
2.4 Technical oversight of the initiative (WHO staff at HQ, RO and country)	880,000	1,217,515
2.5 Development of M&E framework and finalization of country M&E components	87,000	72,543
2.6 Documentation and dissemination	60,000	37,044
<b>Sub-total phase 2</b>	<b>7,743,000</b>	<b>7,084,719</b>
<b>Phase 3: Final review and replanning</b>		
3.1 Carry out country external evaluation	400,000	113,580
3.2 Organize review and re-planning meeting	86,000	31,053
3.3 Documentation and country case studies	100,000	
3.6 Documentation and dissemination	30,000	13,200
<b>Sub-total phase 3</b>	<b>616,000</b>	<b>157,832</b>
<b>Grand Total: 1 + 2 + 3</b>	<b>8,110,000</b>	<b>7,492,551</b>
<b>Summary</b>		
I. Total contribution received	8,110,000	
III. Interest	196,190	
II. Total funds made available	8,306,190	7,492,551
III. Unobligated balance ( I - II )		813,639
IV. Pledges outstanding	0	

## Annex 1: Findings by country

This section presents summary evaluation findings for each country. Findings presented relate to the three Initiative goals, and reference the interventions and specific objectives selected by the country. The first paragraph presents a brief contextual background, while the subsequent paragraphs highlight the in-country processes, outputs, strengths and challenges.

In some cases, a general conclusion has been provided. In a few cases where partner synergies created through collaboration, joint training, scale-up or capacity building were not easily separable from the Initiative's efforts, an aggregate quantification of the outcomes from the collective efforts of all partners within districts has been provided. To standardize reporting by countries, goals and intervention area, the following major indicators were relied upon:

- number of people trained;
- % increase in local population covered by trained health personnel;
- commodity / service / infrastructure availability and sustainability;
- number of people accessing service, by gender and age; and,
- % of planned activities completed on time after review of timelines due to external delays.

## Burkina Faso



Burkina Faso has for the last five years engaged international development partners and friendly countries to assist it in implementing HIV/AIDS prevention programmes. This has seen HIV/AIDS prevalence, estimated by UNAIDS among the 15-49 age group, drop from 4.2% in 2002 to 2.3% in 2005. Under the WHO/OPEC Fund Initiative, US\$400,000 was allotted to implement activities in a number of health districts, to further develop the National HIV/AIDS Strategic Framework. The general objective was to reduce morbidity and mortality rates from HIV and STIs in the targeted sites.

The Initiative's specific objectives were to: provide care and Support for PLWHA in the health districts of Bobo Dioulasso, and Kossodo, in Ouagadougou; create 3 new sentinel HIV surveillance sites in the border sites of Banfora, Dori and Fada; and prevent HIV/AIDS among youth and uniformed service recruits.

Before the project, there was a general lack of training materials for HIV/AIDS care and support, and Kossodo hospital was not able to provide VCT services, due to the lack of trained staff. The Ministerial Committees on Health and Defense had little technological capacity to manage information. There were no second generation surveillance sites in the border towns of Burkina Faso. During ensuing reviews, epidemiological surveillance and home-based care were found to benefit greatly from increased targeting of clients, as a result of the project's flexibility. The project developed and supported 3 new sero-surveillance sites, and aided in the development and dissemination of registers and training manuals for care and support of PLWHA. 33 health professionals were trained in second generation surveillance techniques. In partnership with the AXIOS Foundation, 18 health professionals were trained in care and support for PLWHA. The number of clients frequenting VCT centres in the two districts has increased from 54 in 2003 to 426 in 2005. The number of people tested has increased from 98 in 2003 to 1284 in 2005. The Kosodo laboratory was rehabilitated by the French Development Agency, and furnished with key epidemiological surveillance equipment used in testing for TB-HIV co-infection. Challenges facing the project included delays in implementation, which further resulted in the delayed integration of the project into the annual health district action plans.

## Burundi



The WHO/OPEC Fund Initiative in Burundi, allotted US\$350,000, covered 7 of the country's 17 health provinces: Bujumbura, Kayanza, Ngozi, Muyinga, Gitega, Ruyigi and Bururi. Under the three broad Initiative goals, its specific objectives were to improve the syndromic management of STIs; to scale up VCT services; to improve care and support for PLWHA; to build management and coordination capacity, and to build monitoring and evaluation capacity. The Initiative experienced delays in planning and implementation due to external factors, including widespread political unrest and delayed fund disbursement.

While the Initiative may be considered a way forward due to its contributions to the change in approach towards the prevention, care and treatment of HIV/AIDS, its performance was also strongly influenced by the humanitarian crises in the neighbouring countries of Rwanda, Tanzania and the Democratic Republic of Congo. However, project managers, once accorded the opportunity, succeeded in adapting it to the changing needs of the country.

HBC tools and guidelines for PLWHA were developed. The testing and treatment system was markedly improved, while training in STI syndromic management improved the number of noted STI cases at a faster rate in the project sites than in other parts of the country. 65% of national STI cases are now noted in areas where the project is carried out. 4 out of every 5 VCT centres in the country are located in the provinces covered by the Initiative or its partners. Training activities succeeded in building staff capacity in VCT for PLWHA. While the total country population in the 7 of 17 provinces covered by the project is 47%, the percentage of new STI cases tested and recorded within these provinces was 53% over the project's duration. While in 2002, these provinces accounted for only 15% of tested cases, by 2004 they accounted for 99% of newly recorded STI cases. 300 health workers were trained in STI management across the provinces. Testing guidelines were available in all the sites. 6,000 algorithms were disseminated during the life of the project.

Capacity for coordination for the national AIDS programme was strengthened at national and district levels through the provision of 7 desktop computers and 7 copiers at District level and 1 desktop and 1 laptop computer and 1 copier at the national level.

Challenges included the lack of medicinal drugs; patients are prescribed drugs for purchase in private pharmacies. This lack also affected the implementation of guidelines. Serious stock outs of reactive agents, testing equipment and other products were also witnessed periodically. VCT centres are irregularly distributed across and within the provinces. Significant delays to planning and programmatic processes were caused by late fund disbursement and protracted political instability.





The Central African Republic has one of the world's highest AIDS prevalence rates, at 15% according to 2002 figures. The rate is as high as 21% in some cities and 28% in rural areas. The WHO/OPEC Fund Initiative allocated US\$450,000 for interventions in the prefectures of Mambéré Kadéï and the country's capital city, Bangui. The project's general objective was the reduction of HIV/AIDS incidence in the country, under the three Initiative goals.

Specific project objectives were to: provide a safe blood transfusion functional centre in Berberati, in Mambéré Kadéï; increase by 50% the production of safe blood samples secured by the national blood transfusion centre; operationalize a risk management system for blood transfusion services in 90% of the sites in Bangui and Mambéré Kadéï; integrate health training into STI management activities for both sites; equip Mambéré Kadéï prefecture with 3 integrated VCT centres; increase by 30% the number of people in Bangui going for anonymous blood tests; and operationalize decentralized coordination structures for HIV/AIDS activities in all project zones.

Project implementation was generally successful. Achievements included the attainment of repeat voluntary blood donors; securing of blood samples, with no breakages noted since 2003; a reduction of HIV-positive bloods samples from 11% in 2000 to 5% in 2004 in Bangui; the revitalization of STI facilities in the two project sites; the implementation of integrated VCT sites; the operationalization of secure blood transfusion centres; repeat usage of the STI, blood transfusion and the VCT centres by the targeted populations, and capacity building within the coordinating agencies. Increased attendance in Bangui UDA was due to a decision to provide free services and consistent availability of the rapid tests. The UNDP project was complementary in the strengthening of VCT services at Gamboula.

Training of all health personnel in the management of hospital waste occurred the second region. The training, which was the first of its kind, received strong support from many partners.

Challenges noted by the project included weak coordination of activities, the persistence of risky practices such as self medication, difficulties in following established procedures while implementing activities, and the conflict context.

# Ethiopia



The vast majority (85%) of Ethiopia's 73 million people live in rural areas, where the current HIV prevalence is 3.7 percent on average. In the urban areas, it is much higher, at 13.7%. The average AIDS prevalence is 4.4%.

Within the overall framework of the WHO/OPEC Fund Initiative, the goal of the interventions was to contribute to the national efforts to prevent the spread and mitigate the impact of HIV/AIDS. The project was co-managed by a department in the MoH and the WHO country office.

This was done through scaling up 4 selected interventions in 6 districts. The main interventions were:

- establishing youth friendly health services in 2 districts;
- strengthening comprehensive management of STIs in 5 districts;
- strengthening management of common OIs in 3 districts;
- establishing and expanding VCT in 3 districts; and
- strengthen monitoring and evaluation in 6 districts.

Several contributions of the Initiative included the training of health workers in VCT and in STI and OI management; the training of peer educators and AIDS club leaders; provision of OI drugs, kits, protective materials and data processing equipment; and the training of programme managers in monitoring and evaluation. Health workers gained experience in capacity building, planning, and in improving communications with other sectors. Health workers also gained experience in organizing training workshops, and were introduced to the idea of Youth Friendly Health Services, as an intervention, for the first time in the country.

Initiative management activity was decentralized to district councils which shared in the planning, implementation, and in undertaking follow-up activities, including monitoring and evaluation. Comprehensive self-assessment tools on a wide range of subjects were prepared and distributed to the regions and districts, and questionnaires were completed by the regions and districts.

Challenges faced by the project included: lack of baseline data; lack of experience in mobilizing funds outside the usual finance utilization; inadequate knowledge in planning and implementation; the lack of job descriptions for team members; lack of communication with other stakeholders at the initial phase of the project; high turnover of trained manpower; and lack of feedback from the higher project management levels.

The Ethiopia project also gave rise to several notable best practices, including the establishment of a sustainable "post-test club," financial support for the establishment of the "Araya (symbol) virgin women association," the development of a written consent form, and the development of an integrated supportive supervision mechanism for STI, VCT, surveillance, and malaria, among others.



It is estimated that there are about 1.37 million people living with HIV/AIDS in Kenya today, with most in the 15 to 49 years age bracket. After peaking at above 10% in the late 1990s, the AIDS prevalence in the country is now 6.7%, according to the Kenya Demographic and Health Survey with the rate among women double that of men (KDHS, 2003). Women account for about 65% of all HIV infected adults. Major challenges include the current high death rate, with an estimated 150,000 AIDS-related deaths recorded annually. The WHO/OPEC Fund Initiative was therefore aimed at providing PMTCT and VCT services in five districts that have benefited little from such interventions in the past. These districts included Kisii, Garissa, Meru Central, Mt

Elgon, and Suba. The aggregate population of the districts, at 1,674,000, represented 5% of the country's population.

The five WHO/OPEC Fund Initiative Districts, which had few or no VCT/PMTCT services in 2002, had operationalized a total of 37 VCT centres and 73 PMTCT centres by end of 2005. There was significant scale-up in service provision, culminating in 30,942 clients accessing VCT and 40,633 PMTCT services, with 18,283 and 28,524 taking the HIV test respectively in the five districts over the three-year project period. In 2005, 19,700 people accessed VCT service in the 5 districts and around 31,000 over the entire project period. Local district health management teams were mandated to decide on the specific activities to implement: the purchase of goods and services, which partners to engage, and the level and type of contributions to partnerships. More VCT/PMTCT sites were launched per district than had been anticipated, as a result of the efficient use of resources and this decentralized decision-making process. Surrounding communities were able to contribute to the service in numerous ways, including as community health workers and lay counsellors. Commercial sex workers were also recruited to drive clients towards VCT services.

While the multiplicity of partners and donors supporting the VCT/PMTCT programme in some target districts is a case study in effective partnerships, it is difficult to accurately attribute successes and failures entirely to the WHO/OPEC Fund Initiative. In each district, many health workers were trained in PMTCT, VCT counseling, training of trainers, health information systems, and supervision. In some districts, in addition to the number of healthcare workers trained in PMTCT through the Initiative funding, other partners including the US Centers for Disease Control, World Vision, Pathfinder and others facilitated the training of close to 200 other health workers.

Key challenges to the Initiative included high staff turnover, an inadequate number of healthcare workers, high burnout rates, unreliable ARV supply, inadequate transportation in Suba District, an island, over-reliance on traditional birth attendants and breastfeeding, lack of support by spouses, neglect of certain districts by potential funding partners, poor demand forecasting and poor supply system for HIV test kits. There is a need for more integrated sites within districts, and for the encouragement of a prevailing collaborative spirit. In Garissa district, all of the Initiative's funding was spent at the Provincial Hospital in the town centre. Regarding project sustainability, while the district teams have considered the Constituency Development Fund provided by the central government to all parliamentary constituencies and the cost-sharing system as alternative funding strategies, financing from these sources may still not suffice to sustain the PMTCT and VCT benefits to which communities have become accustomed.



HIV prevalence among Malawi's adult population is about 15%, with the majority unsure of their HIV status. Sentinel studies show that 10 - 25% of women attending antenatal clinics are HIV infected, presenting opportunities for a potential increase in the incidence of mother-to-child transmission of HIV. The WHO/OPEC Fund Initiative was introduced in 2003, focusing on VCT and PMTCT in 11 health facilities in Zomba, one of Malawi's 27 districts, situated in the southern part of the country. The district has a population of 630,000 people (460,000 rural and 170,000 urban). Zomba district was chosen because it has a disproportionately large number of major institutions which attract a transitory population of at-risk adults. The goal of this VCT/ PMTCT project, which was implemented as part of general health sector reforms, was to reduce incidence of HIV transmission and improve quality of life for those infected and affected with HIV/ AIDS. The project was coordinated by the District AIDS Coordinating Committee through a task force comprising all stakeholders involved in HIV/AIDS activities in the district.

Specifically, the project aimed to: raise awareness of VCT and PMTCT services to 75% among the sexually active population; build essential human resource capacity for implementation of VCT and PMTCT services; strengthen the existing VCT centres and establish 10 additional ones; establish 11 PMTCT sites; provide psychological-social, physical and material support to VCT and PMTCT clients; and to establish effective and efficient coordination, monitoring and evaluation systems for VCT and PMTCT services in Zomba District. A key decision was made by the Ministry not to recruit project staff specifically for the project in order to allow for project ownership and sustainability. This decision had both positive and negative consequences for the project, as reported in the next section.

The project accelerated the formulation and dissemination of tools for VCT and PMTCT, while complementing other national and partner efforts. Most of the planned activities were conducted and awareness of VCT and its uptake increased by about 500% during the project, from about 2,000 clients at start of the project to about 20,000 clients at the end of August 2005. 32% of these were HIV positive and were referred to care and support services. Through the Initiative, VCT registers, which are now used in all VCT sites nationally, were printed. 11 out of the 17 sites providing VCT services in the district were either set up or supported through the Initiative. 605 women accessed PMTCT services; 24% of them were HIV positive. Partnerships were formed with organizations providing HIV/AIDS care and support services, including Inter Aide, Dignitas International, the Malawi Army, and the Christian Health Association of Malawi. The Initiative renovated all intended sites.

Challenges included: the inability to scale up PMTCT services; the need to integrate refresher training and the provision of supplies into existing services, and inadequate numbers of trained lay counsellors. Despite purchase of computers, record keeping is still inadequate and not harmonized across partners, which impedes project monitoring. Entrusting the experienced district health officers with fund management could have reduced delays. Training of more health workers and lay counsellors is recommended.



Mozambique ranks among the top ten most HIV/AIDS affected nations in the world, with a sero-prevalence of 16.2%. The WHO/OPEC Fund Initiative in Mozambique, initiated in June 2003, promoted PMTCT by implementing a comprehensive package of antenatal, obstetric, postnatal and infant care interventions in Manica and Sofala provinces, in the country's most affected region. This region has an estimated sero-prevalence of 20.4%, while the national average is 16.2%. With a grant of US\$450 000 from the WHO/OPEC Fund Initiative, Mozambique defined targeted interventions for the prevention of HIV transmission from infected mothers to their infants, under the three overall goals of the Initiative. Specific objectives included: expanding access to voluntary HIV counselling and testing among pregnant women; ensuring access to care

and treatment for HIV positive women, their children and partners; and increasing access to psychosocial support services for pregnant and postpartum women living with HIV/AIDS in seven rural districts of these provinces.

The project was implemented by Health Alliance International (HAI), a US-based NGO, in collaboration with the Provincial Directorates of Health (DPSs) of Manica and Sofala. Some project outputs include: the dissemination of the national policies, guidelines and tools which were routinely used in the field. To achieve this, many training activities were carried out. This was accomplished mainly through numerous health worker trainings, supervision and technical assistance sessions were held. Almost all clinical staff at all levels in the two provinces were trained; more than 100 of them were posted at the seven WHO/OPEC Fund Initiative sites. By providing practical field testing through use and dissemination, the project contributed to the development, refinement and updating of national policies guidelines and tools.

All seven PMTCT sites were renovated. The Chimoio Day Hospital was completely renovated and equipped. 11,000 women were counselled in 2004, with a similar number and 95% being tested in 2005. Currently, availability of commodities and supplies for PMTCT constitutes a best practices model for procurement and supplies at the provincial level, as no site experienced stock outs, in contrast to the MoH system which experiences chronic deficiencies. The project has established partnerships with civil society (NGOs, CBOs, FBOs and churches, etc.). An important food support partnership with the World Food Program (WFP) was established to provide food supplements to participants of the HIV Positive Mothers groups. The project, which has contributed to the provision of Quality Standard services, can be considered a national model for district interventions. The national PMTCT programme has improved markedly, while incidence of MTCT has diminished.

Challenges facing the project: PMTCT activities need to be better integrated into the Mother and Child Health Programme. Fund disbursement needed to be timely. Project ownership needs to be improved through mainstreaming into the National Health Service. Stigma and discrimination issues raised by the project are not well understood, and need further study in order for corrective measures to be provided. While sustainability of management and activities may be carried out by the district officers and MoH, financial sustainability may prove a long-term challenge.

## Rwanda



Rwanda has a HIV prevalence of 3% among its 15 - 49 population. The country was allotted US\$350,000 to finance an integrated response to HIV and STI, principally through VCT, PMTCT, OI treatment and STI prevention and care. The Initiative was implemented at the central level and in the three health districts of Kibungo, Gahini and Kiziguro. The WHO/OPEC Fund Initiative role extended from support to project implementation.

Regarding the Initiative's goals, the activities carried out in Rwanda certainly contributed towards their attainment, though not all goals were reached. Normative guidelines in medication and psycho-social care were established and applied in a majority of cases, and the Initiative provided a catalyst to build national capacity; a training syllabus and algorithms were developed and used. While the Initiative could still be improved in terms of effectiveness and attainment of goals, many people from the targeted population benefited from them. While VCT and PMTCT services could yet be improved, the Initiative can be credited with some positive results: training was carried out for health workers, and clients benefited from tests and quick reporting on their sero-status. Performance in STI management activities was average at best. Although training was limited to caregivers, half of these benefited from algorithms for STI management algorithms.

Owing to complex relations between the WHO office in Rwanda and the national health office, WHO went beyond supporting to implementing the Initiative. This had harmful consequences on field supervision, limiting its effectiveness. Long delays in fund disbursement and heavy administrative procedures pushed back implementation and inculcated laxity in project implementation. Few supervisory activities were undertaken.

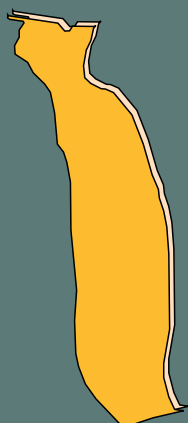


The overall HIV prevalence among blood donors in Tanzania, with a population of about 35 million, is currently 7%. Allotted US\$500,000 by the WHO/OPEC Fund Initiative, Tanzania selected two intervention areas: VCT and HBC. The objectives of the WHO/OPEC Fund Initiative in Tanzania were: to strengthen VCT services and to improve the access to HBC services in 8 selected project implementing districts. The project relied on implementing partners already working in the chosen districts in different interventions, in collaboration with council health

management teams in each district. Overall supervision and coordination was undertaken by the MoH. Italian partner Collegio Universitario Aspiranti Media Missionari (CUAMM) was an implementing agency in Iringa region, while Centro Mondialita Sviluppo Reciproco (CMSR) was the implementing partner in Dodoma region. The Zanzibar AIDS Control programme (ZACP) implemented the Initiative in Zanzibar. Principles which promoted the achievement of project goals were: capacity building for health care workers, community mobilization, and inclusion of stakeholders. The procurement and distribution of medicines, reagents, supplies, and IEC materials was also well carried out.

**Achievements:** 3,210 clients who were counselled and tested for HIV and received their results. Of these, 1,253 were male and 1,957 female. HIV prevalence among adults was 39%. The HIV prevalence rates differed by districts, with the highest recorded in highest in Iringa rural and the lowest in Wete districts. 4,475 patients received HBC services through the project. Of these 1,937 were male and 2,536 female. 48 counsellors, 16 districts HBC trainers, and 100 HBC providers based at dispensaries and health centres were trained. The Initiative established 36 VCT sites, 16 of which are providing both VCT and HBC services. 25 HBC sites were established and 13 are providing both HBC and VCT services. The Initiative built partnerships with other implementers, strengthen health sector infrastructure, and linked to other national initiatives such as care and treatment, and has laid the groundwork for project sustainability.

The main challenges have been the ongoing delays in fund disbursement, causing discontinuity in implementation activities and service delivery within the districts. This has resulted in mistrust between the implementers and the WHO Country office, and the missing some of the targets. Another challenge was in human resources: service providers work on part-time basis to enable them perform other duties in their health facilities. The Initiative has illustrated that collaborating partners within districts, including civil society and council health management, with training and supervisory support from the MoH, can provide an opportunity for sustainable projects to thrive. There is need for additional resources for scaling up the already established services and a further need to review the selection criteria for training of service providers and strengthening of the supportive supervision mechanisms.



In Togo, US\$350,000 was allotted to strengthen the implementation of interventions under the national strategic plan. At the beginning of the Initiative, programme managers from WHO and the national AIDS control programme carried out HIV epidemiological surveillance study to update prevalence figures, setting up 13 sentinel surveillance sites in prenatal clinics, equally distributed between rural and urban areas. HIV prevalence was found to be 4.8% among pregnant women.

The three principle interventions carried out in Togo were: treatment, care and support for people living with HIV/AIDS; STIs and OIs through ARV; and PMTCT and institutional capacity building. The interventions include the specific objectives of: capacity building for 100 healthcare workers in 6 sites to provide care and support for PLWHA and those infected with STIs; supply the six sites with sufficient essential medicines to treat 300 people with OIs and STIs, every six months; capacity building for 32 health workers in 5 sites in PMTCT; supply 5 PMTCT sites with equipment and nutrition every 4 months as per the normative framework, and rehabilitate two sites, Anié and Lome centres, to ensure confidentiality of PMTCT activities. The funds were also used to support 3 NGOs in providing community care for 165 PLWHA; to supply 13 sites with reactive agents for HIV surveillance activities; to ensure follow-up and supervision from the central level to the districts at least twice a year, and from the district level to the 6 project sites at least once a month. Finally, the funds were used to reinforce the capacity of the national AIDS control programme (PNLS). Project activities began in 2004, with the first tranche used to develop normative tools (care and support guidelines for STI and OI treatment using antiretroviral drugs/ARV). ARV medication was bought through a Global Fund grant, supplemented with a Nevirapine grant from Axios Abbot Pharmaceuticals.

Training in care and support for STI cases was carried out for 49% of the health workers originally planned. 59% of these were trained through the Canadian Sida 3 project. 21 doctors and assistants, and 28 paramedicals were trained in OI treatment, care and support. 382 PLWHA received ARV treatment while 211 PLWHA were treated for opportunistic infections; this represented 70% of the cases originally planned. In the six project sites 2064 STI cases were treated in 2004 and by September 2005, 1,864 cases were treated. Data verification for OI proved difficult due to issues in the collection process. Regarding STI, it was difficult to separate between partner and Initiative efforts. The Anié and Lome testing centres were rehabilitated to enhance confidentiality. 97% of health workers were trained in the implementation of PMTCT interventions. Two sites began implementation earlier because they had benefited from training by UNICEF. Users were generally satisfied and the women noted the hospitability and empathy of service providers.

The Initiative encountered the following challenges: waiting times at the PMTCT centres were, on average, too long; men were seldom involved, while women generally requested more support in income generation activities. It emerged from the management committee that while they were generally informed and updated on the Initiative, they were not really included in its day-to-day implementation. Nevertheless, project managers recognized the important contributions made to the national HIV/AIDS control strategy.





Uganda has achieved a scale-up of the health sector response at all levels within the National HIV/AIDS Strategic Plan. The WHO/OPEC Fund Initiative was therefore designed to consolidate these achievements. Implemented since June 2003 with a total funding allocation of US\$508,500, the interventions selected were VCT, PMTCT, HBC, ART and surveillance services, which were to be extended to community and household levels in 11 focal Health Service Districts (HSDs): Arua, Gulu, Hoima, Iganga, Kampala, Kitgum, Lira, Masindi, Mpigi, Pader, and Soroti. These were the districts that had previously participated in the WHO/Italian Initiative. A further purpose of this selection was to maximize the benefits from the WHO/OPEC Fund Initiative and share lessons with other efforts aimed at scaling up HSD-wide interventions in the country.

The overall country project goal was to contribute to the further reduction of the HIV/AIDS prevalence and assist in improving the quality of life of people with HIV/AIDS by strengthening the health systems in the provision of care and prevention. Specific objectives of the Initiative were: to increase the total number of health sub-districts with VCT sites from the current 29% (16/55) to 47% (26/55); to establish a model for scaling up PMTCT within one HSD setting; to increase the number of HSD within the 11 districts implementing HBC from 20% (11) to 60% (22); and to strengthen the capacity of 11 districts to collect, analyse and utilize HIV/AIDS data and information for planning and management of HIV/AIDS services.

The main objectives and targets of the WHO/OPEC Fund Initiative have been met and the role of the WHO/OPEC Fund Initiative in meeting these targets was substantial, especially in providing the framework and tools for other implementers to reach the HSDs and communities. The WHO/OPEC Fund Initiative added value in two main ways: first, by going beyond the 11 targeted districts to nationwide coverage and second, by rapidly mobilizing the implementation capacity of all districts. Within the 2 years of project implementation, the joint effort of the WHO/OPEC Fund Initiative and other partners had led to: the training of over 1300 staff (including medical officers, clinical officers, midwives, nurses, nursing assistants and counsellors) that are providing comprehensive HIV care, including ART, in all 56 districts. 150 health facilities, both public and private, have been accredited to provide ARV. All districts have capacity to train VCT counsellors, counselling assistants and counselling aides. In a sampled period of 12 months, 4,762 antenatal mothers in Mpigi and Masindi were counselled, tested and received test results. The Uganda experience with the WHO/OPEC Fund Initiative provides an opportunity to learn and recognize best practices, for example, using national level referral laboratories for training catalyzed linkages contributed to vertical referral and quality assurance in the implementation of the national laboratory support policy and plan.

Challenges included poor facilitation, inadequate test kits, and diversion of staff attention due to multiple donor programmes. Opportunities exist to facilitate training in sub-district facilities.



Zambia's population is estimated at close to 10 million (2000). Based on current occupation rates, projections are that by the year 2014, AIDS patients will occupy 45% of all hospital beds. The health care system at the national level is severely strained by the HIV/AIDS pandemic. It is against this backdrop that Zambia was allotted US\$561,250 to implement the client home-based care kit initiative in 3 districts (Mongu, Chipata and Mansa). In addition to the overall goals of the WHO/OPEC Fund Initiative, the objective of the Zambia intervention was to

contribute to the further reduction of HIV/AIDS prevalence and to improve the quality of life for people with HIV/AIDS in Zambia, through strengthening health systems for the provision of appropriate care, support and treatment to HIV/AIDS infected persons. It was designed to provide 24,000 client kits to care for 4,000 PLWHAs. Other specific objectives of the project were to provide training for HBC providers, procurement of 24,000 HBC kits for 4,000 PLWHAs, monitoring and evaluation, and reporting and supervision.

Home-based care client kits were procured for distribution to the three districts (Chipata had 1,338 kits in 2004 and 1,129 kits in 2005; Mongu had 1,202 kits in 2004 and 902 kits in 2005.) Clients were satisfied with the proximity of services. Food and nutrition support helped improve clients' health, while patients were discharged from the HBC programme. More clients were able to find out their HIV status. A community health information system, to be linked to the existing HMIS and the new national HIV/AIDS monitoring and evaluation framework, was developed. 22 facilitators were trained. Refresher training was provided for caregivers after three months of implementation in each district. Computers, printers, 480 T-shirts, 150 bags, 150 pairs of shoes, 150 umbrellas and 43 bicycles were bought and distributed to districts for caregivers. Joint training activities, monitoring, and use of a unique manual facilitated partnership and collaboration between providers. Clients were linked through a centralized food supply point. Clients were appropriately referred to additional services.

The programme included a counseling component that linked home-based care to ART and therefore to training by health providers in HIV rapid testing. The programme has led to the use of a two-pronged HBC approach, through which both health facility-based HBC and community-based HBC have been strengthened. Both Mongu and Chipata have increased the number of HBC sites and partners. Mongu increased its HBC sites from 4 to 8. Chipata has increased from 2 to 8 sites. This increase now provides one care giver per 11 clients in one community programme. Both Mongu and Chipata have increased the number of HBC sites and partners to 8. Originally, Mongu had 4 while Chipata had 2 sites. This increase has led to a care giver/client ratio of one to 11 in one community programme. The programme is therefore effective in terms of increased coverage.

Challenges faced by the programme include: change of staff and lack of handover at the Central Board of Health; understaffing leading to overloading of project officers; lack of execution of defined roles at the province resulting from not engaging provincial staff; and lack of focus on HBC during performance audits. At the district level, non-submission of statistics and information on registered clients by districts impeded procurement and distribution of logistics.

## Annex 2: Key questions addressed by the final evaluation

The specific objectives of the final evaluation were to assess progress towards achievement of the Initiative's three broader goals, by reporting on the baseline and progress:

### 1. Filling gaps at the normative level in their national response to HIV/AIDS:

- *What guidelines, policies and tools existed at the beginning for each of the intervention areas, and to what extent were the national guidelines disseminated in the field / districts?*
- *To what extent has the project contributed to the development of national guidelines, policies and tools? What additional benefits has the project provided in this area?*

### 2. Building national and local level capacity by training health workers and rehabilitating infrastructure to make them more effective for service delivery:

- *What capacity and gaps existed, at each relevant level, at the beginning of the project to carry out the selected interventions in the following categories, and how has the project contributed to expanding capacity in these categories at the national level? E.g., Human resources (skills development), management and supervisory systems, infrastructure, availability and supply of commodities and supplies at the service delivery level.*
- *To what extent has the project contributed to the establishment of partnerships with civil society, other sectors, other partners (including UN and bilaterals)?*
- *To what extent has the project contributed to the provision of quality standard services, according to quality assessment against recognized standards of services?*

### 3. Scaling up key interventions by offering quality services and making drugs available to communities:

- *To what extent have implementation experiences / models been implemented, at the national and district level, at the beginning of the project?*
- *What were the limitations to scaling up of selected interventions in the implementation districts?*
- *To what extent has the project contributed to the development of implementation experiences / models at the district level?*
- *To what extent has the project contributed to the establishment / expansion of selected interventions in the same or additional districts?*
- *To what extent has the project established linkages with planned or ongoing initiatives to ensure continuity, and contributed to the establishment of partnerships?*
- *To what extent has the project contributed to expanding services, increasing coverage, and/or increasing use by clients and patients?*
- *To what extent has the project been integrated into on-going efforts?*



