MEASURE Evaluation

Working Paper Series

Know Your Response

Country-Level HIV-Prevention Response Census and Mapping Tool Kit

Lessons Learned For Practical Application in Developing Country Settings

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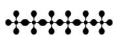

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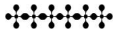

MEASURE Evaluation

KNOW YOUR RESPONSE
COUNTRY-LEVEL HIV-PREVENTION RESPONSE CENSUS AND MAPPING TOOL KIT

Lessons Learned For Practical Application in Developing Country Settings

By
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List of Acronyms

ARV	Antiretroviral
ART	Antiretroviral Therapy
CSO	Central Statistics Office
DATF	District AIDS Task Force
DACA	District AIDS Coordination Advisor
DHS	Demographic and Health Survey
GHI	Global Health Initiative
HIV	Human Immunodeficiency Virus
INESOR	Institute of Economic and Social Research
KYR	Know your response
NAC	National HIV/AIDS/STI/TB Council
MSM	Men Who Have Sex with Men
NGO	Non-Governmental Organization
PEPFAR	President's Emergency Plan For AIDS Relief
PLWH	People Living With HIV
PWID	People Who Inject Drugs
QAS	Questionnaire Appraisal System
STI	Sexually-transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV and AIDS
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

1. Purpose of the Lessons Learned Report

The objective of this report is to identify, document and disseminate lessons learned from the pilot test of the Know Your Response: HIV Prevention Tool Kit which was pilot tested in Zambia and Ghana in September-October 2013. The report identifies what worked well, what did not work well, and what needs to done differently in the future. The report also assesses the technical methods and tools, and makes recommendations for future improvements.

2. Project Overview/Description

The Know Your Response: HIV Prevention Tool Kit was designed to provide a comprehensive picture of gaps in HIV-prevention intervention by collecting information on what entities are engaging in HIV prevention (who), the scope of HIV prevention activities (i.e., the different elements delivered) (what), and their geographic coverage (where), and priority populations. The specific objectives of the too lkit are to:

- Determine what specific HIV-prevention interventions are being implemented and what resources are available to implement them.
- Determine who is doing what and where.
- Assess the extent to which the HIV-prevention response matches current HIV-transmission patterns, are focused on geographic areas where HIV is spreading most rapidly, and cover technical recommendations for key populations at higher risk of HIV exposure.

The HIV-prevention response analysis tool kit consists of five instruments:

1. Policy Questionnaire: Provides a broad view of the policy environment for HIV prevention by collecting information from decision makers on the extent to which policy actions for moving towards prevention goals and the scaling up of prevention interventions have been addressed in a given country. The Policy Checklist also assesses the extent to which policy actions related to HIV-prevention take into consideration gender and Positive Health, Dignity and Prevention principles.
2. Strategic Information Checklist: Assesses the extent to which the existing information system addresses the three main categories of activities related to strategic information for the HIV prevention response: (a) surveillance of HIV and sexually-transmitted infections; (b) monitoring and evaluation; and (c) research. The Strategic Information Checklist also includes information needs relevant to assessing the degree of integration of gender and Positive Health, Dignity and Prevention principles into HIV-prevention programming.
3. Program Implementers Core Questionnaire: Assesses the extent to which HIV-prevention interventions in the NGO sector are focused on geographic areas and populations where HIV is spreading most rapidly; cover the relevant technical recommendation in each prevention area.
4. Program Implementers Modules for Key Populations at Higher Risk of HIV Exposure: Assesses the nature and comprehensiveness of the NGO programmatic response for key populations at

higher risk of HIV exposure and other vulnerable groups, thereby permitting an analysis of actual gaps between location, needs and scale of these priority populations and current programmatic efforts to address their needs.

5. District Questionnaire
    a. Module 1: Health Facility: Collects information from district health officers regarding HIV interventions that are based at private and public health facilities. The objectives of this module are to assess the extent to which district-level health facilities address technical HIV-prevention recommendations and to determine barriers and facilitators to full implementation of technical recommendations.
    b. Module 2: Government non-Health Sector HIV-Prevention Questionnaire: Assesses the extent to which district-level government services outside of the health sector address technical HIV-prevention recommendations.

The tool kit was piloted in Southern Province, Zambia and Greater Accra, Ghana in September-October 2013. The objective of the pilot test was to: (a) identify and eliminate problems in the KYR tools and enable corrective changes or adjustments to be made before actually collecting data from the target populations; (b) permit a thorough test of the logistical arrangements and planned statistical and analytic procedures to enable MEASURE Evaluation to assess their usefulness for the data; (c) determine whether data collected via the tools yield information that is needed for programmatic decisions.

3. Executive Summary

The pilot test revealed that, while the tools collected valuable data for HIV prevention programmers and policy makers, a paper questionnaire is not the ideal format for data collection. An electronic data base to be completed and periodically updated by district officers and program implementers would be preferable.

3.1Success Factors

- Design went beyond just tracking PEPFAR activities to helping governments track their overall HIV-prevention response. The tool kit also builds on and complements UNAIDS' ongoing efforts.
- Considerable country buy-in for and ownership of the study in both countries.
    - Zambia NAC, District AIDS Task Forces (DATFs) and District AIDS Coordination Advisors (DACA) heavily involved in the following processes: (a) Questionnaire Appraisal through an off-site workshop; (b) Cognitive interviewing to highlight questions that were difficult to understand or could be interpreted differently by different respondents; (c) pilot testing of the questionnaire; (d) mobilization of program implementers to respond to Program Implementer Core Questionnaire and Modules. During the dissemination seminar and in newspaper reports, the study was presented as being implemented by the NAC and INESOR/University of Zambia.
    - The Ghana AIDS Commission took the lead in coordinating implementation of the study, including lending their support and the use of their logo to program implementer and

district level governmental questionnaires. They also provided a letter of support for IRB clearance and personally coordinated and hosted the strategic information and policy checklist/ focus group discussions. Ghana AIDS Commission staff also participated in the strategic information and policy checklists in terms of contributing information.

- Program Implementers surveyed in both countries considered the tools to be well drafted and the range of interventions included for each key population to be an "eye opener" with regard to additional interventions that they could implement for a given key population, and additional key populations that could be targeted (e.g., MSM, transgender)
- Data obtained from the Program Implementer Core Questionnaire and Modules highlighted geographic gaps in HIV-prevention efforts.
    - At the dissemination seminar, the Zambia NAC suggested that the study could be scaled up to other provinces. Participants requested that a chart book be developed to compare the availability of HIV-prevention efforts across the districts of Southern Province.
    - Maps produced based on these data show where gaps in priority interventions for key populations in Greater Accra are not yet being implemented at scale.
- Tool kit captures HIV-prevention activities implemented by the non-governmental public service sector (e.g. NGOs, CSOs, and FBOs), public health sector, and public non-health sector. The data provided by the tool kit have never been collected in Zambia or in Ghana and are invaluable to the NAC and the NGOs surveyed because they are not available from the routine health information system and existing data bases. The Ghana AIDS Commission was especially happy with the fact that the data could be mapped as they are moving towards regular and ongoing service mapping efforts.

3.2 Primary Challenges

- Though comprehensive, the questionnaires are too long and cannot be effectively self-administered or interviewer administered. Respondents need to consult reports and others in their offices in order to pull together data needed to complete the questionnaire.
- Validity and reliability of the data were not assessed.
- Obtaining an up-to-date list of program implementers, health facilities and schools was challenging.
- Changing donor priorities as to what data are needed for program and policy decision making (from knowing what to implement to measure the quality, intensity, and impact of program activities).
- Obtaining data on budget/funding and numbers of people reached by HIV-prevention activities (due to high potential for double counting).

3.3 Top Recommendations

- Increase country involvement in tool kit design/adaptation; engage district and provincial staff (e.g., DACAs and DATFs in Zambia and MMDA and MMA Health Coordinators in Ghana); for a given category of interventions, adapt tools for use in-country by creating sub-groups of

interventions to reflect field realities. This should be done by the NAC in consultation with program implementers and district officers.

- Move beyond what is being delivered and where to examine dimensions of intervention quality, intensity with interventions are being delivered and over which periods of time, and impact of programs
- Develop electronic data base to replace paper format of tool kit. Questionnaire is time consuming and cannot effectively be interviewer administered as respondents need to check existing data bases and reports in order to complete the data collection instruments
- Build capacity of in-country staff to analyze data and improve their knowledge of WHO recommendations for priority HIV-prevention interventions in order to facilitate data interpretation
- Identify priorities for mapping and ensure that adaptations to tool do not destroy mapping ability (i.e. collection and identification of data at district level)
- Provide a glossary of terms in language easily understandable to program implementers or district officers working at the grassroots level
- Develop a more comprehensive data base or questionnaire to capture government HIV-prevention efforts outside of the health sector
- Develop data analysis, data use and dissemination plans for the study to foster use of the data for program and policy decision making

4 Lessons Learned

Project Area / Overall Impact on Project	What Worked Well	What Did Not Work Well	Recommendations for Future Projects
Tool Kit Design and Focus	• Donor and CA input provided into tool kit design (USAID/Washington, USAID/W, Prevention Technical Working Group in US, USAID Mission, and UNAIDS Headquarters and UNADIS RST ESA) • Design went beyond just tracking PEPFAR activities to helping governments track their HIV-prevention response • Tool kit builds on and complements UNAIDS ongoing efforts	• Limited involvement of PEPFAR country teams in tool kit design and limited country input (only from Lesotho NAC) • Tool kit development and pilot test took longer than expected • Changing and conflicting donor priorities as to what data are needed for program and policy decision making (from knowing what to implement to quality, intensity, and impact of program activities)	• Increase country involvement in toolkit design/adaptation • Move beyond what is being delivered and where to examine dimensions of intervention quality, intensity with interventions are being delivered and over which periods of time, and impact of programs • Collect data to enable econometric modelling of the allocative efficiency of HIV-prevention programs • Increase use of GIS mapping potential of collected data
Tool Kit Adaptation In-country	• Zambia NAC, District AIDS Task Forces (DATFs) and District AIDS Coordination Advisors (DACA) heavily involved in the following processes: (a) Questionnaire Appraisal through an off-site workshop; (b) Cognitive interviewing to highlight questions that were difficult to understand or could be interpreted differently by different respondents; (c) pilot testing of the questionnaire; (d) mobilization of program implementers to respond to Program Implementer Core Questionnaire and Modules.	• Although the Zambia NAC was heavily involved in the adaptation of the data collection instruments, this was done at the central level and not at the provincial or district level. • The Ghana AIDS Commission was involved in a review of the tools but declined to customize them for the Ghanaian context, instead implementing the entire questionnaire “as-is” and leading to a great deal of non-priority data. No staff at the MMA or MMDA level (i.e. Health Coordinators) were involved in the review of the tools or data collection methods.	• Future tool kit adaptation efforts should engage district and provincial staff (e.g., DACAs and DATFs in Zambia and Health Coordinators in Ghana).

Project Area / Overall Impact on Project	What Worked Well	What Did Not Work Well	Recommendations for Future Projects
Program Implementer Core Questionnaire	• Used pre-determined categories of prevention activities based on HIV-prevention program nomenclature published by UNAIDS in 2009. Allowed for standardization of interventions across program implementing organizations. • Reference period of past 12 months ensured recent program efforts were captured • Core questionnaire was comprehensive and collected data on intervention site ("it's a good questionnaire as it is able to collect data from all angles." HIV Program Implementer, Livingstone)	• Categories do not allow any variation in the field and assumed standardization of content of HIV-prevention programs, particularly behavioral prevention -- across the field, which is not the reality on the ground (e.g., respondents stated that condom-compatible lubricants not provided in Zambia except through the Planned Parenthood Association of Zambia; alcohol prevention considered to be an important intervention for HIV-prevention but was not included in UNAIDS nomenclature) • Tools tried to capture coverage by asking implementers to provide estimates of general population and key populations/other vulnerable groups reached by an organization's HIV-prevention programs. Double counting was a problem for respondents (e.g., PLWH counted in general population as well as in key population); reluctance to provide data on exact numbers of key populations served for behaviors that are criminalized (FSW, MSM, PWID) • Programs did not use conventional 12 months cycle from January to December and reporting period differed depending on which donor was funding program activities	• For international comparisons, continue to use standardized up-to-date categorizations • For a given category of interventions, adapt tools for use in-country by creating sub-groups of interventions to reflect field realities. This should be done by the NAC in consultation with program implementers • Make sure intervention categories are not multidimensional. • Delete questions on budget, finances or funding • Delete questions on number of target population reached in a given reference period due to low quality. Instead simply record whether priority key populations are served or not served in a particular district. • Include a glossary of terms in language that can be understood by program implementers at the grassroots level • Questionnaire should be sent ahead of time and completed by the program implementing organization in roundtable format, drawing on published report and knowledge/experiences of all program and finance staff members • An electronic questionnaire format would be ideal if all program

Project Area / Overall Impact on Project	What Worked Well	What Did Not Work Well	Recommendations for Future Projects
		• Organizations found it difficult and uncomfortable to report budget, funding/finances from government and donors (e.g., "donor gives the government and government gives it to NGOs – whose funding is it?" • Terminology considered to be best understood by medical people and not program staff. • Questionnaire is too long and cannot be completed on the spot by a single organization representative or be self-administered. Some questions are multidimensional.	implementing organizations at the district level have access to working, virus-protected computers and internet access. Alternatively, a tablet based data collection could be used to simplify the collection of data by research assistants. • Update lists of program implementers ahead of time.
Program Implementer Modules for Key Populations at Higher Risk of HIV Exposure (and other vulnerable populations)	• Modules were comprehensive. • Organizations surveyed considered the tools to be well drafted and the range of interventions included for each key population to be an "eye opener" with regard to additional interventions that they could implement for a given key population/vulnerable group and additional key populations that could be targeted (e.g., MSM, transgender) • Data obtained from the Modules (as well as the core questionnaire) were considered useful for highlighting program gaps and lobbying for money for donor funding to help fill these gaps	• Did not include module on HIV-prevention among people with disabilities. • Some program implementers reacted negatively to modules on MSM and transgender and people who inject drugs as these behaviors are criminalized in Zambia. Sex work is also criminalized but did not elicit similar reactions. The concentrated nature of the epidemic in Ghana, and national focus on key populations meant that these kinds of reactions were not seen in Ghana. • The Modules were bulky with inadequate spaces to write responses to open-ended responses. Module completion	• Streamline the key population module by prioritizing which key populations should be covered based on nature of the epidemic (generalized or concentrated or mixed) • Prioritize interventions to be directed to each key population/vulnerable group for inclusion in the module; do not include every possible intervention • Include people with disabilities as a priority population group. • NAC should lead country-specific changes to the Modules. • An electronic module format would be ideal if all program implementing organizations at the district level have access to working, virus-protected

Project Area / Overall Impact on Project	What Worked Well	What Did Not Work Well	Recommendations for Future Projects
		was time consuming. • Age limit for youth module was 10-24 years; some organizations also target ages 7-9; others only have data for age 15-24 years. • Difficulty locating program implementers on NAC list – no physical premises and working telephone contact numbers	computers and internet access. • Update lists of program implementing organizations ahead of time. • Assess validity and reliability of responses provided • Collect data on program content
District Questionnaire – Health Facility Module	• Captures HIV-prevention interventions in government health facilities; provides data for the public sector • Including question on number of public and private health facilities in a district helped assess proportion of public health facilities offering a particular HIV-prevention intervention • Shed light on shortcomings of the data capturing and recording systems in the Ministry of Health	• Inconsistencies between number of health facilities in the health facility listing and number of health facilities declared in beginning sections of the module. Affected prevalence estimates. • Question on source of information for data on prevention services offered in health facilities only asked once but should have been asked for all questions. • Data provided on services offered in each public health facility in the district need to be validated. • Questionnaire needed to be sent ahead of time in order to enable respondents to consult district health data bases and reports. Questionnaire cannot be interviewer-administered or self-administered at one point in time • Limited number of private health facilities in a given district did not permit comparisons between public and private health facilities.	• Move from paper questionnaire format to establishment of electronic data bases in national health information system to provide information on HIV-prevention services at public health facilities. • Validate data provided in electronic system through site visits for a limited sample of health facilities. • Delete health facility table from health facility module. It is time consuming and it would be better if data are incorporated into national health information system.

Project Area / Overall Impact on Project	What Worked Well	What Did Not Work Well	Recommendations for Future Projects
District Questionnaire – Government Non-Health Sector HIV-Prevention Module	• Captures government HIV-prevention activities outside the health sector and provides picture of HIV-prevention as a multi-sectoral program. These data are not captured in Ministry of Health databases.	• Not all government sectors were included in the questionnaire (e.g., agriculture, transportation) • Zambia Army and Zambia Air Force declined to be interviewed because of national security concerns; hence data on government programs for uniformed personnel are restricted to Zambia Police and Prison Officers. • Data for this module were largely incomplete. Only 6 out of 12 districts in Southern Province Zambia, provided data on HIV-prevention programs in schools; so no conclusions can be drawn about the content of school-based HIV-prevention programs at the Provincial level. Similarly in Ghana, few districts provided school data which were of dubious quality. Data for other non-health sector populations were largely absent, meaning that data for this tool in Ghana could not be analyzed.	• Develop a more comprehensive instrument or data base to capture government non-health sector HIV-prevention programs. • Due to limited number of prisons at provincial level, only include this module if data are being collected at the national level. • Delete the matrix on interventions available at each public primary, secondary and tertiary institution in a district. This information can only be collected reliably through a school survey rather than through the responses of three government representations from the education office in each district. However, these data are not available from existing school data bases. • As the individual modules for each sector are not long, they can be readily completed and scaled up to the national level if recommended changes are made. • Data on the percentage of prison officers or policemen reached with HIV-prevention services need to be validated and information collected on the source of data for coverage estimates provided.

Project Area / Overall Impact on Project	What Worked Well	What Did Not Work Well	Recommendations for Future Projects
Strategic Information Questionnaire	• Shed light on gaps in strategic information collected: No data are collected on MSM, clients of sex workers and people who inject drugs.	• Small sample size (8 respondents) in Zambia and individual questionnaire format did not yield in-depth information • Round table discussion in Ghana with document review concurrent to discussion provided rich discussion in Ghana. However, the round table took 4 hours to complete.	• An evaluation of the national information system would be a more useful and efficient approach for collecting data on the scope and quality of the HIV-prevention data
Policy Questionnaire		• Program implementers, civil society , and respondents to the policy questionnaire were largely unfamiliar with the National HIV/AIDS Strategic Framework of 2011-2015 in Zambia, the Act on Gender-based Violence of 2011; the rights of property inheritance under the inter-estate Act of Zambia. Therefore they were unable to assess the content and implementation of most HIV-prevention policies • Although the questionnaire recommended a group interview, in Zambia, individual interviews were conducted due to the difficulty of finding a time that worked for most people.	• Administer the policy questionnaire using a round table format. • Distribute relevant policies/acts and documents ahead of time so that respondents are familiar with their content and stipulations • Pay careful attention to the selection of respondents for the policy questionnaire; ensure that relevant groups of stakeholders are represented.

Project Area / Overall Impact on Project	What Worked Well	What Did Not Work Well	Recommendations for Future Projects
Data Tabulation and Analysis	• The variables were entered as 0,1 (dummy/binary) variables thereby facilitating tabulation and analysis	• There is limited country capacity to tabulate the data, especially in situations that required aggregating data across districts or across interventions • Data interpretation skills are limited in country due to lack of familiarity with WHO or national recommendations regarding HIV prevention interventions, especially for various specific key populations • The program implementers core questionnaire and modules yielded	• Knowledge of HIV-prevention intervention and data analysis skills of in-country teams need to be strengthened in order to increase in-country capacity to analyze and interpret the data • Develop focused data analysis and tabulation plan to guide in-country teams • Make data available to country for further analysis
Data Use and Dissemination	• Dissemination workshop in Zambia and development of framework for linking data to action highlighted potential uses of the data to improve programs • The opening of the dissemination seminar by the provincial Deputy Permanent Secretary drew attention of policy makers and the media • Dissemination Seminar participants were interested in using the data to improve their programs and in learning how to complete the framework for linking data to action. They stayed until 6:30 PM to complete the framework. • Participation of newspaper reporters increased visibility of the HIV/AIDS situation in Southern Province	• Representatives of the Ministry of Health and Ministry of Education did not attend the Dissemination Seminar in Zambia. The Ghana AIDS Commission elected for electronic dissemination of findings due to difficulties in scheduling in the summer months. • Lack of travel and hotel funds to support NGOs to attend the dissemination seminar limited their participation in Zambia. • Newspaper reporters left after the opening ceremony and did not capture information about the study's findings in Zambia • Data not mapped in Zambia because district boundaries have not yet been redrawn by the Zambia Central Statistics Office to take into consideration the	• Develop a dissemination plan for the study; continuously disseminate findings to different audiences using different/tailored formats • Prepare news releases about study findings for the benefits of the press • For dissemination meeting, invite specific personnel who can and has the authority to make decisions; document dissemination meeting recommendations and action items with dates and responsibilities for action items assigned. • Need to identify priorities for mapping and ensure that adaptations to tool do not destroy mapping ability (i.e. collection and identification of data at district

Project Area / Overall Impact on Project	What Worked Well	What Did Not Work Well	Recommendations for Future Projects
		addition of two new districts to Southern Province (Pemba and Kazungula). Mapping was successful in Ghana, however, and the ability to map the data was the most interesting aspect for GAC.	level)

5 Research Highlights

5.1Zambia

- The study revealed geographic disparities in the availability of HIV-prevention program implementing organizations in the NGO sector. Close to 70 percent of program implementers worked in five of the twelve districts of Southern Province: Choma, Kalomo, Livingstone, Mazabuka, and Monze. There were important gaps in HIV-prevention efforts the districts of Pemba, Kazungula, Siavonga, and Zimba
- Although low levels of condom use and low levels of male circumcision were identified as key drivers of HIV transmission in the 2009 Zambia Modes of Transmission Report, No organization surveyed promoted or implemented voluntary medical male circumcision in 8 out of 12 districts of Southern Province. In addition, no organization surveyed distributed condoms in Zimba and in urban areas of Kazungula and Pemba or implemented condom social marketing, comprehensive sex/HIV education and social mobilization activities in Pemba.
- No NGO surveyed implemented mass media campaigns or interpersonal education and persuasion programs in Pemba, Siavonga, and Zimba and none implemented any interventions affecting knowledge, attitudes and behavior in the past 12 months in urban areas of Kazungula, and to a lesser extent, in urban areas of Gwembe.
- One in every five organizations surveyed did not integrate gender into HIV-prevention activities. While cross-generational sex has been identified as a key factor in HIV transmission among young people, half as many NGOs addressed cross-generational sex compared to violence against women in HIV-prevention activities.as
- The HIV-prevention specific needs of young people aged 10-24 years, people living with HIV, and pregnant women, infants and young children were targeted by 87 percent, 71 percent, and 62 percent of NGOs surveyed in Southern Province. Fewer than two percent of NGOs targeted people who inject drugs and men who have sex with men, largely because these behaviors are illegal in the Zambian context. Although twenty percent of NGOs surveyed in Southern Province targeted female sex workers with HIV-prevention interventions, no NGO did so in five districts: Gwembe, Namwala, Pemba, Sinazongwe, and Zimba. Furthermore, only two districts had NGOs targeting female sex workers for each of the four WHO recommended priority interventions for this key population.
- There were gaps in the implementation of HIV-prevention interventions targeted at people living with HIV and pregnant women, infants and young children. No organization surveyed worked in Pemba and Kazungula in the past 12 months to provide recommended interventions to prevent illness and infection in people living with HIV. In four districts – Gwembe, Kazungula, Pemba, and Sinazongwe, No organizations surveyed provided the following interventions for treatment and prevention of HIV in pregnant women, infants, and young children: HIV VCT; STI diagnosis and treatment; family planning/reproductive health care; antiretroviral drugs; infant feeding counseling and support; financial and/or in-kind sustenance support/social welfare; and linkages/referrals to psychosocial support services.

- Seven out of 12 districts provided information on the provision of HIV-prevention services in public and private healthcare facilities. The data showed that fewer public health facilities offered socially marketed male and female condoms in Kalomo and Livingstone than in Choma, Mazabuka and Kazungula. Less than 20 percent of public health facilities offered VMMC in Choma, Livingstone, Mazabuka, and Sinazonga. By cmparison, over 90 percent of public health services in the seven districts offered PMTCT services. The proportion of public health facilities providing HIV treatment with antiretroviral drugs ranged from 100 percent in Choma to 14 percent in Sinazongwe.
- Health workers in Livingstone, Kazungula and Sinazongwe had training needs in prevention with positives, general HIV-prevention education and PMTCT. No public healthcare facilities in Kazungula and Sinazongwe were reported as having at least one health worker, who had, within the last two years received pre-service or in-service training in prevention with HIV positives or general prevention education. There was limited availability of health workers who had been recently trained on TB diagnosis and treatment in public healthcare facilities in all districts, with the exception of Kalomo.

5.2 Ghana

- The 136 program implementers active in Great Accra are not evenly distributed in terms of geography or in terms of the kinds of interventions being implemented. Some districts, such as Accra Metro, Dangme West, and Tema Municipal have many program implementers who are implementing interventions in all of the intervention categories including standard interventions in common use, work on knowledge, attitudes, and practices, harm reduction, reduction of barriers to services and negative social outcomes of HIV, as well as mitigation of biological outcomes of HIV. Ga Central reports no program implementers currently working and many more districts (including Ningo Prampram, Ga East, Nwakatang Madina, and Dangme East) only have one or two implementing partners reporting and/or have an entire category of interventions that no implementing partner is offering. Implementers working in the area of mitigation of biological outcomes of HIV (e. g., treatment, care, and prevention of opportunistic infections) appear to be the least represented of intervention categories among implementing partners, though that may be expected as that might be perceived as a gap to be filled by the Health Sector.
- Of the 136 program implementers, 30 report working with Key Populations. However, the most common key populations served are pregnant women, people living with HIV, and youth. Despite the focus on certain populations in the national strategic plan, only 4 districts (out of 16) have implementing partners reporting working with MSM in the last 12 months. Partners report serving female sex workers in only seven districts, their clients in only five, with transgender populations in only three districts, Intravenous drug users in 2 districts, and incarcerated populations in only two districts. Medical male circumcision was only offered in one district by an implementing partner.
- 14 of 16 districts provided information on the provision of HIV services by public and private healthcare facilities in the district. It could be reasonably expected that many of the gaps seen in service provision such as the mitigation of biological outcomes of HIV and medical male

circumcision could be filled by this sector. However, some significant gaps were found in the health sector as well including a lack of medical male circumcision (only 5 districts reported providing medical male circumcision within the last 12 months), few facilities with capability for diagnosis and treatment of opportunistic and secondary infections, and limited provision of family planning services targeted to PLWHIV. Another category that represents a significant gap for facilities is in the widespread lack of training, supplies, and equipment needed to prevent nosocomial HIV infections as well as in the extremely limited availability of post-exposure prophylaxis for either health care workers or clients.

- Only 10 of 14 districts reporting have a working group dedicated to HIV prevention and only seven of these have a written mandate. Eight of these 10 meet at least quarterly to review and coordinate HIV prevention activities within the district.
- The strategic information and policy checklists reveal a significant gap in policies and data analysis that consider gender. Gender is sometimes "implicit" in policies and in strategic information with certain targets such as "male participation in PMTCT". Also a limited amount of routine health information is disaggregated by sex. Recent moves have been made to increase enforcement of domestic violence laws on the books. There is also action to change inheritance laws in Ghana to better protect widows. Some confusion was expressed among stakeholders on whether HIV prevention policy in Ghana includes medical male circumcision. A review of the documentation shows that this is a strategic intervention according to national policy. This level of confusion may explain the relative low availability/provision of medical male circumcision at the service delivery level. On the other hand, significant amounts of work at the policy and strategic information level have been done in the area of HIV stigma reduction and reduction of stigma against criminalized populations. The government and international donors acknowledge the key role of civil society in this work.

6 Discussion

The value added of the KYR study is the provision of information that cannot be obtained from the routine health information systems (RHIS) and that is needed by districts for their operational plans and for deciding which HIV-prevention interventions and activities should be prioritized. This is particularly the case in Zambia, where the last KYR synthesis and Modes of Transmission Study was conducted in 2009. Although Zambia has instituted the National AIDS Council Online Stakeholder Management System and the National AIDS Council Activity Reporting Form Submission System, these data bases cannot collect information about HIV-prevention interventions targeted at men who have sex with men and people who inject drugs as these behaviors are illegal in the Zambia context. Information on these key populations is also excluded from the RHIS, making the KYR study valuable for shedding light on HIV-prevention activities that are targeted at MSM and PWID by the NGO sector. The value of the KYR study was highlighted in the opening remarks made by Provincial Deputy Permanent Secretary of Southern Province, Douglas Ngimbu, at the Dissemination Workshop of Findings of The Know Your HIV Response Pilot Study in Southern Province to be Held in Choma on 2th June 2014:

"The knowledge to be shared here today will enable the different players to scale-up approaches to HIV prevention and reinvigorate the response in order to make a sustained impact on HIV incidence rates. Further this will enable us to embark on programmes that are evidence-informed, community-owned and that use a mix of biomedical, behavioural and structural interventions which are especially prioritised to meet the current needs of those populations deemed to be most at risk. Therefore, the 'Know Your HIV Response' study is a valuable starting point for developing clear packages that are specifically targeted at various groups of vulnerable populations."

In Ghana, the KYR study provided the first complete list of program implementers in Greater Accra and maps that have been used by the Ghana AIDS Commission for program planning.

Compared to the RHIS, the KYR takes a longer time to provide data needed for program and policy decision making. However, the RHIS is limited in the extent to which it can provide information in sufficient detail to show gaps in the HIV-prevention response in both the NGO and government sectors. The RHIS also excluded information on HIV-prevention in the government non-health sector, making it difficult to get a comprehensive picture of the HIV-prevention response. In Zambia, the online system shows the number of active organizations operating in a given district and ward to provide four groups of interventions: impact mitigation, prevention, response management and treatment. Nine prevention interventions are included in the online system: (1) blood safety; (2) condom distribution; (3) HIV counseling and testing – static; (4) HIV counseling and testing – mobile; (5) male circumcision; (5) post-exposure prophylaxis; (7) prevention of mother-to-child transmission; (8) sexually-transmitted infections; and (9) social and behavioral change.

Zambia's online Activity Reporting Form Submission System provides information on only a limited number of interventions, which are not tailored to the prevention needs of key and other vulnerable populations. The system also does not provide information on intervention site. These data are available from the KYR study. There is the added issue with the online system of protecting organizations serving MSM and PWID from societal backlash. Due to these factors, the Zambia NAC saw the KYR study as complementing the RHIS and as a mechanism for meeting the continuous need for the NAC to know who is doing what and where, especially in view of NGO turnover and funding fluctuations and shortfalls. That said, there is a need to support community-based routine data collection systems in Zambia and to conduct special studies on MSM, PWID and clients of female sex workers.

Regarding the feasibility of scaling up the KYR study to the national level, it will be necessary to first streamline the tools and implement an electronic data collection system as the questionnaires are long, unwieldy in paper format, and cannot be effectively interviewer-administered. It would also be important to increase district-level involvement in the tool kit design and adaptation to come up with data collection tools that reflect field realities. Capacity strengthening in data analysis and increased knowledge of HIV-prevention interventions are needed at the district level. The provision of a glossary of terms for program implementers and targeted plans for data analysis/tabulation, use and dissemination would also be required. If these needs can be met, it is recommended that the KYR study be implemented every three years between demographic and health surveys.

To summarize, strengthening DHSI/RHIS systems could yield richer data that can be mapped to the district level. However, it would need to include all implementers, regardless of size and type of funding. Also, it would require adding a large number of variables to the DHIS/RHIS system to capture information about the complete range of possible interventions and key populations which may overburden routine data entry. An advantage of the KYR approach is that "eye-opening" nature of the questionnaire. It drew attention to the breadth and depth of possible interventions and got program implementers thinking strategically about programming. The KYR approach acts, therefore, as a complement to periodic strategic planning. The approach is ideal for implementation in specific regions of interest but is not suitable for a national data collection effort due to the expense and complexity of the tool and data collected. In the implementation of the tool kit, attention must be paid to the potential sensitivities of documenting NGOs that are working with MSM and PWID in settings where these behaviors have been criminalized.

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