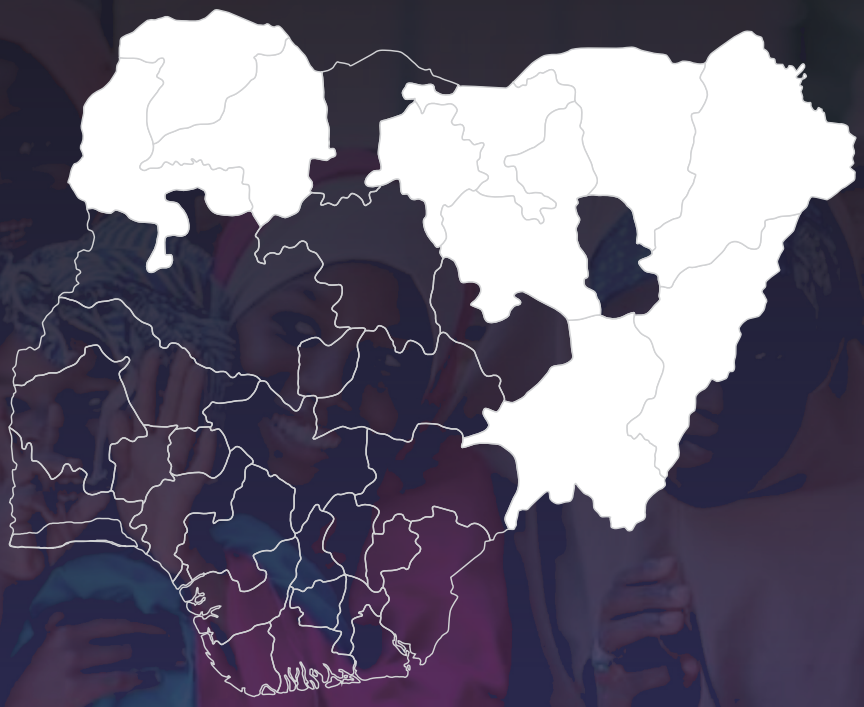
The Community HIV Services for Action and Response 2 **(CARE-2)** Project



Strengthening

HIV CARE

in Northern Nigeria

Society for Family Health
...Creating Change, Enhancing Lives

Executive Summary

CARE-2 closes after seven years with 42,794 clients currently on treatment across ten states in Northern Nigeria. Over the life of the project, 489,048 people were tested for HIV, 55,472 people living with HIV were identified at an overall positivity of 11.3%, and 49,678 clients were initiated on PrEP at a 100% initiation rate among those assessed as eligible. TB treatment success across the ten states reached 90%.

The programme began in 2019 in Adamawa and Bauchi and expanded in stages to Sokoto, Kebbi, Zamfara, Borno, Kano, Taraba, Yobe and Jigawa. What began as a two-state programme closes as a ten-state platform with 12 Community Centres, 123 CCSAPs and a last-mile workforce operating through axial supervision.

The strongest lesson from the ten states is that there is no single case-finding formula. Jigawa relied overwhelmingly on community outreach; Yobe on partner notification; Kano on index testing; and Borno combined outreach and network-based approaches in a security-constrained environment. The implication for future programming is straightforward: modality mix should follow local yield and access conditions rather than a centrally prescribed formula.

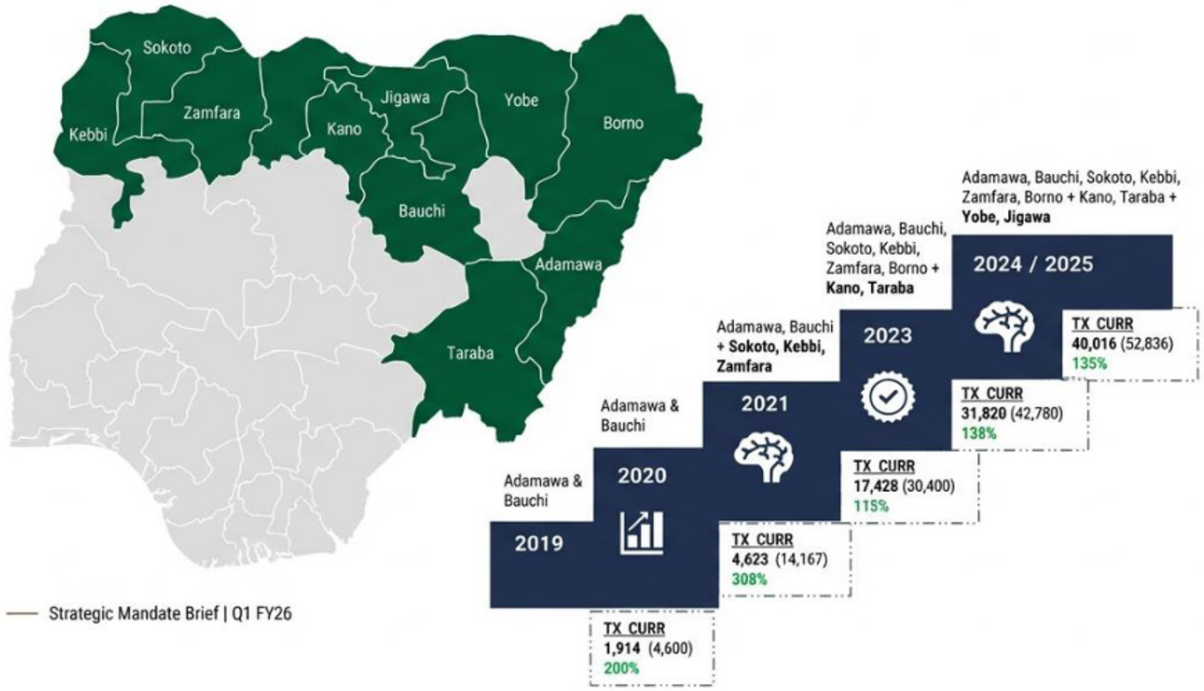
Performance also varied materially. TB treatment success ranged from 63% in Kano to 96% in Adamawa, Jigawa and Taraba. PrEP initiations ranged from 11,013 in Bauchi to five in Yobe. Positivity ranged from 6.5% in Zamfara to 15.5% in Borno. The value of the closeout record is therefore not to present a uniform picture, but to show what worked, where gaps remained and what each state now needs to protect.



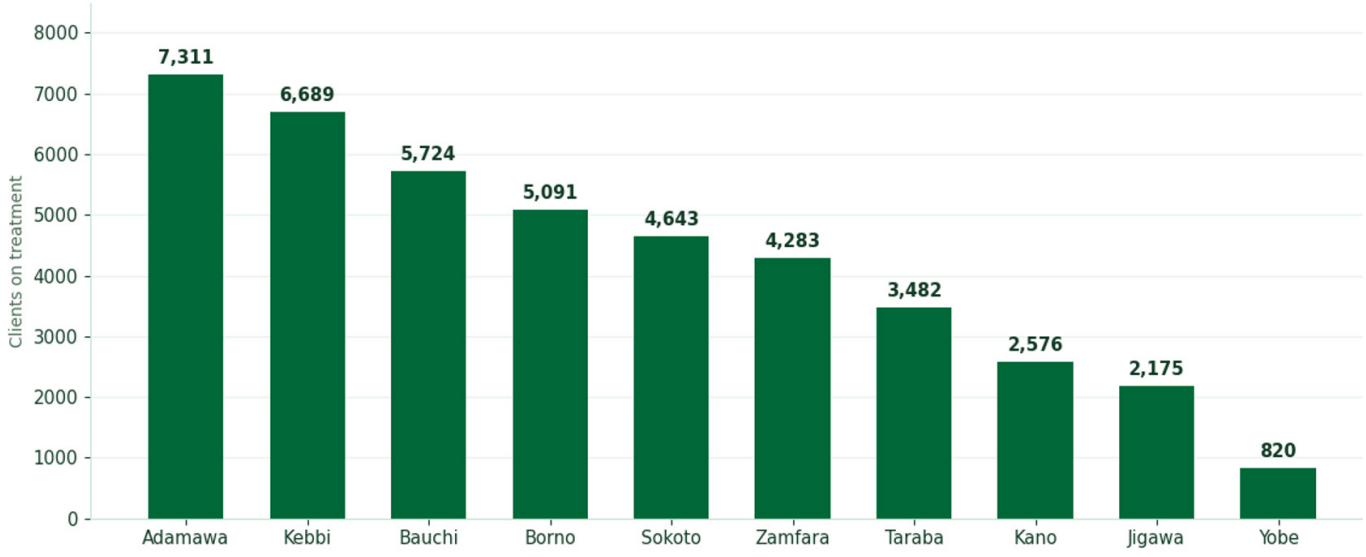
CLOSEOUT MESSAGE

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Project's Geographical Coverage & Footprint

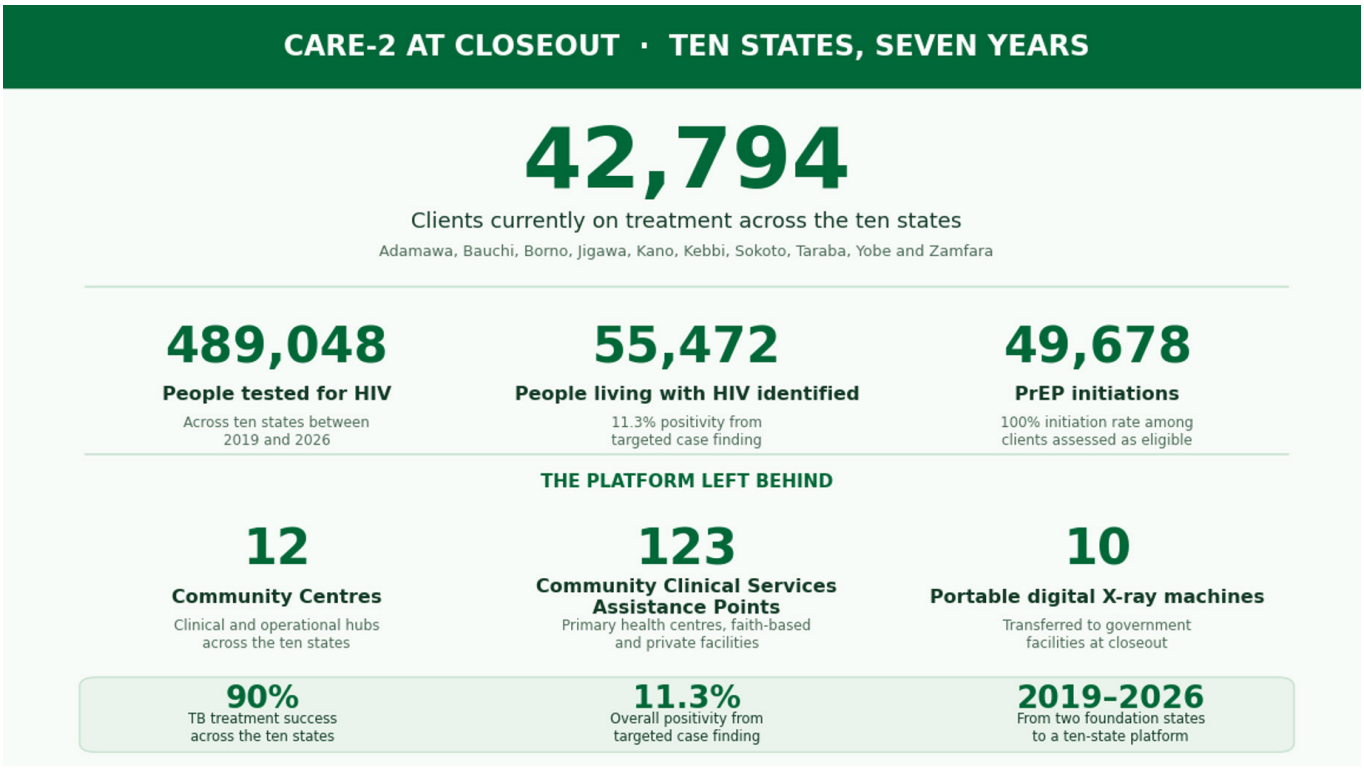


Clients currently on treatment (TX_CURR) by state, at closeout



Total across the ten states: 42,794 clients on treatment.

42,794 *clients currently on treatment*	**489,048** *people tested for HIV*	**55,472** *people living with HIV identified*
49,678 *PrEP initiations*	**90%** *TB treatment success*	



CARE-2 at closeout across ten states.

01



Programme Journey and *Country Footprint*

CARE-2 expanded in deliberate stages, using the experience of earlier states to adapt the model as it entered new geographic and operating environments.

Project Goal

Accelerate HIV epidemic control and reduce burden by strengthening local systems.

Strategic Mandate: Key Result Areas

1. Increased demand for and access to prevention/treatment.
2. Strengthened sustainability and organizational systems (Data/QA).
3. Enabling environment and community-supportive health systems.

Target Population

Comprehensive services tailored for individuals within the community, aiming for UNAIDS 95-95-95 targets by 2030.

CARE-2 geographic expansion and ten-state footprint.

Period	Programme Evolution
2019	CARE-2 launched in Adamawa and Bauchi.
2020	The operating model was refined in the two foundation states.
2021	Sokoto, Kebbi and Zamfara joined through the Northwest cluster.
2022	Borno joined, extending the model into a humanitarian and security-constrained setting.
2023	Kano and Taraba joined, expanding scale and Northeast reach.
2024–2025	Yobe and Jigawa completed the ten-state footprint.
2026	CARE-2 closes with a ten-state community service platform and a verified treatment cohort.

Operating context

The project operated across a wide range of security, demographic and health-system contexts. Six of the ten states experienced significant security constraints, while population mobility and displacement affected continuity in several states.

- Twelve Community Centres provided clinical and operational hubs across ten states.
- One hundred and twenty-three CCSAPs extended HIV services through government-linked primary health care, faith-based and private facilities.
- Ten portable digital X-ray machines supported community and facility-based TB screening.
- Locally rooted community workers, case managers and peer navigators extended access into areas where conventional facility models were less reliable.

From pilot to platform

CARE-2 expanded in stages because the operating model was being tested and adapted as the context changed. Adamawa and Bauchi provided the foundation; Sokoto, Kebbi and Zamfara extended the model across the Northwest; Borno tested it in a humanitarian setting; Kano and Taraba added scale and geographic diversity; and Yobe and Jigawa completed the ten-state footprint.

TB and prevention

The 12 Community Centres and 123 CCSAPs form a tiered service architecture: clinical depth at the hubs, routine differentiated services at community-proximate facilities, and last-mile access through locally rooted workers. The transition challenge is to keep the connections between these layers functioning.

02



Results at Closeout

Across ten states, the closeout data show both the scale of the platform and the differences in how states achieved it.

Indicator	Ten-state closeout	What it shows
Clients currently on treatment	42,794	Verified treatment cohort across all ten states
People tested for HIV	489,048	Large-scale targeted testing
People living with HIV identified	55,472	11.3% overall positivity
PrEP initiations	49,678	100% initiation among eligible clients assessed
TB treatment success	90%	Material state variation
Community Centres	12	Clinical and operational hubs
CCSAPs	123	Community-proximate service points
Portable digital X-ray machines	10	TB screening capacity transferred to government

What the results tell us

- Community outreach identified ***42,840*** clients, index testing ***15,930,*** partner notification services ***12,762*** and sexual-network testing 3,168 across the project.
- Kano recorded the highest index-testing share at ***55%***; Yobe recorded the highest partner-notification share at ***91%***; Jigawa recorded ***99.7%*** of identifications through community outreach.
- Borno recorded the highest positivity at ***15.5%***, while Zamfara recorded the lowest at ***6.5%***.
- Kano's ***63%*** TB treatment success is the clearest state-level gap at handover and warrants focused follow-up.
- Biometric verification was used to deduplicate treatment cohorts and confirm repeat visits across the states.

WHAT THE TEN STATES LEAVE BEHIND

The measurable inheritance is a verified cohort, functioning community service architecture and government-owned assets. The less visible inheritance is the operating knowledge about which approaches work in which settings.

Case finding: ten states, different answers

Jigawa identified 99.7% through community outreach; Yobe identified 91% through partner notification; Kano derived 55% of identifications from index testing; and Borno combined high outreach yield with substantial index and partner-notification contributions. Successor programmes should use local yield data to set modality mix rather than prescribe a single recipe.

Treatment and suppression

The 42,794-client treatment cohort is the result of connected community identification, rapid linkage, differentiated dispensing, case management, viral-load collection and data verification. Adamawa closes with 7,311 clients, Kebbi with 6,689 and Bauchi with 5,724—the three largest cohorts.

TB and prevention

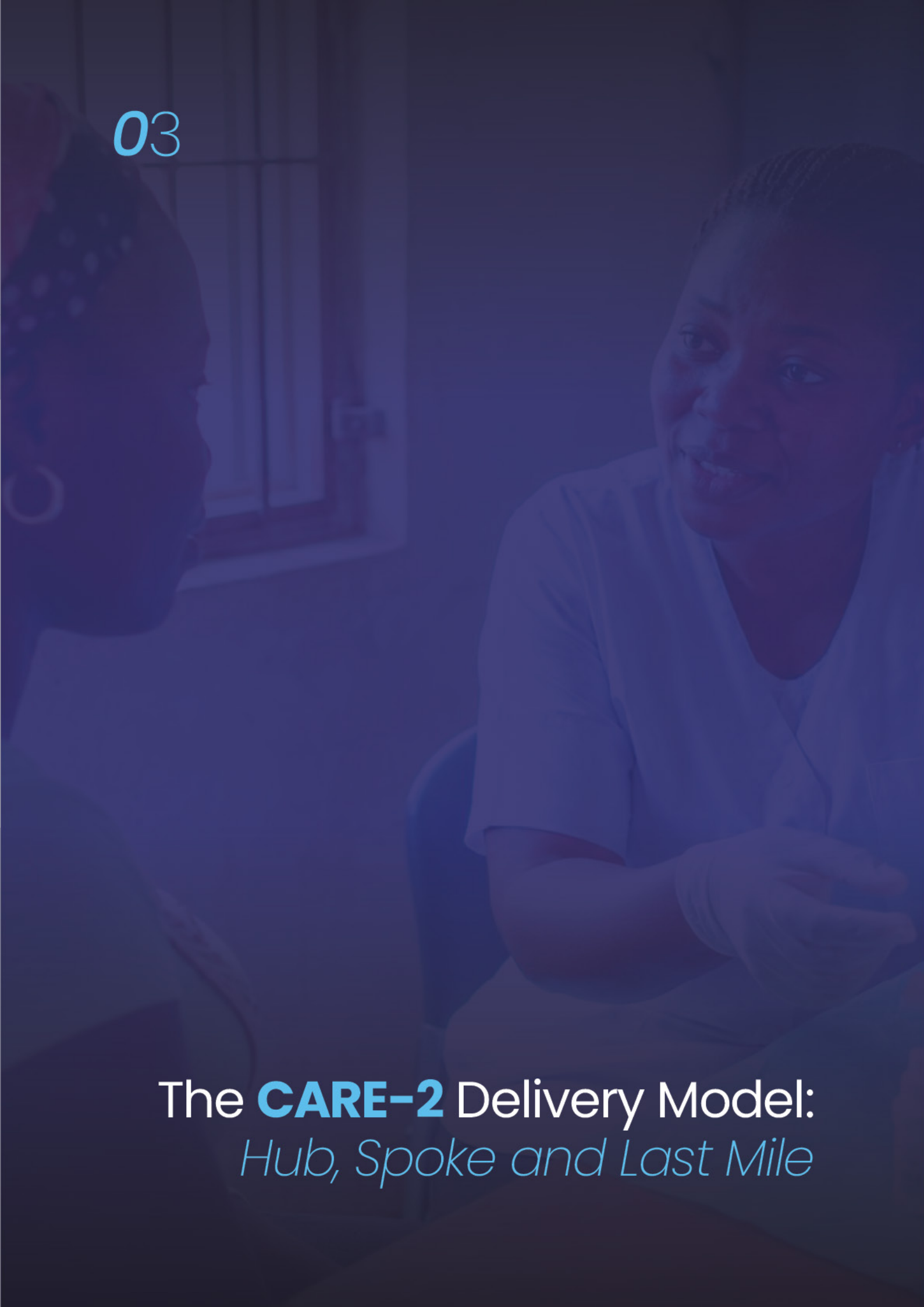
TB treatment success reached 90% overall, but Kano's 63% is a clear handover gap while Adamawa, Jigawa and Taraba reached 96%. PrEP initiations totalled 49,678, ranging from 11,013 in Bauchi to five in Yobe. Initiation capacity was generally strong; prevention demand generation was more uneven.

What the variation means

The state range is itself a programme result. It shows that CARE-2 generated evidence about which delivery choices perform under different conditions. The successor portfolio should use that evidence to allocate effort—not simply reproduce the same mix of activities everywhere.

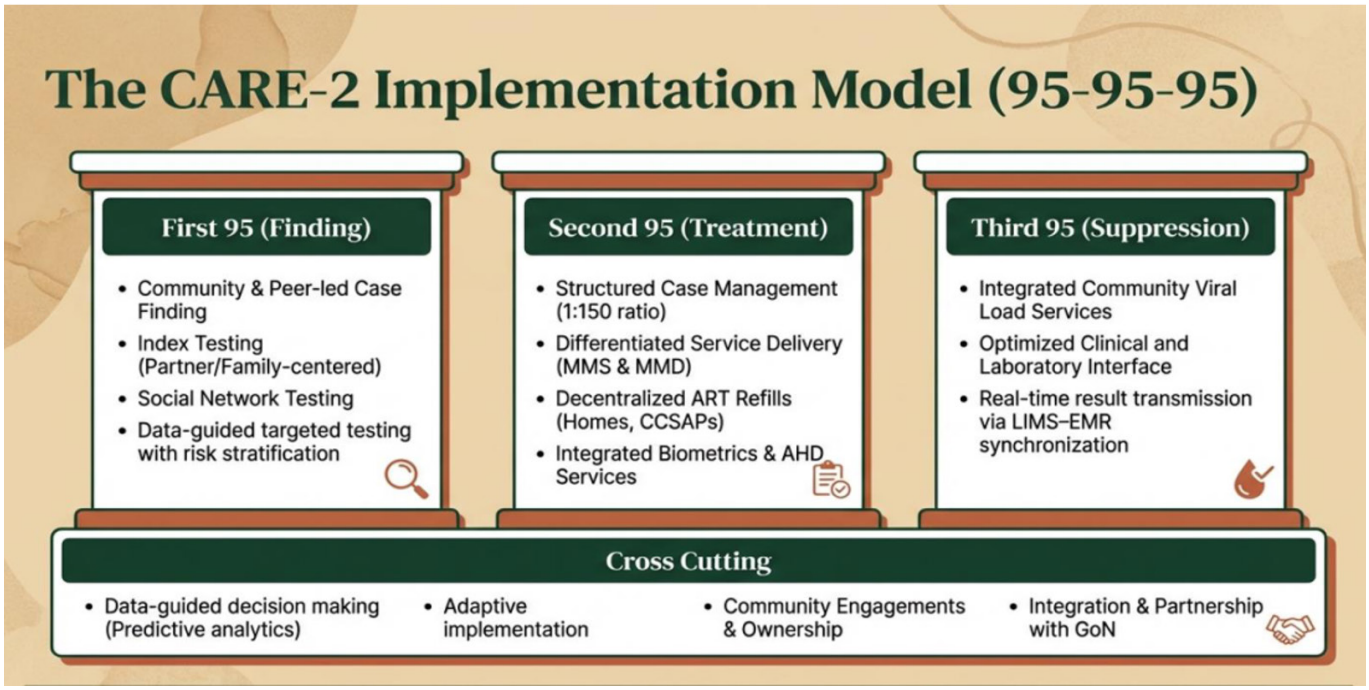


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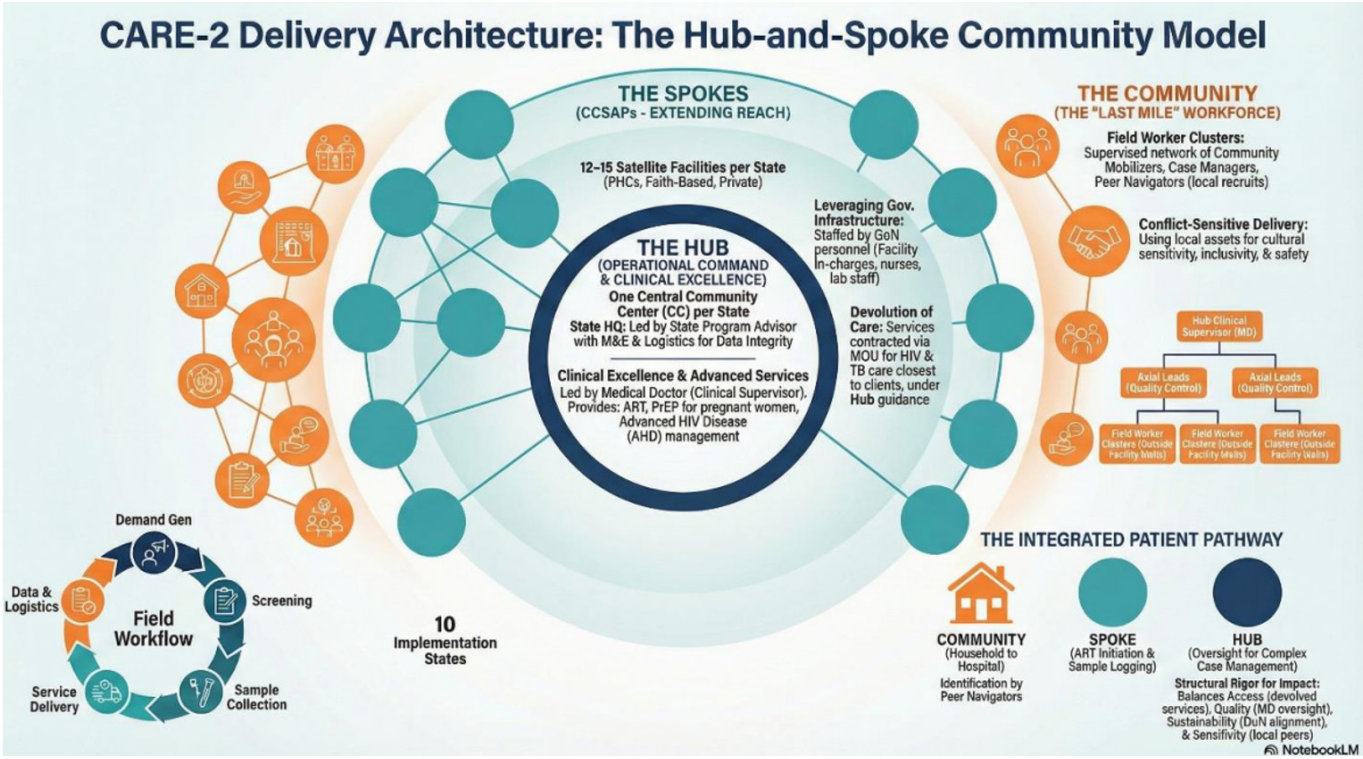


The **CARE-2** Delivery Model:
Hub, Spoke and Last Mile

Across the ten states, CARE-2 used the same basic architecture but adapted the balance between hub, spoke and last-mile delivery to local conditions. The model combined centralized clinical oversight with community-proximate service delivery and structured supervision.



The CARE-2 95-95-95 implementation model.



Hub-and-spoke architecture linking clinical oversight, CCSAPs and community delivery.

Layer	Primary role	Core functions	Transition implication
Hub – Community Centre	Clinical & operational base	ART/HTS; AHD; TB; PrEP; referrals; supervision; pharmacy/lab; data oversight	Keep clinical leadership, referrals and performance management in place
Spoke – CCSAPs	Devolved service points	ART refills; adherence support; VL collection; TB screening; referrals	Embed within government PHC structures and routine supervision
Last mile – community workforce	Household/community access	Demand generation; screening; sample collection; refills/support; follow-up	Retain approved community roles and referral pathways
Axial supervision	Quality & accountability bridge	Clusters/axes; supportive supervision; real-time problem solving	Make supervision and accountability part of routine management

The architecture in practice

Each layer has a distinct job. Community Centres hold the clinical and operational centre of gravity; CCSAPs devolve routine services into existing facilities; last-mile workers create access and continuity at household and community level; and axial supervision prevents decentralization from becoming fragmentation.

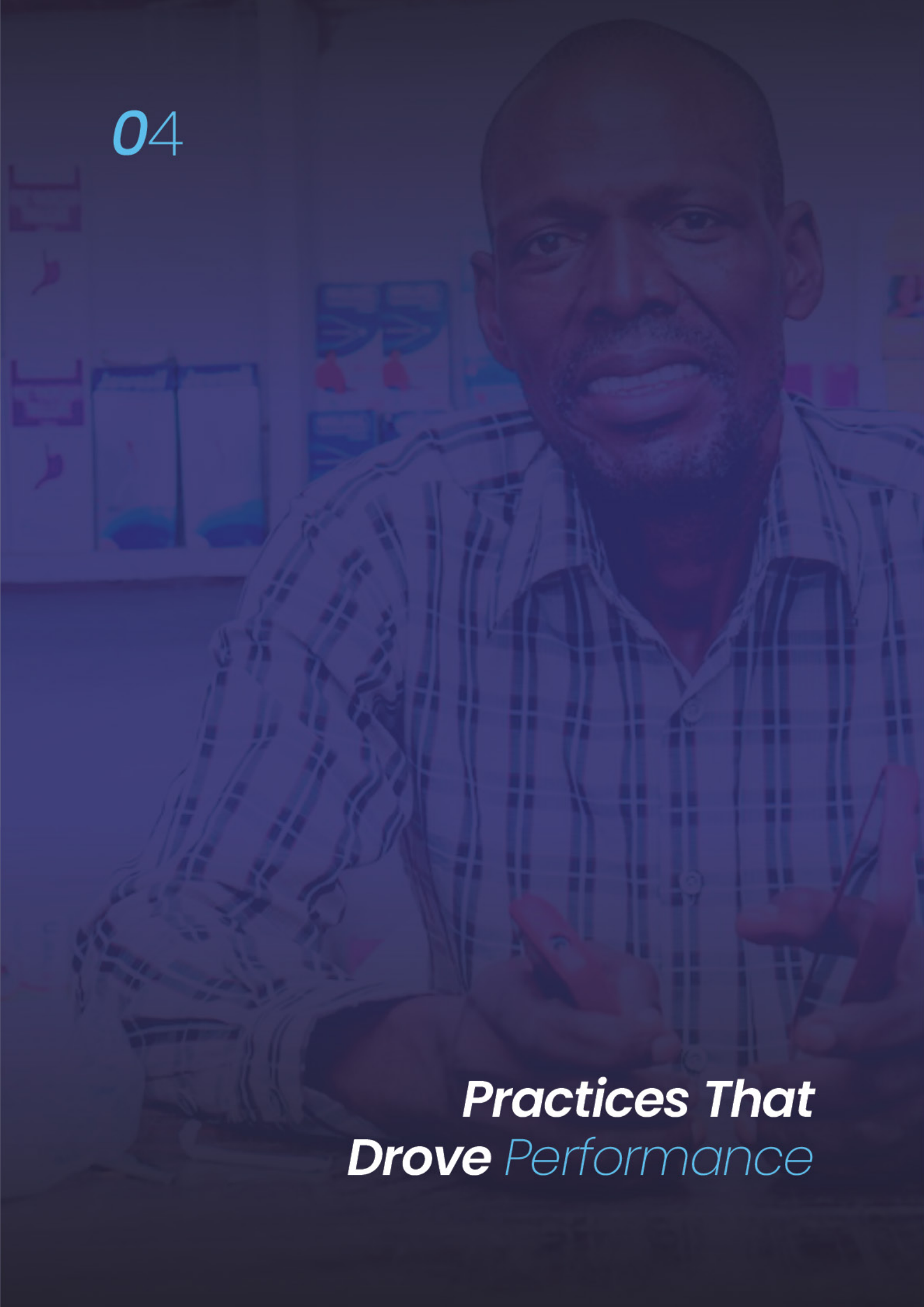
Why this matters for transition

The implementation model links the first 95 to community and peer-led case finding, the second to structured case management and differentiated service delivery, and the third to integrated community viral-load services and optimized clinical-laboratory interfaces. Data use, adaptive implementation, community ownership and government partnership cut across all three.

A transition-ready architecture

The strongest feature of the model is that it separates functions without separating accountability. The hub can hold clinical standards, the spoke can absorb routine service demand, and the last mile can create access, while data and supervision connect all three.

04



Practices That Drove Performance

The strongest lessons are the practical operating disciplines that can be carried into routine government programming.

Practice	What it looked like in the state	Why it mattered
Targeted case finding	States used different mixes of outreach, index testing, partner notification and social-network testing based on local yield.	Improved targeting without assuming one modality would work everywhere.
Differentiated service delivery	Home refills, multi-month dispensing and flexible appointments were used across states in different combinations.	Reduced unnecessary facility visits and supported continuity.
Case management	Case Managers and peer navigators tracked clients, supported adherence and helped close referrals.	Provided a practical bridge between diagnosis, treatment and retention.
Routine data use	Dashboards, weekly reviews and rapid escalation channels supported corrective action.	Made programme data useful for management rather than reporting alone.
Integrated HIV/TB delivery	TB screening was incorporated into HIV enrolment, refill and follow-up contacts, with community screening where feasible.	Reduced parallel client journeys and strengthened case detection.
Security-informed delivery	Local intelligence, security clearance, locally recruited staff and flexible deployment were used in affected states.	Allowed service continuity in settings where access could change quickly.

Operational disciplines worth protecting

- Weekly review of programme data with named actions and follow-up.
- Active client tracking for missed visits, viral-load gaps and referrals.
- Reliable specimen movement, commodity forecasting and cold-chain management.
- Regular quality improvement and data-quality review rather than end-of-cycle correction.
- Community engagement as part of service delivery, not a separate communications activity.

The hub is more than a facility

Community Centres functioned as clinical and operational nerve centres, combining clinical supervision, pharmacy and laboratory oversight, case management, data review, referral coordination and field support.

The spoke layer protects government ownership

The 123 CCSAPs were built through existing PHCs and, where appropriate, faith-based and private facilities. Government staff remained responsible for direct service delivery while CARE-2 supplied technical assistance and training.

The last mile closes the access gap

Community Mobilizers, Peer Navigators and Case Managers provided demand generation, screening, sample collection, refill support, adherence follow-up and referral. Axial supervision connected this layer back to the hubs.

Data use as a management routine

The project's data discipline was deliberately low-friction: dashboards, routine review and rapid communication were used to identify problems between formal reporting cycles. The lesson for successor programmes is that frequency and follow-through can matter more than sophisticated analytics platforms.

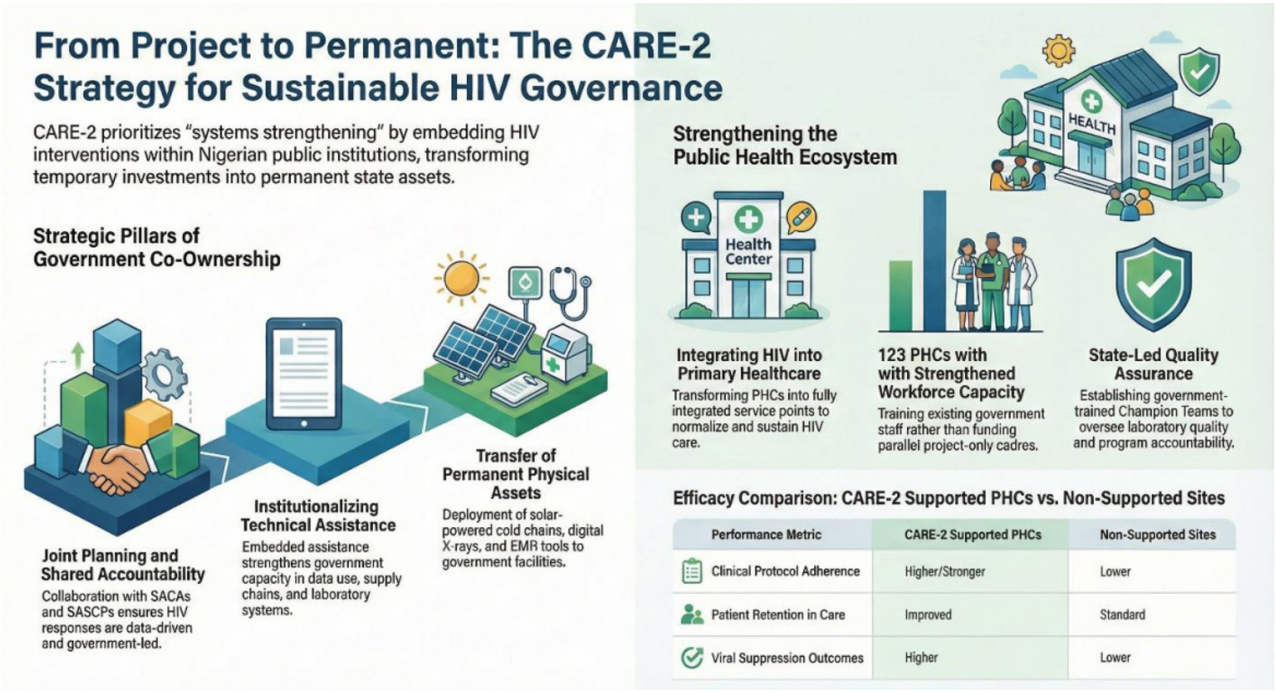


05



Government Partnership **and** Systems Strengthening

CARE-2 was designed around government ownership. Rather than building a parallel cadre, the project worked through government structures, strengthened government staff and left infrastructure and data systems in public facilities.



CARE-2 strategy for sustainable HIV governance and systems strengthening.

Area	What CARE-2 strengthened	Legacy to protect
Government co-ownership	Planning and coordination with state HIV agencies, PHC structures and TB programmes.	Keep government structures at the centre of programme management.
Workforce capacity	Mentorship and on-the-job support across 123 PHCs and community platforms.	Retain competencies through routine supervision and refresher support.
PHC integration	123 CCSAPs using existing government-linked facilities.	Keep HIV services within the PHC system.
Infrastructure and technology	Solar cold chain, portable X-ray, EMR devices, laptops and laboratory equipment.	Assign ownership, maintenance and replacement responsibilities.
Quality assurance	Laboratory QA champion teams, TWGs, QI teams, DQV and supportive supervision.	Institutionalize these routines in state management.
HIV/TB integration	Coordinated case finding, sample movement and DOTS capacity.	Maintain integrated referral and treatment pathways.

The Sustainability Test

The transition test is whether each function has a clear owner, a person or team to do the work, a funding route, a monitoring mechanism and a contingency plan when routine delivery is disrupted.

- **Ownership:** Community Centres, CCSAPs, equipment, records and digital systems have clear institutional homes..
- **People**: Clinical, case-management, laboratory, pharmacy, M&E and community functions have defined post-project roles..
- **Money**: Routine budgets cover essential service delivery, commodities and maintenance..
- **Data**: Client records, biometric verification and reporting access remain secure and usable.
- **Community trust**: Peer, community and local leadership structures remain part of demand generation and adherence support.

Workforce and PHC capacity

CARE-2 deliberately avoided building a parallel cadre of project-funded workers. It strengthened government facility in-charges, clinicians, nurses, laboratory scientists, pharmacists and M&E staff across 123 PHCs. The main workforce legacy is therefore embedded competency rather than a temporary project payroll.

Permanent assets and technology transfer

Government facilities retain solar-powered cold chain, portable digital X-ray machines, solar-powered laptops, EMR devices, data tools and laboratory improvements. Technology transfer was paired with capacity building so equipment is more likely to remain usable after closeout.

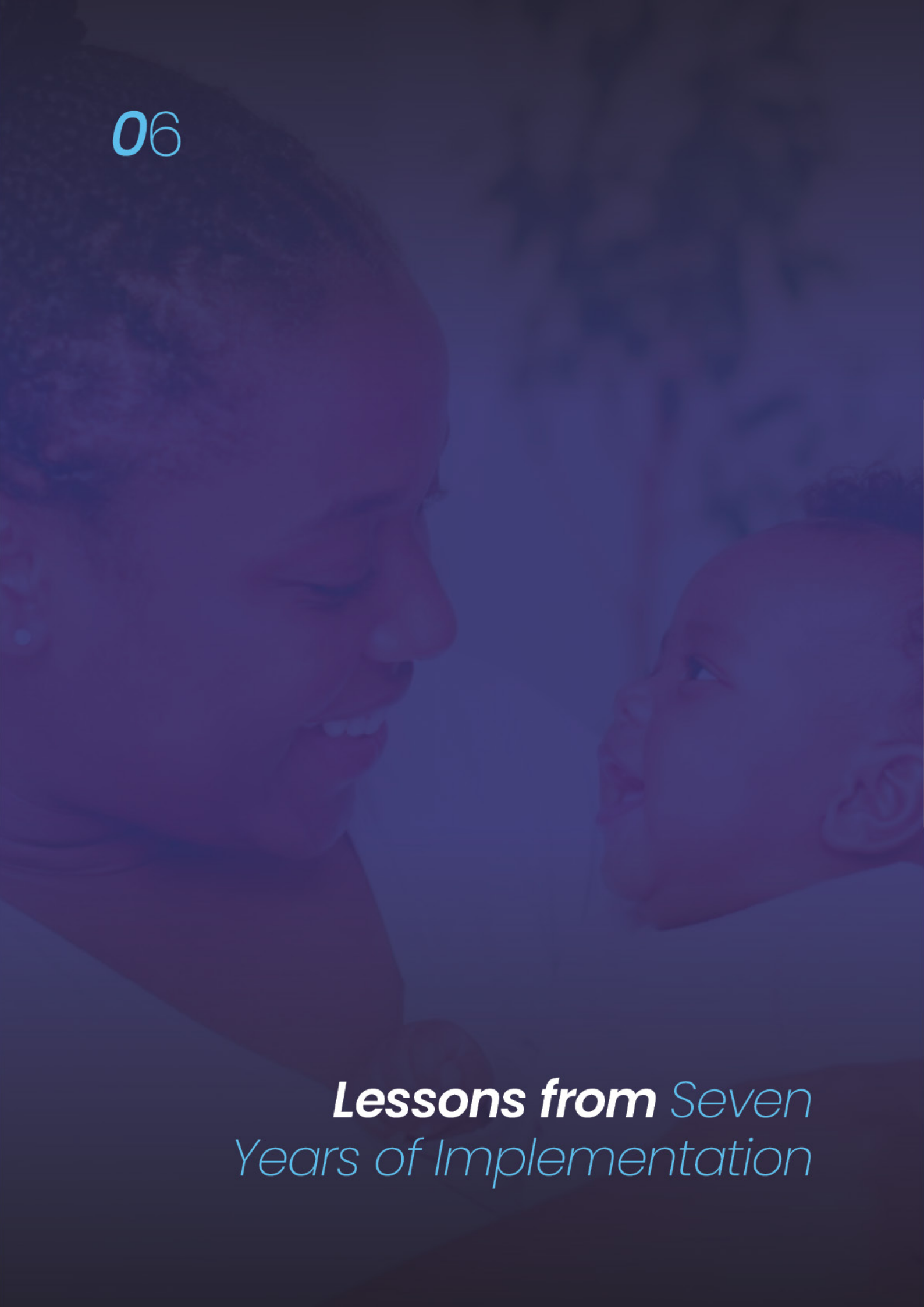
Quality and governance

State Laboratory Quality Assurance Champion Teams, Technical Working Groups, Quality Improvement teams, DQV and joint supportive supervision created institutional routines for accountability that can continue after project-specific management teams exit.

Local government and HIV/TB integration

Collaboration with LACAs and STBLCPs supported geographically targeted testing, sample movement and integrated HIV/TB services. Community Centres were also strengthened as functional DOTS centres, expanding TB capacity without creating a parallel programme.

06



Lessons from Seven Years of Implementation

The ten-state experience provides a practical set of lessons for future community HIV programming in Northern Nigeria.

Lesson	What the experience shows
There is no universal case-finding mix	State results show that the right modality depends on local epidemiology, access and social networks.
Community platforms can extend the formal system	CCSAPs and community workers were most effective when linked tightly to government facilities and clinical oversight.
Security is a programme function	Insecurity affects access, staffing, commodities, client tracking and service continuity; it cannot sit in a separate risk register.
Retention needs a mobile-client mindset	Population movement in Bauchi and Borno showed why cross-community tracking and flexible refills matter.
Prevention demand is the constraint	The 100% PrEP initiation rate among eligible clients masks large differences in the number of clients assessed and engaged.
Low-tech management disciplines remain powerful	Frequent review, clear escalation and follow-through often mattered more than sophisticated technology.
Some gaps need explicit handover ownership	Kano TB treatment success and the lack of a domestic financing pathway for some KP services require named post-project owners.

What should not be lost at handover

- The hub-and-spoke community service architecture.
- The use of local yield data to determine case-finding modality mix.
- Biometric verification and disciplined treatment-cohort management.
- Regular data review with action tracking and escalation.
- Security-informed service planning in affected states.
- Government ownership of the infrastructure, tools and workforce capabilities built through CARE-2.

What the ten states delivered

The project provides ten worked examples of adaptive implementation. Community outreach dominated in Jigawa and Bauchi; network-based approaches were especially important in Yobe and Borno; index testing was central in Kano. The lesson is to match modalities to local yield, population structure and access.

What treatment continuity required

Home-based ART refills, multi-month dispensing, flexible appointments, case-manager navigation and viral-load collection aligned to refill visits repeatedly appeared in the strongest models.

What the outliers teach

Kano's 63% TB treatment success is the clearest performance gap; Yobe's five PrEP initiations show the scale of prevention-demand constraints; and Jigawa's 99.7% outreach share demonstrates the risk of over-dependence on one modality.

Operating under insecurity

Six states implemented under active security constraints. Security intelligence before deployment, locally recruited staff, community intelligence networks and flexible field planning recur across the strongest experiences. Insecurity therefore belongs inside programme design and budgeting, not in a separate risk register.



07



Transition and Sustainability Roadmap

At country level, transition is less about a single handover event and more about making the CARE-2 operating model routine within state systems and successor programmes.

Priority window	Immediate transition actions	Outcome to protect
0–3 months	Confirm state-by-state ownership of Community Centres, CCSAPs, equipment, records and essential service functions.	No avoidable disruption to services.
0–6 months	Transfer data access, biometric processes, dashboards, SOPs and quality routines.	Continuity of programme visibility and data integrity.
0–6 months	Map community and case-management functions into government or successor arrangements.	Preserved last-mile access and institutional knowledge.
3–12 months	Embed supply chain, MMD, VL, TB and adherence pathways into routine state supervision.	Treatment and suppression outcomes protected.
3–12 months	Maintain security planning, contingency access and cross-community referral mechanisms in affected states.	Service continuity under changing conditions.
12–24 months	Use closeout baselines to identify state-specific gaps and direct QI and partner support.	CARE-2 lessons become routine practice rather than project memory.

Priority indicators for post-closeout monitoring

Domain	Suggested management signal
Case finding	Yield/positivity by modality and LGA; linkage after diagnosis.
Treatment	TX_CURR; interruption; retention; MMD; missed-appointment follow-up.
Viral load	Coverage; suppression; EAC and repeat VL outcomes.
TB	Screening; treatment initiation; treatment success by state.
Prevention	PrEP assessment, initiation and continuation; PBFW services.
Data & quality	Timeliness; DQV; biometric duplication; QI actions closed.
Transition	Function with named owner, funding route, staff and indicator in each state.

What the ten states inherit

The measurable inheritance is a verified cohort of 42,794 clients, 12 Community Centres, 123 CCSAPs, ten portable digital X-ray machines, solar-powered cold chain, laboratory equipment, EMR and data tools. The less visible inheritance is a trained government workforce, quality-assurance teams, QI routines and community relationships.

Transition principle

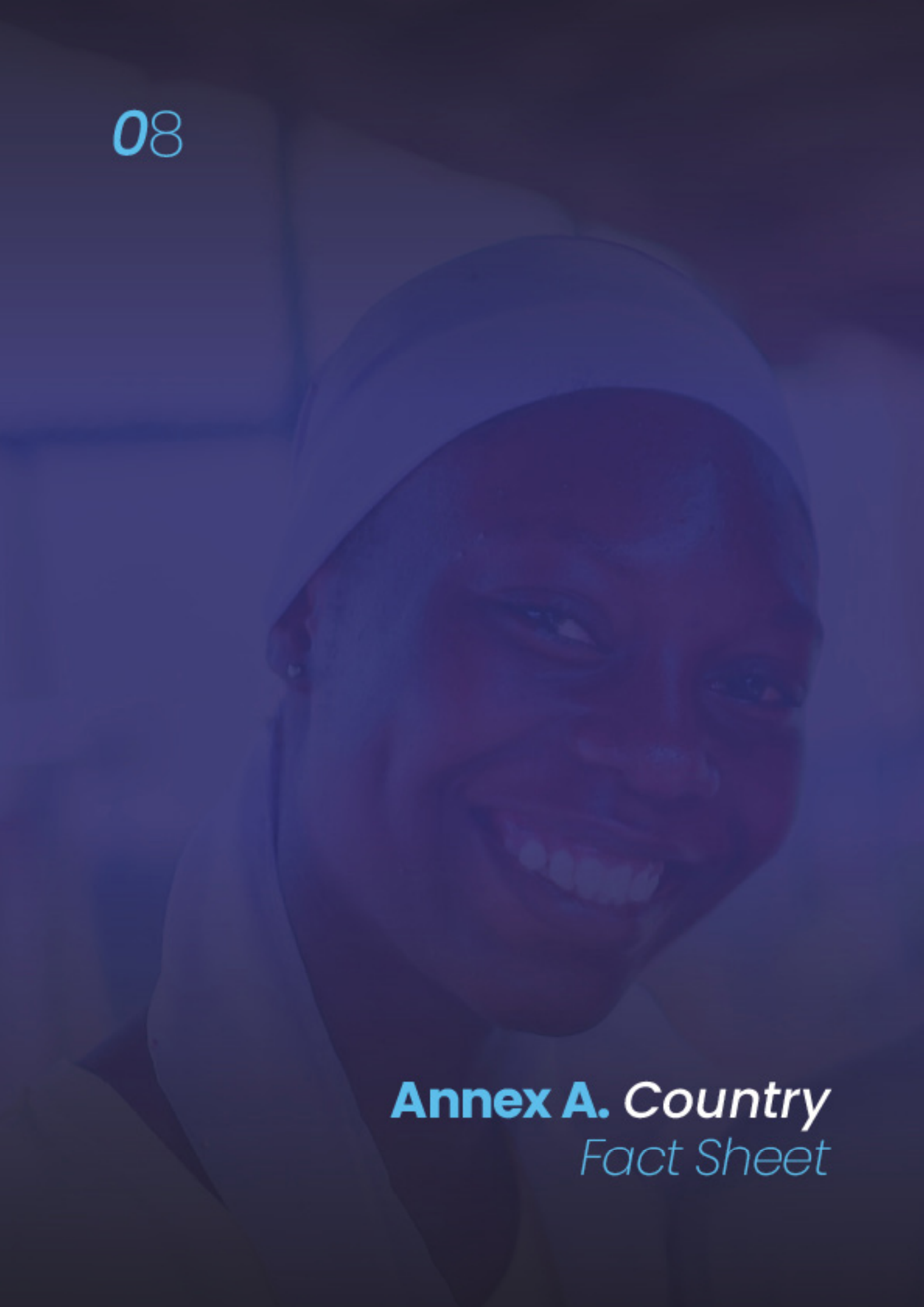
The next phase should manage the portfolio as ten state-specific operating systems within one national learning architecture. Each state needs a named owner, people, financing route, data mechanism and contingency plan for every essential function. Country-level coordination should focus on learning and standards rather than imposing a uniform delivery recipe.

Financial stewardship and transition economics

The attached implementation brief reports an approved budget of about USD 34.6 million, with roughly USD 31.5 million obligated, a 68% cumulative burn rate and about 95% of funds received liquidated or committed. The transition implication is to protect the high-value functions—service continuity, commodities, data, supervision and asset maintenance—rather than simply preserve project expenditure patterns.



08



Annex A. Country Fact Sheet

Original country-level closeout figures are retained here and the table is formatted to match the state briefs. Taraba testing and case-finding figures remain excluded pending reconciliation, as stated in the source document.

Domain	Suggested management signal
Implementation period	2019 – 2026
States	10
Community Centres	12
CCSAPs	123
Portable digital X-ray machines	10
Total tested for HIV	489,048
People living with HIV identified	55,472
Positivity rate	11.3%
PrEP initiations	49,678
PrEP initiation rate	100% among eligible clients assessed
TB treatment success	90%
Clients currently on treatment (TX_CURR)	42,794
Viral load suppression	Not reported project-wide in the supplied document
Client verification	Biometric capture and repeat-visit fingerprint verification used to deduplicate treatment cohorts and confirm repeat visits.

Results Summary

State	Joined	TX_CURR	Tested	Identified	Positivity	CCSAPs	PrEP	TB success
Adamawa	2019	7,311	69,972	8,788	12.6%	15	6,088	96%
Bauchi	2019	5,724	89,271	12,068	13.5%	19	11,013	95%
Sokoto	2021	4,643	58,859	5,897	10.0%	10	5,030	94%
Kebbi	2021	6,689	80,464	8,849	11.0%	20	8,183	95%
Zamfara	2021	4,283	65,656	4,274	6.5%	11	7,752	85%
Borno	2022	5,091	46,808	7,237	15.5%	8	1,576	93%
Kano	2023	2,576	30,131	3,843	12.8%	16	5,233	63%
Taraba	2023	3,482	—	—	—	12	4,330	96%
Yobe	2024	820	16,559	2,138	12.9%	6	5	86%
Jigawa	2025	2,175	28,822	2,239	7.8%	6	468	96%
All ten	2019–26	42,794	489,048	55,472	11.3%	123	49,678	90%

Source note: figures are reproduced from the supplied closeout data. Entries shown as unavailable should be completed from the locked project results sheet before external publication.



09



Annex B. Success Story

Stories from the Ten States

Selected closeout experiences documented by the state teams

- ***Adamawa*** — From weakness to strength: Community-based identification, integrated HIV/TB care and adherence support helped Hapsatu recover from advanced disease and return to farming.
- ***Bauchi*** — A centrifuge at Town Maternity Alkaleri: A CCSAP used its own support to procure a centrifuge, turning a laboratory bottleneck into lasting facility capacity.
- ***Borno*** — The cry that changed everything: A case manager linked a mother and child to HIV care and nutrition support after insecurity had closed the family's usual access to services.
- ***Jigawa*** — From trauma to triumph: Home-based follow-up and respectful counselling helped a newly diagnosed client regain confidence and return to everyday economic activity.
- ***Kano*** — Thread by thread: Clinical and psychosocial support helped a client stabilise his health while reconnecting with his tailoring business.
- ***Kebbi*** — From despair to dignity: Clinical management, nutrition and psychosocial support accompanied a major physical recovery and viral suppression.
- ***Sokoto*** — A second chance at life: Rapid TB screening, treatment and sustained follow-up helped a newly diagnosed client move from fear to stable care.
- ***Taraba*** — Steady hands again: Community testing and counselling helped a welder regain health and return to his trade.
- ***Yobe*** — A mother's journey in Damaturu: Clinical care, psychosocial support and community follow-up helped a mother recover after HIV affected both her and her child.

Reading the country fact sheet

The ten-state table should be used as a transition baseline rather than a league table. It highlights where states need protection of mature systems and where successor programmes need targeted corrective action—particularly Kano's TB completion gap and the uneven PrEP demand profile.

How to use the baseline

The ten-state table should function as a management baseline, not a league table. It identifies where systems are mature and where successor support should be concentrated, particularly Kano's TB completion gap and the uneven prevention-demand profile.

The human dimension of systems change

The stories demonstrate that the platform's value is cumulative: community access creates the first contact, clinical services convert that contact into treatment, case management protects continuity, and other health and social services address the barriers that would otherwise undermine recovery.

Zamfara — Reaching the unreachable: A brief security window allowed a team to reach an isolated community, identify a family through index testing and start three people on treatment.

Key Takeaways

Taken together, the stories show what the aggregate results cannot: CARE-2's value was not only in the number of clients reached, but in the practical ways community access, clinical care, adherence support and local problem-solving changed individual outcomes.



Kano State






Jigawa State





Borno State





Adamawa State






Bauchi State






Zamfara State





Yobe State





Taraba State






Sokoto State





Kebbi State





