INTEGRATED HIV/AIDS, TUBERCULOSIS AND MALARIA (ATM)
RESPONSE RESOURCE KIT
FOR CIVIL SOCIETY ORGANISATIONS IN NIGERIA

MODULE 2

The Global Fund
To Fight AIDS, Tuberculosis and Malaria
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ACOMIN
Civil Society in Malaria control, Immunization and Nutrition

Stop TB

MODULE 2
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Roles Of CSOs

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ROLES OF CSOs

Objectives

At the end of the training, participants are expected to:

Appreciate the roles of the CSOs in contributing to the effective programming and delivery of quality integrated AIDS, tuberculosis and malaria services in Nigeria;

Comprehend the roles of the CSOS in contributing to increased ATM interventions and services uptake through the Primary Health Care Centres (PHC) in Nigeria; Understand the roles of the CSOs in participating actively and effectively in the multi-sectoral response across the three disease areas HIV/AIDS, tuberculosis and malaria in Nigeria;

Have adequate information on the roles of the CSOs for effective prioritisation of the nation's ATM needs and the actual implementation of the prioritised interventions particularly at the community level;

Understand the roles of the CSOs in effective policies and institutional frameworks formulation for integrated ATM response in Nigeria;

Comprehend the roles of the CSOs in contributing to an enabling health, social and political climate of reduced vulnerability to HIV and AIDS, tuberculosis and malaria through target groups' appreciation of interventions and ownership of same.

Training Contents

Integrated response (Prevention messages, Counselling, Referrals, Care and Support: Treatment/HBC)

Multi-sectoral response

Supply chain management

Information sharing (Programme development & Policy formulation)

Monitoring, evaluation and reporting

Resource mobilisation

Oversight Functions and Supervision of ATM Programmes

Policy influencing

Advocacy

2.1. Integrated Response (Counselling, Referrals, Care and Support: Treatment/HBC)

TB/HIV Epidemiology in Nigeria

Tuberculosis (TB) and Human Immunodeficiency Virus (HIV) are among the leading causes of death in Nigeria and indeed Africa. They constitute a lethal combination of diseases that individually have significant impact on public health with each making the impact of the other worse. **HIV is the most powerful known risk factor for reactivation of latent tuberculosis infection to active disease**; it also increases the risk of recurrent tuberculosis which may be due to endogenous reactivation or exogenous re-infection. The rise in tuberculosis cases in People Living with HIV and AIDS (PLWHIV) poses an increased risk of tuberculosis transmission to the wider community. TB is the leading cause of death among People Living with HIV.

The extent to which HIV fuels TB depends on the degree of overlap between the population infected with TB and the population infected with HIV. Nigeria has a high degree of overlap between HIV and TB infected population among the 15-49 years age group. The Median HIV prevalence among antenatal clinic attendees rose from 1.4% to 5.8% between 1991 and 2001 (2001, National HIV Sentinel Survey) with a decline to 4.4% in 2005 (2005, National HIV Sentinel survey). While recorded HIV prevalence among TB patients rose from 2.2% in 1991 to 19.1% in 2001 (2001, National HIV Sentinel Survey among High risk groups), it is now estimated at 27% in 2005 (2006 WHO Global Report). About 3.1 million Nigerians are already thought to be infected with HIV in 2005 (NASCP, 2005 National HIV Sentinel Survey) at a TB/HIV co-infection rate of 27%, this suggests that over 800,000 Nigerians are co-infected. At this rate, an additional burden of 35,200 TB cases annually is added from the HIV-infected people.

The TB/HIV epidemic impacts negatively on existing AIDS and TB programmes in several ways.

Impact of HIV on TB Control Programmes
- Increased case load of active TB attributable to HIV
- HIV-related morbidity and mortality in TB patients
- Higher default rates and lower cure rates

- High rates of adverse drug reactions during TB treatment
- Increased risk of TB transmission
- Increased burden on TB services human and infrastructural resources
- Delay of access to health services for TB suspects due to the stigma of HIV and AIDS
- Increased smear-negative tuberculosis cases leading to low case detection

Impact of TB on HIV control programmes:
- Increased case load of active TB among PLWHIV;
- TB may accelerate the progression of HIV-related immunosuppression;
- Increased morbidity and mortality from TB among PLWHIV;
- Difficulties with diagnosing TB among PLWHIV owing to the different clinical presentations of HIV-related TB;
- Increased burden on HIV services human and infrastructural resources.

TB/HIV Collaborative Activities in Nigeria

Prior to 2002, functional collaboration between the TB Control Programme and the HIV Control Programme did not exist. The National Tuberculosis and Leprosy Control Programme (NTBLCP) and National HIV and AIDS and Sexually Transmitted disease Control Programme (NASCP) held the first joint meeting in September 2002 during which the strengths and weaknesses of both programmes were analysed, and possible areas of collaboration identified. A subcommittee comprising two members each from both programmes was set up to facilitate implementation of collaborating activities.

An implementation plan was developed by the subcommittee and National Agency for the Control of AIDS, with technical support from the World Health Organisation (WHO) to implement TB/HIV activities in Nigeria. This was followed by a consensus-building meeting involving all the TB/HIV stakeholders from various organisations in the country with the participation of other technical partners on the Joint International DOTS (Directly Observed Treatment Short Course) Monitoring Mission to Nigeria.

One of the outcomes of the meeting was the setting up of a TB/HIV Working Group which was officially inaugurated in July 2006 by the Honourable Minister of Health and whose terms of reference include:
- Facilitate collaboration between TB and HIV and AIDS programmes at all levels;
- Support government to coordinate activities of partners;
- Review periodically the National TB/HIV Strategic Framework Guidelines and any other documents to guide all stakeholders for better TB control

among HIV-infected people and effective HIV prevention and   care among TB patients;

- Support in the dissemination of the Technical Guidelines;
- Mobilise financial and technical resources for implementing collaborative TB/HIV activities;
- Promote National research in TB/HIV control.

TB/HIV Working Group was set up and inaugurated in 2006 in seven states of the federation (Adamawa, Benue, Ebonyi, Gombe, Ogun, Rivers and Sokoto). The Federal Ministry of Health (FMOH), with support from United States Agency for International Development (USAID) and WHO, is presently implementing collaborative TB/HIV activities in thirty-six DOTS and ten ART sites from six states (Adamawa, Benue, Ebonyi, Ogun, Rivers and Sokoto). A new TB recording and reporting format with TB/HIV information has also been adopted and currently used in some states in the country.

The Framework for TB/HIV Collaboration

The NTBLCP has adopted the STOP TB strategy which includes TB/HIV collaboration and also aims at detecting at least 70% of existing smear-positive pulmonary tuberculosis (PTB) cases and treat at least 85% of them successfully to prevent new TB infections. However, considering the influence of the HIV epidemic on TB, it has become imperative to intensify case detection of TB among people living with HIV and AIDS (PLWHIV), prevent HIV infections in people already infected with TB and to reduce the likelihood of latent TB in PLWHIV progressing to active disease.

The NASCP, on the other hand, coordinates the health sector's response to HIV and AIDS in Nigeria. It has the primary responsibility to ensure qualitative and comprehensive care and support for PLWHIV in Nigeria. It prescribes guidelines for increased access to Anti-Retroviral Therapy (ART), management of opportunistic infections, palliative care, and laboratory services. It also guides and coordinates disease prevention activities such as Prevention of Mother to Child Transmission (PMTCT), blood safety and behavioural change communication for proper use of condoms. Beyond these primary responsibilities, there is need to adequately manage TB which is the leading life-threatening condition affecting PLWHIV.

Collaboration will therefore be based on well-defined responsibilities and ensuring complementary activities between the two programmes i.e. functional collaboration rather than structural programme integration; and the need to

generate evidence in order to effectively respond to TB/HIV in a comprehensive manner.

Challenges in TB/HIV collaboration

Coordination
There is a need to establish TB/HIV working groups at Federal, State, LGA, Ward, community levels and facilities for regular joint meeting and joint planning among key stakeholders.

Patients should only be placed on IPT if:
  they are HIV positive;
  active TB has been excluded; and
  are motivated to adhere to treatment

HCT and basic HIV and AIDS services will be provided in the already existing DOTS centres, while DOTS services will be provided in the ART centres. This will however follow a phased approach.

Health workers at the primary level facilities should offer HCT and give supportive treatment as required.

TB/HIV services at different Levels

Level of health service	DOTS/TB Services	HIV and AIDS Services
Tertiary	Diagnosis and treatment of TB, and provision of CPT,HCT, and condom promo and BCC	HCT, ART, OI's, IPT, CPT
Secondary	Diagnosis and treatment of TB, and provision of CPT, HCT and condom promo and BCC	HCT, ART, OIs, IPT, CPT
Primary	Diagnosis and treatment of TB, provision of CPT condom promo, and BCC	HCT and OIs, ART,CPT.
Community	Suspect TB and monitor treatment	Suspects and monitor treatment, OIs.

*Note that IPT to child contact of smear-positive TB cases is to be offered by DOTS/TB services. DOTS implementation is at tertiary, secondary and primary levels. ART services which are presently limited to the tertiary and secondary level facilities are expected to be extended to primary health care level.

Community level

At the community level, community and home-based TB/HIV care providers are to suspect TB and provide support for DOTS and ART treatment. Collaborative linkages are to be established between existing networks of PLWHIV support groups and health facilities.

Diagnosis and Monitoring

HIV testing/diagnosis should be at all levels equipped with adequate laboratory support for such services. TB diagnosis is to be performed at all levels provided laboratory support for AFB sputum microscopy exists. Diagnosis of smear negatives, extra pulmonary case and paediatric cases should be made by medical officers.

HCT

This should be done at all levels with trained counsellors, including stand alone services. Peer counsellors at the community level can also provide counselling services. All TB patients should be offered HCT.

Drug delivery

Anti-TB drugs should be available at all levels where there is a trained general health worker that will ensure DOTS. Administration of ART is to be limited to healthcare facilities, NGO or faith-based clinics where there are existing trained health care providers.

Provision of drugs and HIV test kits

The Federal Ministry of Health will facilitate and ensure un-interrupted supply of drugs including anti-TB, ARV, INH and Cotrimoxazole for prophylaxis, HIV test kits, etc.

Data collation

The existing recording and reporting format of both NTBLCP and NASCP will be revised to include essential elements of the collaborative activities.

Concurrent administration of ART and Anti-TB drugs

All TB, HIV and TB/HIV patients are to be treated using the standard approved treatment regimens in line with the National Guidelines.

Diagnostic Framework

A key component of the TB / HIV framework is the diagnostic framework shown in Figure 1 below. This requires the existence of appropriate referral mechanisms to allow the assessment of HIV status in patients with active TB, as well as to determine if HIV-positive persons are suffering from TB.

Building capacity for HIV Counselling and Testing is as important as building diagnostic capacity for TB screening through sputum smear microscopy.

Some practical implications of the framework are shown in the diagram below. Diagnosis of TB will be the responsibility of the TB Control Programme. This requires that all HIV-positive clients should be screened for symptom of TB and be sent for Laboratory diagnosis when necessary or be referred to the TB Control Programme to undergo examinations to rule out active TB, and to decide on the need for INH Preventive Therapy (IPT). HIV and AIDS programmes will be responsible for providing IPT services.

Similarly, diagnosis of HIV is the responsibility of the AIDS Control Programme. All TB suspects/ patients should be offered HCT.
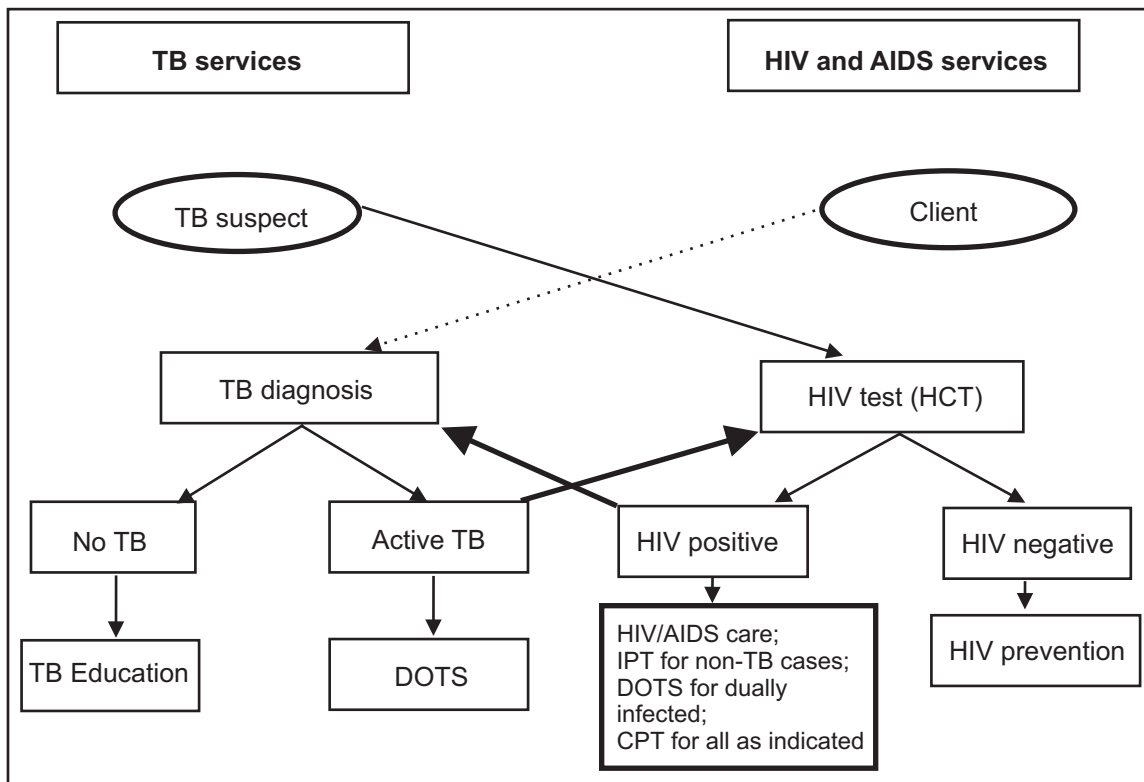
Goal of TB/HIV Collaborative Activities
The goal of TB/HIV strategy is to reduce TB/HIV-associated morbidity and mortality through collaboration between NTBLCP and NASCP.

Objectives
The objectives of collaborative TB/HIV activities are:

1.   To establish the mechanism for collaboration between TB and HIV and AIDS programmes

2.   To decrease the burden of TB among people living with HIV.
3.   To decrease the burden of HIV in TB patients.

Targets:
While the country scales up DOTS and HIV and AIDS services with the aimed of achieving universal access, it is also expected that NTBLCP, NASCP and partners worked together towards reaching the TB/HIV targets stated below.

Indicator	2007	2008	2009	2010
Proportion of TB patients tested for HIV and counselled	59.5%	68.0%	76.5%	85.0%
Proportion of HIV+TB patients completing 6 months of CPT (only)	30.4%	38.8%	48.8%	61.2%
Proportion of PLWHIV screened for TB	68.7 %	80%	90%	100%
Proportion of newly diagnosed PLWHIV, no TB, completing IPT	19.0%	19.0%	19.0%	19.0%
Proportion of HIV+TB patients receiving care and support	70.0%	80.0%	90.0%	100.0%

Strategies

To establish the mechanism for collaboration between TB and HIV and AIDS programmes
1.   Set up a coordinating body for TB/HIV activities effective at the National, State, LGA, facility and community levels
2.   Carry out joint TB/HIV planning and implementation
3.   Conduct surveillance of HIV prevalence among TB patients
4.   Establish effective monitoring and evaluation system

To decrease the burden of TB in people living with HIV and AIDS
1.   Establish intensified TB case finding
2.   Provide IPT for PLWHIV (in appropriate settings) after excluding active TB
3.   Ensure TB infection control in health care and congregate settings

To decrease the burden of HIV in TB patients
1.   Provide HIV testing and counselling
2.   Introduce HIV prevention methods
3.   Introduce Cotrimoxazole preventive therapy

4. Ensure HIV and AIDS care and support
5. Introduce anti-retroviral therapy

Specific Activities

To establish a mechanism of collaboration between TB and HIV Programmes

Set up a coordinating body for TB/HIV activities effective at the National, State, LGA, facility and community Levels
a. Constitute and inaugurate National, State and LGA Levels TB/HIV Working Groups
b. Hold quarterly meetings of the TB/HIV Working Groups
c. Meetings of working groups to establish specific TB/HIV strategic plans
d. Strengthen secretariat support for TB/HIV Working Groups

Conduct surveillance of TB/HIV prevalence
a. Conduct meetings to design a survey protocol
b. Conduct a national surveillance of HIV prevalence among TB patients
c. Conduct a national surveillance of TB prevalence among HIV patients

Carry out joint TB/HIV planning and implementation
Planning and implementation will focus on the following areas:
a. Resource Mobilisation for TB/HIV;
i. Advocate for resources man, material, money, time etc from the NTBLCP, NASCP and NACA;
ii. Ensure that proposals from TB and HIV partners include joint TB/HIV activities;
iii. Yearly identify funding sources for TB/HIV activities, remaining gaps and budget flows from both programmes (GFATM, PEPFAR, etc);
iv. Hold yearly partners'/Annual review meetings with key stakeholders at all levels to debrief on current technical and financial implementation state.

TB/HIV training and capacity building
i. Strengthen capacity of the National and State TB and HIV Control Programmes to plan and coordinate joint TB/HIV activities.
ii. Build capacity and train health care workers at all levels including CBOs, NGOs and PLWHIV on joint TB/HIV collaboration.

TB/HIV advocacy, programme communication and social mobilisation
i. Pay advocacy visits to officials of States' ministries of health, ministries for Local Government, LGA Chairmen and heads of public and private health institutions

ii.   Develop and review joint TB/HIV BCC and community mobilisation strategies

iii.   Produce and disseminate BCC materials in English and local languages for appropriate target audience such as health facilities and CBOs

Enhancing community involvement

i.   Develop joint TB/HIV programme communication and social mobilisation strategies that address the role and needs of individual clients, patients and communities affected by HIV and AIDS and TB;

ii.   Sensitise the community; especially support groups for PLWHIV and CBOs providing home-based care about collaborative TB/HIV activities;

iii.   Use the community to advocate for resources and opportunities to implement collaborative TB/HIV activities.

Operational Research

i.   Train focal-point programme officers at the national and state level on TB/HIV Operational Research;

ii.   Conduct evaluative studies of pilot TB/HIV collaborative programmes and use the results in planning for the scale up phase;

iii.   Collaborate with teaching hospitals and institutions of medical research.

Strengthen monitoring and evaluation (M&E) system

a.   Working Groups to develop a joint strategy for Monitoring and Evaluation of joint TB/HIV collaborative activities;

b.   Review and adapt existing M&E reporting formats to include information on TB/HIV implementation;

c.   Develop a set of core indicators for M&E for TB/HIV collaborative activities.

To reduce the burden of TB in People Living With HIV and AIDS (PLWHIV)

Establish intensified TB case-finding

a.   Training HIV and AIDS counsellors to screen for TB at HIV and AIDS clinics, HCT and ART sites;

b.   Training Medical Officers on early detection/diagnosis and management of smear negative and Extra pulmonary TB;

c.   Implementing screening tools and algorithms for HIV+ smear negative TB suspects through better access to chest x-rays and sputum AFB culture;

d.   Strengthening the referral mechanism between the HIV counselling and testing sites and the TB diagnostic centres;

e.   Establishing a recording and reporting system and a referral form to track and monitor patients;

f.   Developing DOTS services within HIV testing and counselling sites to scale

up DOTS for PLWHIV diagnosed with TB

Provide IPT for PLWHIV (in appropriate settings) after excluding active TB
a.   HIV and AIDS programmes to provide IPT as part of the package of care for PLWHIV when active TB has been safely excluded;
b.   Information about IPT to be made available to all PLWHIV.

Ensure TB infection control in health care and congregate settings
Each health care and congregate setting should have and implement a TB infection control plan, supported by all stakeholders, that includes administrative, environmental and personal protection measures to reduce transmission of TB. Some of these activities include
a.   Develop TB infection control policy and guidelines for health care and congregate settings
b.   Provide joint TB/HIV IEC materials in waiting rooms
c.   Provide bio-safety cabinets in laboratories handling TB specimens for culture and sensitivity
d.   Train health workers working in congregate settings on early detection and treatment of TB
e.   Develop approaches to avoid overcrowding of TB patients in health care and congregate settings

To reduce the burden of HIV in TB patients

Provide HIV tests and counselling for all TB suspects/patients attending DOTS clinics
HIV testing and counselling for TB patients, using rapid tests, offer an entry point for a continuum of prevention, care, support and treatment for HIV and AIDS as well as for TB.

a.   Train DOTS staff on HIV counselling and testing
b.   Provide uninterrupted supply of HIV test kits and related commodities
c.   Establish and strengthen referral and linkages with other relevant services
d.   Provide IEC and outreach to encourage TB patients to undergo HIV testing

Introduce HIV prevention methods among TB patients
a.   Regular supply of condoms (female and male) for distribution in DOTS clinics
b.   Train health workers in DOTS clinics to be able to provide health education to TB patients on responsible sexual behaviour and practices, reduced number of sexual partners and encourage systematic use of condoms
c.   Train health workers in DOTS clinic on Syndromic management of STI.

Introduce Cotrimoxazole Preventive Therapy (CPT)

Cotrimoxazole preventive therapy is promoted for the prevention of several bacterial and parasitic infections in eligible adults and children living with HIV and AIDS.

a. Ensure adequate supply of Cotrimoxazole for use in DOTS clinics
b. Train health worker in DOTS clinics on CPT
c. Develop and distribute instructions to TB health staff on CPT (dose, strength, duration, distribution, etc)
d. Commence CPT in eligible patients
e. Adapt TB data collection system to include information on CPT

Ensure HIV and AIDS care and support for dually infected patients

a. Establish referral linkages with HIV and AIDS care and support services in the community to provide continuum of care and support for people living with HIV and AIDS who are receiving or who have completed their TB treatment.
b. Establish referral linkage with ART sites.
c. Train Health Workers in DOTS clinics to monitor patients on ART on adherence and drug side effect.
d. Train MOs/Health care workers on management of dually infected patients

Introduce Anti-Retroviral Therapy (ART) in appropriate health facilities providing DOTS services

a. Develop one TB-ART point delivery service or referral system
b. Establish referral linkages with ART sites
c. Adapt and introduce information on ART among TB patients.

Monitoring and Evaluation

Monitoring and evaluation are necessary to track what is being done and whether the programme is achieving its set objectives, some of the indicators for the identified interventions are shown below (see next page).

Data generated from the clinics will be collated at LGA level, sent to the state programme for collation and analysis and this will be sent to the National Control programmes in line with existing flow of data for the two programmes. Data from the states will be   processed and analysed by M&E unit of both NTBLCP and NASCP. Feedback will be disseminated to all the necessary stakeholders. The M&E subcommittee of the National TB/HIV working group will also provide support for the collation, analysis and dissemination of TB/HIV data.

Objectives	Activities	Indicators	Periodicity	Responsible Party
1. To establish the mechanism of collaboration between TB and HIV/AID Programmes	1.1 Set up a collaborating body for TB/HIV activities at all levels	Existence of a coordinating body for TB/HIV activities at all levels which meet at least quarterly.	Annually	NTBLCP/ NASCP
	1.2 Conduct HIV seroprevalence among TB patients	HIV sero-prevalence among TB patients (Number of all newly registered TB patients who are HIV-positive, expressed as a proportion of all newly registered TB patients)	Quarterly	NTBLCP/ NASCP
	1.3 Carry out joint TB/HIV planning at all levels	Joint TB/HIV planning (Existence of joint planning at national and state level for collaborative TB/HIV activities between the NTP and NACP e.g. joint advocacy, training, development of IEC materials)	Annually	NTBLCP/ NASCP
	1.4 Strengthen monitoring and evaluation system	1. Monitoring and evaluation of collaborative TB/HIV activities (Presence of an integrated national M&E system for collaborative TB/HIV activities that informs annual NTP and NACP planning cycles and their mid-term (3–5-year) plans.)	Annually	NTBLCP/ NASCP
		2. Number of quarterly Joint supervisory and monitoring visits conducted	Quarterly	

Objectives	Activities	Indicators	Periodicity	Responsible Party
2. To decrease the burden of TB in people living with HIV	2.1 Establish intensified TB case finding	Intensified TB case finding among PLWHIV. 1. (Number of PLWHIV, attending for HIV testing and counselling or HIV treatment and care services, who were screened for TB symptoms, expressed as a proportion of all PLWHIV attending for HIV testing and counselling or HIV treatment and care services)	Quarterly	NASCP
		2. Rate of new cases of TB diagnosed in clients attending HIV testing and counselling services or HIV treatment and care services (Number of cases of newly diagnosed TB identified in PLWHIV attending for HIV testing and counselling or HIV treatment and care services (who were screened for TB symptoms), expressed as a proportion of all PLWHIV attending HIV testing and counselling services and HIV treatment and care services (who were screened for TB symptoms)	Quarterly	NASCP
	2.2 Provide IPT for PLWHIV with latent TB after excluding active TB	1. Proportion of HIV-positive clients given treatment for latent TB infection(Number of newly diagnosed HIV-positive clients who are given	Quarterly	NASCP

Objectives	Activities	Indicators	Periodicity	Responsible Party
		treatment for latent TB infection (TB preventive therapy), expressed as a proportion of the total number of newly diagnosed HIV-positive people)		
		2. Number of HIV positive clients who start IPT and complete at least 6 months of treatment expressed as a proportion of newly diagnosed HIV patients	Quarterly	NASCP
	2.3 Ensure TB infection control in health care and aggregate settings	1. Proportion of health care and congregate settings that have a TB infection control Policy(Number of health care facilities and/or congregate settings with a written infection control policy, expressed as a proportion of the total number of health care facilities and/or congregate settings evaluated)	Annually	NTBLCP
3. To decrease the burden of HIV in TB patients	3.1 Provide HIV testing and counselling for TB patients	1. Proportion of all registered TB patients who are tested for HIV(Number of registered TB patients who are tested for HIV (after giving consent) expressed as a proportion of the total number of registered TB cases)	Quarterly	NTBLCP
		2. Proportion of all registered TB patients who are tested and are HIV-positive (Number of registered	Quarterly	NTBLCP

Objectives	Activities	Indicators	Periodicity	Responsible Party
		TB patients who are tested for HIV (after giving consent) and who test HIV-positive, expressed as a proportion of the total number of all registered TB patients who are tested for HIV) 3. Proportion of TB patients tested who receive post-test counselling (Number of registered TB patients who are tested for HIV (after giving consent) and who receive their results through post-test counselling, expressed as a proportion of all registered TB patients who are tested for HIV	Quarterly	NTBLCP
	3.2 Promote HIV prevention methods among TB patients	1. Proportion of HIV-positive clients given treatment for latent TB infection(Number of newly diagnosed HIV-positive clients who are given treatment for latent TB infection (TB preventive therapy), expressed as a proportion of the total number of newly diagnosed HIV-positive people)	Annually	NTBLCP
	3.3 To provide Co-trimoxazole preventive therapy (CPT)	2. Number of HIV positive clients who start IPT and complete at least 6 months of treatment expressed as a proportion of newly diagnosed HIV patients.	Quarterly	NTBLCP

Objectives	Activities	Indicators	Periodicity	Responsible Party
	3.4 Ensure HIV and AIDS care and support for dually infected patients	1. Proportion of HIV-positive TB patients referred to HIV care and support services during TB treatment (Number of HIV-positive TB patients referred to HIV care and support services (as defined in local or national HIV and AIDS policy) during TB treatment, expressed as a proportion of the total number of HIV-positive TB patients)	Quarterly	NTBLCP/ NASCP
	3.5 Introduce Anti-retroviral Therapy (ART)	1. Proportion of HIV-positive registered TB patients given ART during TB treatment (Number of HIV-positive registered TB patients who are started on ART or continue previously initiated ART, during or at the end of TB treatment, expressed as a proportion of all HIV positive registered TB patients)	Annually	NTBLCP/ NASCP

Surveillance

The importance of surveillance in the implementation of joint TB/HIV activities cannot be over emphasised. Except for prevalence surveys, existing monitoring systems do not track the proportion of HIV patients with active TB. Surveillance of TB / HIV is required to:

● Monitoring the impact of HIV on the TB epidemic
● Demonstrate the magnitude of TB as an opportunistic infection among AIDS cases.
● Provide information for advocacy, policy decision and programme planning.

The Epidemiology of Malaria in Nigeria

Incidence of malaria varies by weather, which affects the ability of the main carrier of malaria parasites, anopheline mosquitoes, to survive or otherwise. Tropical areas including Nigeria have the best combination of adequate rainfall, temperature and humidity allowing for breeding and survival of anopheline mosquitoes. The burden of malaria varies across different regions of the world and even within a country. This is driven by the variation in parasite vector--human transmission dynamics that favour or limit the transmission of malaria infection and the associated risk of disease and death. Of the four species of Plasmodium that infect humans--*P. falciparum*, *P. vivax*, *P. malariae* and *P. ovale*. *Plasmodium falciparum* causes most of the severity and deaths attributable to the disease, which is most prevalent in Africa south of the Sahara, where Nigeria has the largest population.

The disease malaria is a major health problem in the country, with stable transmission throughout the country. It accounts for about 50 percent of out-patient consultation, 15 per cent of hospital admission, and also prime among the top three causes of death in the country (National Malaria Control Plan of Action 1996 to 2001). More importantly, it is a social and economic problem, which consume about US$3.5 million in government funding and US$2.3 million from other stakeholders in various control attempts in 2003 (World Health Organisation [WHO], 2005).

Approximately 50% of the Nigerian population experience at least one episode per year. However, official estimate suggests as much as four bouts per person per year on the average (WHO, 1995 and 2002). The trend is rapidly increasing due to the current malaria resistance to first line anti-malarial drugs (WHO, 2000). The above suggests that malaria could be the largest contributor to total disease burden and productivity losses resulting from major tropical diseases in the country. Evidence on Nigeria given by the malaria report 2005 shows that malaria incidence throughout the country had been on the increase over the years ranging between 1.12 million at the beginning of 1990 and 2.25 million by the turn of the millennium 2000 and 2.61 million in 2003.

The disease carries with it two categories of costs; morbidity and mortality costs. Malaria morbidity affects households' welfare (through families' allocation to treatment and prevention of the disease), and decline in productivity, through lost time. In the case of mortality, losses to households include lost of future income and cumulative investment on the dead due to malaria.

Malaria has implications for the development of household members and the

country through various mechanisms. One, malaria impairs the ability of people to work hard by losing productive time during care-giving activities, while adults with malaria severely compromise household/family resources, as their capacity to work, earn income and save for their families is reduced. Added to this, the illness generates new financial demands to cover medical treatment, threatening food supply and in extreme cases funeral expenses. Two, it affects child's development and compromise future productive capacity due to absenteeism from school associated with malaria attack. Also, malaria is known to be a main cause of anaemia, epileptic convulsions, growth faltering, and neurological squeal. These are all likely to affect children's performance at school. Three, in the agricultural sector/rural area, peak of malaria transmission has been found to coincide with the peak of planting and harvest seasons when demand for labour is suppose to be high.

At the household level, where fundamental decisions are made, malaria strip families of their main sources of financial and non-financial resources. For the affected individuals, the consequences include emotional distress caused by illness and sometimes death. Associated with this is the critical need to care for those infected and to find ways of replacing their contributions to the household and the community. A decrease of labour productivity resulting in loss of income, reduction of savings, and food, reduced support for the elderly; death of adult children, and the growing burden of orphanage is left to the family and concerned friends which finally trickle down to the national economy. This translates into substantial direct, indirect, intangible costs, and life time loss of earnings, all of which determine poverty and welfare status of the households and finally the economy at large.

2.2. Multi-Sectoral Response

HIV and AIDS, Tuberculosis and Malaria require multi-sectoral and multi-level response that traverses many sectors and establishments within the various sectors. For instance, the public sector, private sector, civil society organisations, faith-based organisations, professional bodies, the trade unions and community associations have different functions to perform in stemming the spread and impact of ATM in any society.

Furthermore, as part of the multi-sectoral and multi-level response to ATM, the different segments of the sectors need to be mobilised for a concerted and integrated response. For instance, in the public sector, the Ministry of Health (and its relevant agencies such as the National Agency for the Control of AIDS, the Roll Back Malaria, National TB Control Programme) and other line ministries such as

Ministry of Education, MDG office, etc, need to be mobilised for an effective multi-sectoral and multi-level response to ATM response. Same must be done at the State and Local government levels as well as the ward or community levels.

2.3. Supply Chain Management

ATM prevention, care and treatment, and mitigation programmes cannot succeed without a reliable and consistent supply of various commodities and test kits, laboratory reagents and medical consumables, etc, needed to support service delivery. Comprehensive and effective prevention diagnosis, counselling and treatment programmes sometimes require various items and products. While the efforts to scale up ATM interventions include increased investment in commodity procurement, not enough attention has been focused on the supply chain responsible for the management and delivery of these commodities.

The sheer volume of commodities required for providing ATM services to initially thousands and eventually millions, of people can be staggering and complex to manage. Investing in effective and efficient supply chains can maximise the use of resources, reduce waste, improve quality of service and ultimately, ensure that customers receive the products they need and donors persuaded to provide even more resources.

PROGRAMME DEFINITION

PROCUREMENT

GOOD MANAGEMENT

USE

STORAGE

DISTRIBUTION
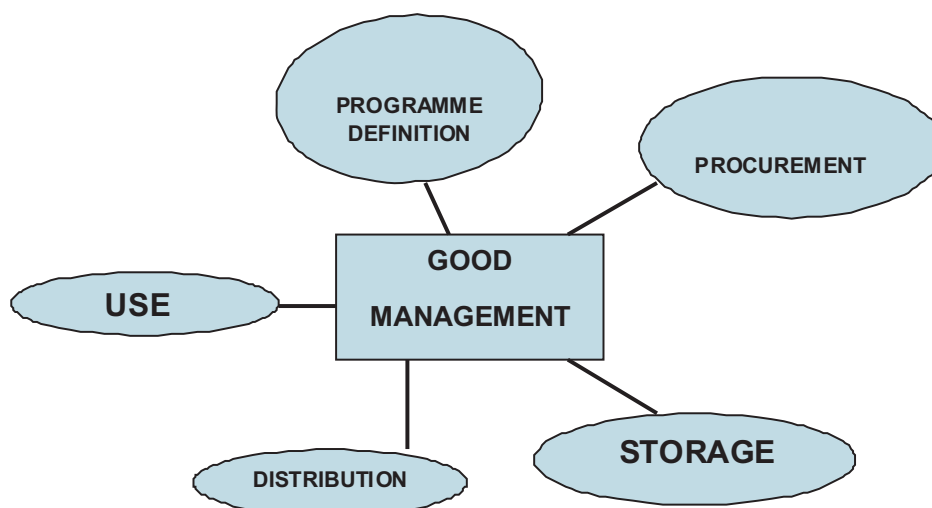
What is a Supply Chain?

The term supply chain describes the links of many organisations, people, and procedures involved in getting commodities to the consumers. Typically a supply chain would include partners from manufacturing, transportation, warehousing and service delivery. A key ingredient of a successful supply chain is that partners are focused on improved coordination and information sharing, but more importantly, all of them are focused on serving the end-customers, who may be patients or clients in health delivery points or the communities. In health care, the supply chain partners usually include manufacturers, pharmaceutical companies, donors or funding agencies, procurement agents including UN agencies, ministries of health, health administrative units, central, zonal, state, LGAs and wards medical stores, as well as NGOs and other designated service delivery points (SDPs).

The Logistics Cycle

Striking the balance between maximising service and minimising the costs of the system is a continuous challenge for health programme managers as well as CSOs involved in health delivery operations. However, because of the high risk of drug resistance due to intermittent treatment, ensuring a full and continuous availability of health products is absolutely critical. On the other hand, maintaining excessive levels of drugs can be very costly.

Regardless the type of supply systems used for getting the commodities to the consumer, whether managed through the public sector or the private sector, the goals of commodity availability and accessibility are dependent on good logistics the ability to accurately forecast, procure, transport and deliver the right goods, in the right quantities, in the right condition, to the right place, at the right time for the right cost. Even for those unfamiliar with the technical components of the logistics process, these goals would seem self-evident.

Why is supply chain management important?

Supply chains help achieve the desired programme impact. These include:
- Increased programme impact and decreases drug resistance through consistent and reliable supply of essential products;
- Enhanced quality of care by ensuring that the products are available for the services being delivered;

- Improved cost-effectiveness and accountability through reduction of loss and wastage;
- Increased customer satisfaction and brings rationality to the system.

In addition, each of the activities in the logistics cycle is also important, because the coordinated completion of each of the activities enables the products to be delivered to consumers.

What is needed for effective supply chain management operations?

Effective supply chain operations require:

1.   Policy Support
Policy makers need to understand the vital role played by logistics; value the tangible benefits and ensure that all customers are reliably supplied.

2.   Customer Focus
The focus of the logistics operations should be on satisfying customer needs. A key to achieving a customer focus is for all the staff involved in the national ATM programmes to know their customers and their needs. For example, a successful logistics system will ensure that products that are simple to use and can be administered on site are delivered to locations that are convenient to the consumers.

3.   Strategic Planning
Supply chain functions should be viewed as a mission-critical function that adds value to the outcomes of the health interventions. A key to achieving strategic planning is to ensure that an assessment of the supply chain is completed early in the process of developing the national ATM programme and the results are used to design and strengthen the system. A performance measure system of the logistics functions which assesses timeliness of deliveries, availability of products at the service sites (measured as percentage product availability or stock-out rates), reduction of waste, etc. should be established and should drive the system.

4.   Logistics Management Information System (LMIS)
Reliable, accurate and timely logistics information should also drive the system. Three key logistics measurements are essential for day to day management of the supply chain: consumption, stock on hand and losses and adjustments. This information is not only important for daily stock management, but, aggregated and analysed, enables managers to project future needs and to better negotiate with and manage suppliers.

How to ensure that supply chain planning is adequate

Logistics systems or supply chain management systems can be continually improved to provide better customer service, improve efficiency or effectiveness. However, there are four key areas that should be addressed early in the process of planning.

A.   Product Selection

The first step to supply chain planning is to know the initiatives the national ATM programme will support and the commodities that will be required to meet that service delivery.

Management

Selecting the right product is essential. Standard treatment guidelines, essential drugs list (EDLs) and national formularies should serve as a basis for product selection. Criteria for product selection are usually based on the standard guidelines provided by the WHO. In addition, to the standard WHO criteria, product choice should also take into account the implications for logistics management.

Logistics considerations for product selection include:

- Standardise and limit the number of commodities that are duplicative. A limited number of products make the logistics functions easier to operate.
- Reduce commodities that require additional accessories such as semi-rapid tests.
- Purchase commodities that ease the burden on the provider and the client. For example, use of rapid assay HIV tests that allow for same day testing and confirmatory testing at the same site so clients don't have to make a return visit at a later date to receive results.

B.   Planning and Forecasting

Where historically data are limited, it is difficult to accurately forecast needs. Quantification of ATM commodities requirements should take into account the following factors:

- Treatment protocols, norms and standards.
- Estimates of numbers of beneficiaries to be served.
- Service absorptive capacity such as staff skills, infrastructure, etc.

- Laboratory infrastructure and capacity for services requiring laboratory diagnostics (e.g. treatment of Malaria, TB, OIs and ARVs).
- Status of the supply pipelines and stock levels in-country.

New or expanding ATM programmes and rapidly changing technologies make it particularly important for supply chains to be able to adapt to changing needs. To ensure an effective and timely response to changes in demand, it is critical to:

a) Initiate/establish a logistics management information system (LMIS) that captures the three essential data items; consumption, stock on hand, and, losses and adjustments and that routinely aggregates and analyses these data at the national level, as early as possible in the project cycle.
b) Ensure flexible procurement mechanisms that allows for changes in quantities and product formulations.
c) Negotiate flexible delivery schedules with suppliers to adjust to programme demands.

C.   Procurement

From a logistics perspective, uncertainty of forecasts, rapid change in technology and, shorter shelf life of some products, requires flexibility in the procurement process that allows for purchasing of smaller quantities, more frequent deliveries and changes in product selection in order to take advantage of new and improved products as they become available. While the unit cost of this type of procurement may be high, delivered cost may be low as it reduces the risk of loss due to expiry, pilferage, or poor storage.

Commodities can be procured either by: (a) the National ATM Programme using National Competitive Bidding, International Competitive Bidding or Limited International Bidding methods (also see the chapter on procurement for other methods); (b) a Procurement agent like a private sector agency or UN agencies. The best procurement method will depend on the nature of the goods procured, capacity etc. It is important that flexibility and staggered delivery are included in the procurement, no matter which type of procurement method is used.

Product Registration and Quality Assurance
Product and supplier registration and quality assurance can take a substantial amount of time that can lengthen the procurement process and result in products being quarantined. Early in the procurement planning, the process of registration and quality assurance should be clearly outlined, streamlined and waivers should be obtained, if necessary.

D.   Distribution

Distribution includes storage, inventory management, re-supply procedures and transportation. There are several ways in which products are delivered to the health care service providers and the consumers/beneficiaries. These include a public sector distribution system, a NGO managed system, commercial systems or a combination of some or all. In order to rapidly mobilise for scaled-up ATM commodity programming, it is likely that many or all distribution networks may be used to get the product to the provider and client as quickly as possible. A key principle that could dramatically improve the distribution and inventory management is to reduce the number of intermediate storage points. This strategy would decrease storage and inventory costs required for the operation.

A major stumbling block to streamlining distribution networks in the public sector is that many of the supply chains mirror government administrative structures. Supply chains increasingly need to de-link from government administrative structures. This is even more critical for HIV products with short shelf lives as, every intermediate storage level, lengthens the pipeline, which increases the risk that the products will expire before reaching the provider and consumer.

The first step in gaining a better understanding of the efficiency and effectiveness of these distribution systems is to conduct an assessment that identifies the limitations and challenges of each of the systems.

Storage

- Adequate and appropriate storage is available at the national level, and at every intermediate level down to the final customer.
- Procurement plans take into account storage capacity.
- Storage space is secure.
- A cold chain system is in place for those products that require it.

Inventory management

- Maximum and minimum inventory control systems are in place.
- FEFO (First Expiry-First Out) and FIFO (First in first out) procedures are used when distributing products.
- Stock cards for record-keeping are used on a daily basis to manage inventory.

Transportation

- Secure transportation system and procedures in place for transporting high-value commodities.
- Cold chain system in place during transportation for those products that require it
- Reliable, timely, scheduled delivery will bring confidence in the system and reduce hoarding behaviours.
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Re-supply

- Supply imbalances will inevitably occur if everyone in the system does not understand or adhere to proper re-supply procedures.
- A push system is a better approach when demand of the commodities exceeds supply.

Logistics Management Information System (LMIS)

- A well functioning LMIS is required if the logistics system is to operate effectively and ensure product availability to the consumer.
- Automated LMIS systems are even more critical due to the sheer volume of data expected to be generated in the management of ATM products.

What are the Specific ATM Products Required?

- ARVs, drugs for OIs, and HIV testing materials
- Anti-TBs and TB testing materials
- Anti-Malarials and Malaria testing materials
- Preventive materials for ATM, such as LLIN, condom, etc.

2.4. Information Sharing (Programme Development & Policy Formulation)

Information sharing is a process of disseminating set of timely data that has been processed and verified among stakeholders. The value of information lies solely in its ability to affect a behaviour, decision, or outcome. A piece of information is considered valueless if, after receiving it, things remain unchanged

Information sharing frame work involves:

- Being knowledgeable of the subject matter, understanding the target audience, mindful of the language and medium of communication.
- Utilisation of shared information by the target audience.
- Getting feedback on the information from all

Roles of CSOs in information sharing:
- They are useful inter-phase between the members of the communities that need ATM services and the service providers.
- They also serve as a means for information sharing for ATM interventions planning, implementation and evaluation of programmes.

Information sharing through print materials and through electronic means should be circulated to all stakeholders with the aim of improving service delivery and ensuring sustainability of programmes.

The information can be used for programme development, policy formulation and legislations in the areas of ATM.

2.5. Monitoring, Evaluation and Reporting

Monitoring & Evaluation (M&E)

Monitoring can be defined as a continuing function that aims primarily to provide the management and main stakeholders of an ongoing intervention with early indications of progress, or lack thereof, in the achievement of results. An ongoing intervention might be a project, programme or other kind of support to an outcome.

Evaluation is a selective exercise that attempts to systematically and objectively assess progress towards and the achievement of an outcome. Evaluation is not a one-time event, but an exercise involving assessments of differing scope and depth carried out at several points in time in response to evolving needs for evaluative knowledge and learning during the effort to achieve an outcome. All evaluations--even project evaluations that assess relevance, performance and other criteria need to be linked to outcomes as opposed to only implementation or immediate outputs.

Distinguishing Between M&E

Confusion between M&E is common. There is a simple distinction between monitoring and evaluation that may be helpful.

Monitoring is the routine, daily assessment of ongoing activities and progress. In contrast, evaluation is the episodic assessment of overall achievements. Monitoring asks: "What are we doing?" Evaluation asks: "What have we achieved?" or "What impact have we had?"

Why is programme M&E important?

Sound M&E is vital in order to:
- Determine Programme Effectiveness
- Identify and Address Problems
- Show Impact
- Gather Evidence of Activities and Results
- Strengthen Fiduciary Responsibility and Accountability
- Show Transparency

M&E Framework

Effective M&E is based on a clear, logical pathway of results, in which results at one level are expected to lead to results at the next level, leading to the achievement of the overall goal.

The major levels are:
- Inputs
- Process
- Outputs
- Outcomes
- Impacts

These levels are described below:

Inputs: Inputs are simply the people, training, equipment, facilities and resources that we put into a project, in order to achieve outputs

Process: Process monitoring and evaluation focuses on programme implementation and uses largely quantitative methods to describe programme activities and perceptions, especially during the developmental stages and early implementation of a programme. It also involves routine gathering of information on

all aspects of a project of programme to check on how project activities are progressing.

Outputs: Outputs are the activities or services we deliver in order to achieve outcomes. The processes associated with service delivery are very important. The key processes include quality, unit costs, accessibility and coverage outcomes. Through quality, economical, accessible and widespread services, key outcomes should occur.

Outcomes: Outcomes are changes in behaviours, skills or state of things.

Impacts: These outcomes are intended to lead to major health impacts. Impacts are long term results of a programme and can be measured with verifiable indicators. Results at the final impact tier may take several years to observe, so it is important to set realistic targets at the impact level.

The trainers should relate these to the various ATM interventions that the trainees are engaged in, and should emphasise that without an effective M&E integrated into ATM programmes, it would be difficult to achieve any meaningful results.

M&E Reporting
Effective programming and M&E should involve proper reporting and dissemination of reports to relevant stakeholders.

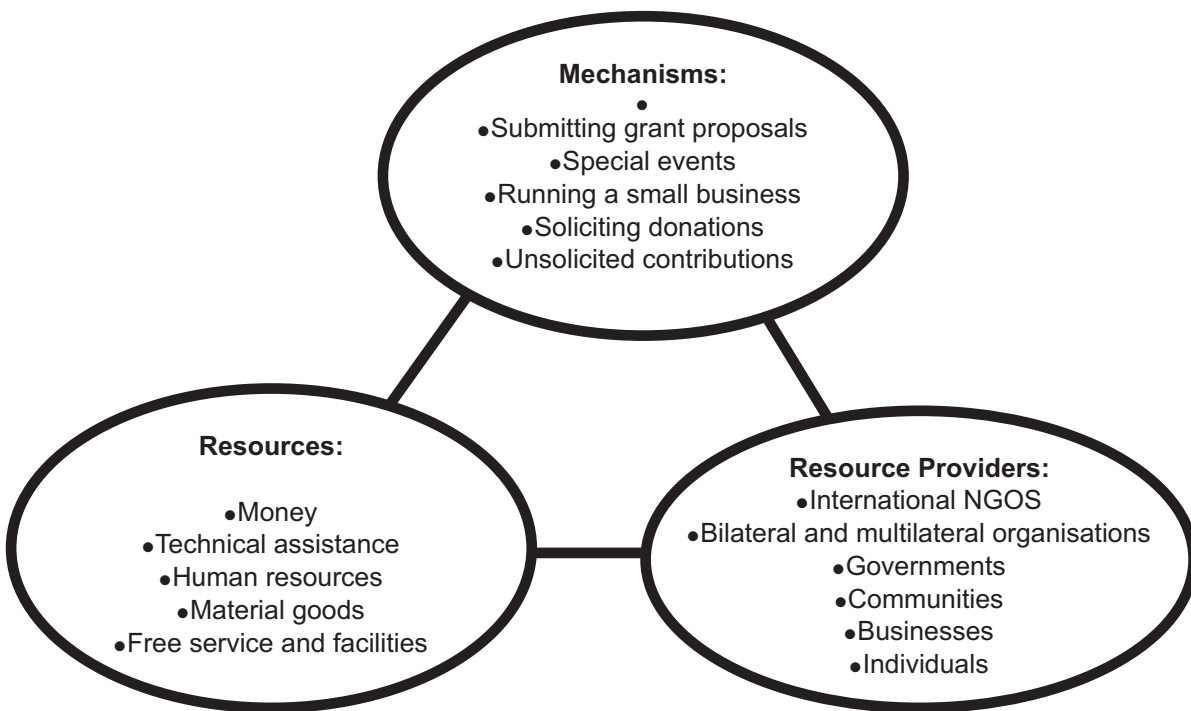# 2.6. Resource Mobilisation

Working definition for resource mobilisation:

<u>Resource Mobilisation' is the process of getting resources from resource providers, using different mechanisms, to implement the organisations' work.</u>

'Resource Mobilisation' is the process of getting resources, from resource providers, using different mechanisms, to implement the organisations' work.
Ways of researching resource providers:
- Search for resource providers websites
- Ask potential resource providers for written information about the resources they provide and how they can be accessed
- Ask the national chambers of commerce and industry for information about socially responsible businesses
- Contact the community relations (or public relations) department of the

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               │      Mechanisms:        │
               │           •             │
               │ •Submitting grant       │
               │  proposals              │
               │ •Special events         │
               │ •Running a small        │
               │  business               │
               │ •Soliciting donations   │
               │ •Unsolicited            │
               │  contributions          │
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Mechanisms:
- •
- •Submitting grant proposals
- •Special events
- •Running a small business
- •Soliciting donations
- •Unsolicited contributions

Resources:
- •Money
- •Technical assistance
- •Human resources
- •Material goods
- •Free service and facilities

Resource Providers:
- •International NGOS
- •Bilateral and multilateral organisations
- •Governments
- •Communities
- •Businesses
- •Individuals

largest companies working in your area.

- Contact embassy libraries, cultural institutes, international organisations (such as agencies of the UN)

- Contact people who know about resource providers or would be good contacts when researching new ideas.

- Read news papers, specialist magazines and reports to keep up to date on how other organisations are funded. Reports and presentations by others will usually acknowledge resource providers

- Ask partner organisations and other NGOs (working both within and outside your field) to suggest organisations to contact for support

- Identify opportunities to meet resource providers.

EXAMPLES OF COMPONENTS OF RESOURCES

Material goods:

- Office or service equipment
- Condoms
- Needles
- Drugs
- Training materials
- Vehicles

Technical Assistance:

- Training
- Programmatic technical input
- Organisational technical input
- Ad hoc support from experts (trainer/facilitators)
- Study visits
- Scholarships
- Publications

Free service and facilities:

- Office space
- Equipment
- Training facilities
- Transportation
- Publishing and printing

Money:

- Money for grant-giving
- Project money
- Core money

Human Resources:

- Regular volunteers
- Secondees (nurses/doctors/counselors)
- Free consultancy

EXAMPLES OF LIST OF MECHANISMS:

Submitting grant proposals

Responding to requests for proposals

- As an individual NGO/CBO
- As an NGO consortium
- As a multisectoral consortium

Unsolicited proposals

- Full proposals
- Concept notes
- NGO consortium proposals
- As a multisectoral consortium

Special events

Programmatic related money generating events, for example, World AIDS Day rallies.

Non-programmatic related money generating events, for example, cultural events.

Running a small business

Renting assets

Selling services

Selling products

Social marketing

Soliciting donations

Direct mail (including for sponsorship programmes, pledged giving)

Donation box

Corporate tie-ins

Major gifts, legacies, endowments

Planned giving

Direct response TV/Print/telethon

Internet

Unsolicited contributions

WHAT ARE THE KEY THINGS YOU NEED TO PREPARE AND TO PLAN BEFORE A MEETING WITH A RESOURCE PROVIDER?

Gather all information required and be prepared for the meeting

If possible, prepare a concept note about the project to hand over to the resource provider

Anticipate difficult questions and think of how you would answer them

Bring along materials about the organisation to give to the resource provider

Decide who should attend the meeting

Make sure you can describe your organisation well

Consider your appearance and clothes

If possible, find out about the person you will meet so that you are psychologically prepared

Carefully research the organisation to know why it provides resources and its programmatic priorities

Prepare a list of questions to ask the resource provider

Prepare to be asked about previous problems in the organisation, prepare honest answers which explain how problems have been addressed in the past

Information to provide the resource provider with:	Difficult questions the resource providers might ask:
--Name and location of the organisation --Organisation's mission and scope of work --How the organisation implements and organises its work --Past experience, including previous resource providers --Organisation's reason for choosing to approach the resource provider --What the resource provider will gain from providing resources to the organisation --How the organisation generates its own resources --Leaflet of the organisation --Comparative advantage of the organisation	--Why did you choose to approach our organisation? Did you approach the government? --Did you take into account all the risks associated with your project? --What are the outputs of the project and when will they be produced? How will this be measured? --What is the capacity of your organisation? How can you show that you will be able to carry out the proposed project? --How will you continue after the resources provided have been used up? Are the project activities sustainable? --What is the public perception of your organisation

Statistics about the problem to be addressed in the project.	in your country? --What will we gain by providing you with resources? --How will you ensure that you are not duplicating the work of other organisations? --How is this project different from others? --Will the beneficiaries be involved in the project? How? --How will you ensure the accountability of the resources we provide? -- Would you be will other NGOs to implement this work? --How would you demonstrate that you have transparent and well-managed financial systems?
Questions to ask the resource provider: -- What are your particular programmatic areas of interest at the moment? --What is the decision-making process in your organisation? --How would you like to be involved in the work? --Do you provide resources other than money? --Can you give multi-year grants? --Would you like to visit our organisation? --Do you support implementing organisations directly?	

Reference: Adapted from a resource mobilisation workshop held in Ulaan Baatar, Mongolia, February 2001

2.7. Oversight Functions and Supervision of ATM Programmes

Why is supervision important?

CSOs have a responsibility to supervise the implementation of ATM programmes to ensure that:

Programme activities are carried out as planned;

Programmes that are successful are scaled up further and those that are not are provided with capacity building or halted;

Funds are spent efficiently, effectively and transparently;

Both beneficiaries and financing agencies are provided with timely and complete

information on the appropriate disposition of funding.

What is Good Supervision?

Good supervision includes the review of the results of monitoring and evaluation, visits to observe development of activities in the field, and discussions with different stakeholders about progress in programme implementation and necessary improvements in programme plans.

What Good Supervision Entails

- Performance can only be judged by a mix of quantitative and qualitative programme (financial/social) monitoring that is evaluated with the participation of both stakeholders and independent experts.
- Operational and management performance is assessed realistically based on developments on the ground rather than on hopes and promises.
- Problems are identified quickly and reported candidly, always keeping in mind the programme's objectives.
- Programme redesign is a normal part of continuous consultation and feedback among key stakeholders, especially by implementing and oversight agencies.
- Emerging issues are addressed proactively, incorporating global good practices adapted to country circumstances.
- Fiduciary aspects are monitored closely to ensure compliance with agreed standards.
- In view of the importance of behaviour change to reduce the spread and impact of ATM on the society, all supervision should emphasise both stakeholder participation and social impact monitoring.

Programme oversight goes on at various levels and uses a variety of mechanisms:

·Implementing agencies in the public sector and in civil society are responsible for first-line supervision, especially with regard to the basic fiduciary requirements of:
1. financial management and reporting;
2. procurement of goods and services;
3. disbursement of funds to beneficiaries; and
4. monitoring and initial evaluation of programme activities.

Oversight functions and supervision include the monitoring of various phases of programme activities: (i) financial reporting and oversight of programme inputs, often on a monthly basis; (ii) reviews with implementing agencies, often on a

monthly basis for trouble shooting and on a quarterly basis to review performance; and (iii) on an annual basis for formal programme review with donors and beneficiary agencies and for fund-raising. (It may be appropriate to plan semi-annual reviews at the beginning of a project.)

Field Supervision Checklist

Preparations for Oversight Functions and Supervision of ATM Activities/Programmes

-       Identify supervision activities, for example, meetings, field visits, stakeholders' consultation, etc.
-       Ensure all relevant background documents and reports are available. For example, project document, annual work plan, M&E reports, financial statements, and previous supervision reports.
-       Identify objectives, methodology, type and timing of supervision.
-       Inform the entities/persons who would be part of the supervision activity and agree on the objectives and supervision dates.

Terms of Reference (TOR)

-       Clearly spell out the objectives of the supervision including inputs and outputs of the project activities as well as outcomes and impact.
-       Identify if there have been any changes in the grant recipient's commitments since the project inception.
-       Get management's approval and share.

Team composition

-       Identify team members based on what focus areas would be covered in the supervision.
-       Ensure appropriate continuity of the team.
-       Have subject matter specialist in the teams.
-       Share TOR and the team composition with key stakeholders involved in the supervision.
-       Incorporate their feedback including adjustments in the logistics.
-        Ensure supervision activities and their timings are suitable for all.

Conducting supervision

-       All members of the team should review the project documents before conducting the supervision.

- Follow up on the daily progress with each team member and record issues, findings, recommendations and decisions agreed with the counterparts constantly strategise the next steps.
- Conduct meetings with the counterpart team/individuals and stakeholders (including grant beneficiaries) focusing on the issues and implementation bottlenecks.
- Conduct field visits. Cover at least 1-5 sub-project sites if possible. Record beneficiary's views, problems and observations.
- Convene team meeting with the counterparts and discuss the findings and recommendations (within the existing capacity of implementing agency).
- Incorporate counterpart's views.

Report preparation

- Address issues listed in the TOR and other issues identified during the supervision.
- Spell out specific suggestions and adequate guidance to the grant recipient of the actions to be taken, by whom and when.
- Assess how much the project/subproject has so far achieved its targets set out at the time project started.
- Get counterpart's observations and suggestions.
- Conduct a team meeting with the grant recipient team and reach agreements on the report findings, recommendation and achievement targets.
- Finalise and share the report with the stakeholders.

2.8. Policy Influencing

At different levels of interventions lack of beneficial policies or inappropriate policies or failure of policy implementation account for poor ATM interventions and services. If CSOs position themselves effectively and transparently among policy makers among the various stakeholders, interventions can be scaled up on ATM programmes.

Identifying issues requiring policy interventions must be generated by the CSOs from services seekers and service providers; and thereafter reconstituted as points for advocacy for relevant stakeholders or bill development for the lawmakers. Successfully influencing policy also requires the right set of policy makers on the subject for which there is a need for policy change or amendment.

2.9. Advocacy

Advocacy for Community ATM Care

ATM Programme managers should sustain advocacy to all stakeholders to proactively canvass support for ATM programme. They should develop area-specific advocacy tools describing such issues as the epidemiologic situation, status of currently available health services and their performance weighed on the scale of targets and the expected benefits of community involvement in ATM care.

(Further details on advocacy are in Module 4 where Community Mobilisation issues are addressed.)

Methods

Plenary presentation, Interactive Discussion, Experience Sharing, Group session/Planning/exercise, Assignment, Group presentation, Demonstration, Role play, plenary discussion, Evaluation

Group work/exercises

GROUP 1: (HIV/AIDS)
1. State ten roles that the CSOs can play in reducing the spread and impact of HIV/AIDS at the community level.
2. What are the most important challenges that make the performance of the roles difficult at the community level?
3. Suggest ways to overcome the challenges.

GROUP 2: (TB)
1) State ten roles that the CSOs can play in reducing the spread and impact of TB at the community level.
2) What are the most important challenges that make the performance of the roles difficult at the   community level?
3) Suggest ways to overcome the challenges.

GROUP 3: (Malaria)
1. State ten roles that the CSOs can play in reducing the spread and impact of Malaria at the community level.
2. What are the most important challenges that make the performance of the roles difficult at the community level?
3. Suggest ways to overcome the challenges.