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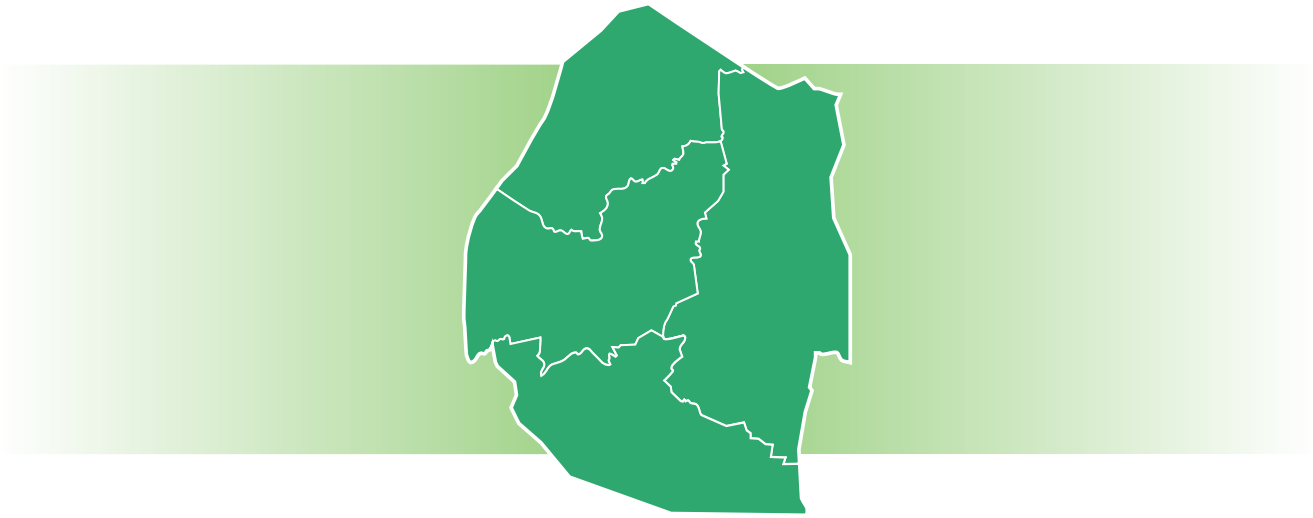
Final Evaluation Report

Strengthening Local Capacity to Deliver Sustainable Quality-assured Universal Coverage of Clinical HIV/TB Services in the Lubombo Region and Central-level Technical Assistance to the Eswatini National AIDS Programme under PEPFAR



August 2020

This work is supported through technical support by the United States President Emergency Plan for AIDS Relief (PEPFAR), funded through the Centres for Disease and Prevention (CDC) under the Grants or Cooperative Agreement Number, 6 NU2GGH001399 05, managed by University Research Co., LLC (URC). Its contents are solely the responsibility of the authors and do not necessary represent the official views of USG, CDC and Department of Health and Human Services.

Strengthening Local Capacity to Deliver Sustainable Quality-assured Universal Coverage of Clinical HIV/TB Services in the Lubombo Region and Central-level Technical Assistance to the Eswatini National AIDS Programme under PEPFAR

Final Evaluation Report

August 2020

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Disclamer

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
APMR	ART Patient Monitoring and Reporting System
ART	Antiretroviral Therapy
ARVs	Antiretroviral Drugs
CBO	Community-Based Organizations
CD4	Cluster of differentiation 4
CDC	Centers for Disease Control and Prevention
CMIS	Client Management Information Systems
COP	Country Operational Plan
DSD	Differentiated Service Delivery
DST	Drug Susceptibility Testing
EID	Early Infant Diagnosis
EMCU	Eswatini Medical Christian University
EMR	Electronic Medical Record
ENAP	Eswatini National AIDS Programme
ENSF	Extended National Strategic Framework
EQA	External Quality Assurance
EWI	Early Warning Indicators
FOA	Funding Opportunity Announcement
FP	Family Planning
GBV	Gender-based Violence
GKII	Group Key Informant Interview
GSH	Good Shepherd Nursing School
HCW	Healthcare Workers
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HIVDR	Human Immunodeficiency Virus Drug Resistance
HMIS	Health Management Information System
HTC	HIV Testing and Counselling
HTS	HIV Testing Services
IMAI	Integrated Management of Adolescent and Adult Illness
IP	Implementing Partner
IPC	Infection Prevention and Control
IPT	Isoniazid Preventive Therapy
KII	Key Informant Interview
LCM	Linkage Case Management
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDR-TB	Multi-Drug Resistant TB
MNCH	Maternal Neonatal Child Health
MOH	Ministry of Health
NaHSAR	National HIV Semi-Annual Reviews
NARTIS	Nurse-led Antiretroviral Therapy Initiation
NCD	Non-communicable Disease
NGO	Non-Governmental Organization
NHSS	National HIV Service Standards
NQMP	National Quality Management Programme
NSTS	National Sample Transport System
NTCP	National Tuberculosis Control Programme
PEPFAR	President's Emergency Plan for AIDS Relief
PHU	Public Health Unit
PIHTC	Provider-Initiated HIV Testing and Counselling
PIHTS	Provider-Initiated HIV Testing Services
PLHIV	People Living with HIV
PMP	Performance Monitoring Plan
PMTCT	Prevention of Mother-to to-Child Transmission of HIV
PrEP	Pre-Exposure Prophylaxis
PY	Project Year
QI	Quality Improvement
QIP	Quality Improvement Project
ReHSAR	Regional HIV Semi-Annual Reviews
RHMT	Regional Health Management Team
SANU	Southern Africa Nazarene University
SD	Service Delivery
SI	Strategic Information
SID	Strategic Information Department
SIMS	Site Improvement Monitoring System
SOP	Standard Operating Procedures
SRH	Sexual and Reproductive Health
SRHU	Sexual and Reproductive Health Unit
STI	Sexually Transmitted Infection
SWASA	Eswatini Standards Authority
TA	Technical Assistance
TB	Tuberculosis
TLD	Tenofovir, Lamivudine, and Dolutegravir
TWG	Technical Working Group
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNESWA	University of Eswatini
URC	University Research Co., LLC
VL	Viral Load
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

1. Executive Summary

This report presents the processes, findings, conclusions, and recommendations of the final evaluation for the "Strengthening Local Capacity to Deliver Sustainable Quality-Assured Universal Coverage of Clinical HIV/TB Services in Lubombo Region and Provide Central Level Technical Assistance to the Eswatini National AIDS Program (ENAP) in the Kingdom of Eswatini" project under the President's Emergency Plan for AIDS Relief (PEPFAR). The project was implemented by University Research Co., LLC (URC) in collaboration with the Ministry of Health (MOH) in the Kingdom of Eswatini through funding from the Centers for Disease Control and Prevention (CDC), from April 2015 to September 2020. The primary audience for this report is CDC/PEPFAR, CDC Lubombo implementing partners (URC and her subawardee partners), the Ministry of Health and her stakeholders at national and sub-national levels, and the Lubombo Regional Health Management Team. Other audiences include other CDC and PEPFAR implementing partners, Health Sector development partners and multinational agencies, and all stakeholders involved in HIV programming in the Kingdom of Eswatini and the Africa Region.

Purpose

The purpose of the evaluation was to assess the program performance in order to understand whether the intended objectives of the project were on track to be achieved by the end of five years. Additionally, this report documents lessons learned for future improvement in program design and implementation, accountability, and transparency. It also generates a set of clear forward-looking and actionable recommendations that are logically linked to the evaluation findings and conclusions. The evaluation was led by a three-member external evaluator team with diverse experience in line with the project objectives and conducted from March to June 2020.

Objectives

The objectives of this evaluation were to: (i) review and document the progress made by the CDC-Lubombo project in supporting ENAP, the Lubombo Regional Health Management Team (RHMT), and health facilities in the ensuring the provision of sustainable quality-assured universal coverage of effective HIV clinical services according to MOH standards and guidelines; (ii) assess effectiveness, efficiency, and quality of the project at national, regional, and facility service delivery levels; (iii) identify implementation gaps and challenges and determine how well the project achieved its goals, objectives, and performance targets; (iv) document lessons learned; (v) make specific proposals for project sustainability (institutionalization and capacity/ability to maintain the project gains); and (vi) develop an exit plan aligned with current levels of funding for clinic staff /human resources. Additionally, the evaluation measured whether or not the project improved the quality of HIV care and treatment services in the Lubombo region, specifically, and in the Kingdom of Eswatini in general, resulting in reduced HIV-related morbidity and mortality; quantified the increase in the number of individuals who are aware of their HIV status and successfully linked to appropriate services in the Lubombo region; and whether or not the project has

contributed to decreased HIV incidence and HIV population viral load suppression in the region.

Evaluation questions

The evaluation was guided by five key evaluation questions:

1. How effective was the project in achieving its goals, objectives, and performance targets?
2. What were the project's strengths, weaknesses, and gaps in planning, management, service delivery, and sustainability?
3. What were the constraints to successful implementation of the project?
4. How well did the project align with PEPFAR global priorities and approaches?
5. What were the implementing partner expenditures for providing comprehensive HIV services to clients (including HIV testing, linkage to treatment, retention, and viral load suppression)?

Methodology

The evaluation employed a non-experimental, descriptive, cross-sectional design that involved a comparison of baseline results, mid-term, and end line status of project implementation. The evaluation employed a mixed methodology of quantitative and qualitative research. The evaluators applied the following data collection methods: (a) the desk review (qualitative); (b) key informant interviews (KIIs) (qualitative); (c) group key informant interviews (FGDs) (qualitative); and (d) health facility direct observation and surveys (quantitative) using questionnaires (sets of closed and open-ended questions).

The evaluation data sources included 34 KIIs carried out remotely by Skype/phone (URC and subgrantee staff, CDC, MOH national and regional authorities, PEPFAR partners, UN agencies, nursing school heads, and nursing councils), 13 FGDs carried out face-to-face with health care providers (nurses, HIV counsellors, expert clients, lay counsellors, mentor mothers, teen club members), and 14 health facility direct observations and surveys (30% of total project-supported facilities).

Several potential methodology limitations, assumptions and constraints were identified. The evaluation sites and respondents were purposely selected. The implementation of evaluation activities was affected due to the COVID-19 pandemic travel restrictions. In most cases, these were addressed or mitigated with the support of the in-country evaluation management team, remote interviews and by triangulating information gathered from various data sources in order to provide stronger evidence-based conclusions.

Main findings and conclusions

The main findings and conclusions are presented for each evaluation question:

Evaluation question 1: Effectiveness

Overall, the project was effective in achieving its objectives and contributed towards achieving the goal of reducing HIV incidence among adults and children and reducing HIV-related morbidity and mortality nationally and in the Lubombo region. This was evidenced by review of UNAIDS and SHIMS reports. UNAIDS estimated reduction in HIV incidence per 1,000 population from 11.3 in 2015 to 4.9 in 2019 and a reducation in HIV prevalence (15-49) per 1,000 population from 28.9 in 2015 to 27 in 2019 (UNAIDS report 2020). Similarly, there was reduction in national HIV incidence and prevalence rates among population 15 years and older by 50% and 13% respectively [Swaziland HIV Incidence Measurement Survey (SHIMS I and II)].

Project Objective 1 was to provide Technical Assistance (TA) to MOH and the ENAP to develop performance standards, up-to-date guidelines, standard operating procedures (SOPs), and data

tools to enhance quality service delivery. Under this objective, the project provided direct technical support to update policies, guidelines, SOPs, job aids, and other key policy documents in line with international standards on HIV Testing Services(HTS), PMTCT, TB/HIV, HIV prevention, and HIV care and treatment services. The project supported integration of HIV care and treatment services guidelines and clinical tools into pre-service training curriculum for the four nursing training institutions in Eswatini to improve the skills of nursing students and graduates. The project further facilitated the implementation of National and Regional HIV Semi-Annual Reviews, setting performance targets monitoring progress at project supported facilities, and conducted service delivery assessments in project-supported health facilities. The project facilitated the national collaborative learning workshops such as the National Viral Load Results Utilization and Quality Improvement Collaborative. The project supported evidence-based programming in HIV drug resistance (HIVDR) monitoring and response by the establishing the National HIVDR Clinical Expert Committee, assisting in the development of Early Warning Indicators protocol and its adaptation, integration of HIVDR and multidrug resistant TB (MDR-TB) management and introduction of new TB and HIV drugs. There was clear evidence from FGDs and KIIs that all this project support was available at the service delivery level.

Project Objective 2 was to build the Lubombo RHMT's capacity to employ strong stewardship and ownership role in quality management of HIV and TB clinical services and collaborate with the quality management (QM) program and support Lubombo RHMT to improve and sustain high-quality performance in HIV/TB service delivery at the facility level. Under this objective, the project contributed to building the organizational capacity of the RHMT, through implementation of a capacity building plan that was aligned to the RHMT terms of reference, identification of response gaps and embedding the support into the regional structures, which elicited interest and promoted ownership. The TA support received from the project was structured in a way that mimicked the regional MOH structure and applied MOH capacity metrics to ensure effective capacity building. Through the RHMT support, 90% (38/42) of the facilities managed to meet their performance targets in the year 2018. The Health Facility Direct Observation and Survey showed that the supervision and mentoring rates at surveyed heath facilities were, 93% (13/14), of which, RHMT was present in 70%. The key informants from RHMT alluded to their improved skills to perform their duties from the TA support received from the project. KII respondents mentioned improvement in the quality of service provision and consequently improvement of key performance indicators. Evidence of increased RHMT stewardship to implement and monitor the regional health work plan was showcased by recognition of the region as the best performing region in HIV/TB services during NaHSAR meeting in November 2018, and RHMT-led Cervical Cancer (CaCx) Screening scale up in Lubombo (Project Annual Reports, 2019).

Project Objective 3 was to support comprehensive and integrated universal scale-up of adult and pediatric HIV and TB clinical services in health facilities in the Lubombo region. Under this objective, the project scaled-up integrated high-quality HIV and TB clinical services in 42 health facilities in Lubombo region, through effective and efficient site level support, promoting integrated quality-assured services, and adherence to SOPs and guidelines. The project achieved its performance indicator targets, as per the PEPFAR country operational plan (COP) yearly targets, in HTS, and PMTCT services. Targets for antiretroviral therapy (ART) initiation, viral suppression, and TB-HIV services were partially achieved. Partial achievement was defined when the target achieved was more than 60% but less than

90% of the set target for a given indicator. [Program Data 2015–2020].

Review of project data showed that MTCT rate at six weeks of age across project-supported sites was 1.3% in year 5 as compared to the national MTCT rate of 2.7% (CI 1.6-4.3) according to UNAIDS, 2018 estimates. The percentage of HIV-positive pregnant in antenatal care on ART for PMTCT in project-supported sites was 96% in Year 1, increased to 98% in Year 3, and to 100% in Year 5. According to a draft Annual Health Performance Report, 2019, this percentage is estimated at 86% for the entire Lubombo region. Percentage of HIV-positive infants (age 6-8 weeks) on ART for PMTCT was 93% in Year 1 and increased to 97% in Year 5. The percentage of HIV-positive adults initiated of ART in project-supported sites was 31% in Year 1, increased to 94% in Year 3, and to 100% in Year 5. Percentage of HIV-positive adults on ART with viral suppression was 93% in Year 3 and 94% in Year 5.

Evaluation question 2: Project's strengths, weaknesses, and gaps

The key strengths of the project were: high-quality technical team, adaptive programming, responsiveness to stakeholders' needs, resourcefulness, human resources management, sub-grantee capacity building and effective project management and leadership. KIIs reported that the project had highly skilled competent TA staff at national and regional levels, the project staff were committed and dedicated despite working in a difficult region and highly responsive to changes in national policies and focused on achieving the objectives of the project. The project management, leadership team had a very good handle of the project implementation cycle and used adaptive programming approach to respond to the need of Lubombo region and the Zonal approach which strengthened project implementation.

A major weakness was the lack of formal exit or sustainability strategy resulting in uncertainty about the continuity of project gains and target achievements when the project ends. There was overdependence of the RHMT on project resources and support staff at health facilities for service delivery. Other weaknesses reported by the KIIs were: inadequate time spent at facility level by the project TA staff to cover mentorship for all technical areas; multiple parallel data reporting systems; perceived mismatch between the project work plan and the priorities /actions of the RHMT, which resulted in the project support not fully integrated into the government structure of the RHMT.

The project gaps included sub-optimal HIV positivity yield (about 5%) in the project support-areas. This rate is lower than anticipated considering that the MOH HIV Annual Program Report for 2018 reported HTS positivity yield of 6.7% for the general population. For Lubombo region, positivity yield was expected to be 10% and was set as a target yield for project around 2017 when PEPFAR changed its focus from looking at number of people with HIV testing to percentage positively yield for HTS services. Semi-annual report for FY20 reported 35% of patients had been lost to follow-up after being on ART for >3months, 4% had been lost to follow-up after being on ART for <3months, and 0.6% had stopped treatment. Qualitative data suggest that the gaps in ART retention were related to loss to follow-up of patients due to seasonal migration, misinformation regarding contact details provided by patients, and occasional stock-out of ARVs.

The were challenges in the diagnosis and treatment of TB in children emanating from a lack of diagnostic tools for this sub-population who are not able to serve sputum samples, lack of specific job aids and drug stock-outs for pediatric TB preventive therapy dosages. In surveyed health facilities, integration of SRH and family planning services with HIV

services lagged compared to other services, notably PMTCT and TB. Respondents reported that more community awareness was needed for prevention and treatment of GBV cases since incident cases are not reported due to stigma and lack of education among community members. For cervical cancer screening and treatment, the gap noted was the community education and health worker counselling skills ensuring the safety of the procedure to the clients. Adolescent HIV Treatment Clubs (Teen clubs) and other community HIV support groups lack funding, and members tend to show up only if given incentives, which is not sustainable beyong project support. Use of lab information management system or m-health based lab results delivery system in surveyed health facilities were not seen.

Evaluation question 3: Project constraints

Lubombo is a remote region with high poverty levels and high transportation costs, which hinders client access to health services. The region's remoteness also resulted in higher unit costs of project implementation. Other constraints were related to human resources shortages and high staff turnover; inadequate infrastructure; logistics, finance and procurement challenges; and commodity stock-outs. Frequent changes in HIV guidelines over the course of the project timeline required the project to constantly update job-aids, checklist, training materials and conduct staff retraining, as well as reconfigure service delivery models to accommodate these changes, and this had a negative effect of project implementation with fidelity. Data from SHIMS-2 (data released in 2017) estimated lower PLHIV burden in the country than earlier anticipated. This resulted in disproportionately high project performance indicator targets for Years 1, 2, and 3. During these years epidemiological estimates were available from UNAIDS (2015) and SHIMS-1 (2012), both estimated higher HIV incidence and prevalence. The project adjusted the indicator targets for the remaining years based on the new epidemiological estimates. All these constraints were mitigated by implementing carefully planned interventions.

Evaluation question 4: Project alignment with PEPFAR global priorities and approaches

The PEPFAR Country Program introduced several changes over the five-year project duration (2015-2020). The project introduced changes to services in line with changes to annual PEPFAR country operational plans (COPs) and aligned the program activities, project performance indicators and targets for epidemic control in priority locations and populations each year. For example, the project started implementation under COP15. The pivot for COP15 was to achieve the UNAIDS 90/90/90 targets and epidemic control by delivering the Right Things—HIV Testing and LTC; ART; VMMC; PMTCT/Option B+; Condoms; Test and Start; PrEP—in the Right Places, that is, focusing programs geographically and on communities with greatest need. Whereas the COP 16 pivot was centered on tailoring client services to reach UNAIDS (95/95/95) using a client-centered approach to overcome the priority barriers to epidemic control. This strategy involved adoption and implementation of Test and Start, DSD models, including six-month multi-month scripting to reach across all age, sex, and risk groups. The project ensured project activities, performance indicators and targets align with changing PEPFAR global priorities and approaches.

Evaluation question 5: Implementing partner (IP) expenditures for providing comprehensive HIV services to clients

The average project total expenditure per year was about $4.5 million. The expenditures related to the Project Management, followed by Policy and Strategic Information, were the highest in Year 1 (39% of total Year 1 expenditures), which gradually reduced by Year 4 (19% of total Year 4 expenditures).

HTS expenditure was lowest in Year 1 (2% of total Year 1 expenditures) and gradually increased by Year 4 (22% of total Year 4 expenditures). HIV care and treatment expenditure were highest in Year 4 (48% of total Year 4 expenditures). HIV prevention expenditures (such as GBV, VMMC, PrEP, Youth activities) were lowest in all years (about 0-5% of yearly expenditures).

The project provided adequate oversight, management, and resources for management and implementation. Implementations was conducted in a timely manner and within allocated budget approved by the CDC. There was unequal distribution of resources among various aspects of HIV services, and HIV prevention services received the least resources. Allocations of resources were discussed with PEPFAR during annual workplan meetings and were based on changing PEPFAR program priorities. There were delays throughout the project in disbursement of funds from URC home office to sub-grantees to carry out service delivery activities in a timely manner. For example, start of VMMC services were delayed for three months.

Recommendations

The evaluation team suggests that URC and CDC consider the following during project design and implementation of future HIV and TB programs in Eswatini. The major recommendations arising from this evaluation are explained in more detail in the main report but summarized below:

a) Ensure project's sustainability strategy at the design stage. At the project design stage, ensure that the project has a sensitive sustainability and exit strategy built into the overall project implementation strategy with timelines for hand-over of the activities to the Ministry of Health. The project should work collaboratively with the MOH to facilitate its commitments and to put in place strategies that strengthen sustainability.
b) Ensure equity in project resources across intervention areas (across HIV preventive as well as curative services);
c) Strengthen the implementation of index testing for HIV;
d) Address other identified service delivery gap areas (diagnostic tools and clinical job-aids to address TB in children, streamlining supply management systems for medications, supplies and HIV test kits, community knowledge on cervical cancer screening and early treatment and gender-based violence prevention, GBV early notification and timely interventions);
e) Test and scale up social protection interventions to improve ART retention and utilization of community support groups;
f) Incorporate use of innovative tools for capacity development (remote training and low-dose, high-frequency training);
g) Optimize laboratory network systems and referral networks to improve HIV-related testing capacity and delivery of results;
h) Ensure the alignment of project reporting systems with the national reporting system; and
i) Review internal processes for funds disbursement to subgrantees.

2. Project Background

Project context

Human immunodeficiency virus (HIV)/Acquired immunodeficiency disease (AIDS) is a major health challenge in the Kingdom of Eswatini with prevalence of 27.2% among adults aged 18-49 years (SHIMS2, 2017). The Government has demonstrated strong commitment to HIV prevention since it was declared a national disaster in 1999 and aims to have an "AIDS free generation" by 2022. In December 2001, the Ministry of Health (MOH) established a National Emergency Response Council on HIV and AIDS to coordinate efforts towards mitigating the HIV/AIDS epidemic. HIV/AIDS strategies were earlier aligned with the Joint United Nations Programme on HIV and AIDS (UNAIDS) 90-90-90 strategy. Further targets were set, harmonized with the latest UNAIDS 95-95-95, which is expected to transform the epidemiology in the country leading to a shift in HIV control strategy. The current 95-95-95 strategy under the Extended National Strategic Framework (eNSF) for HIV and AIDS seeks to ensure that by 2023, 95% of all people living with HIV will know their HIV status; 95% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy and 95% of all people receiving antiretroviral therapy will have viral suppression. According to the UNAIDS 2020 report, Eswatini has achieved 95-95-95 targets at the national level.

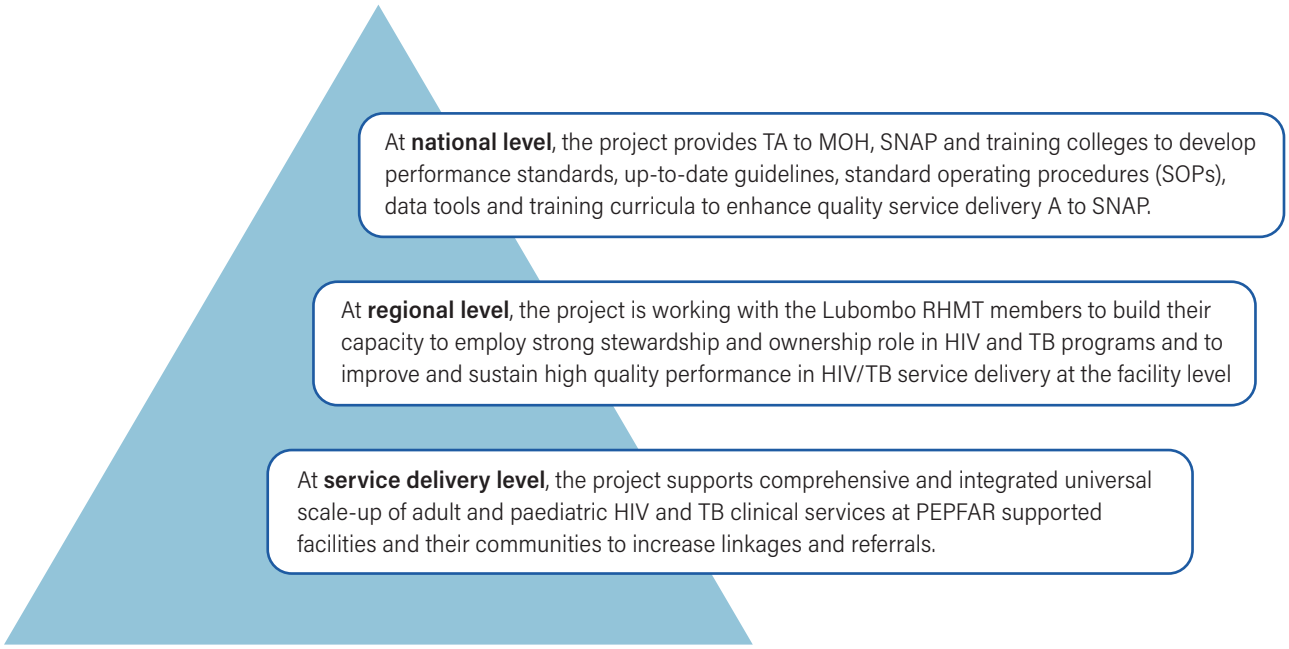
Project description

University Research Co., LLC (URC) in collaboration with the MOH in the Kingdom of Eswatini implemented a Centers for Disease Control and Prevention (CDC)-funded project to contribute to national efforts for HIV/AIDS epidemic control. The CDC-funded project named "Strengthening Local Capacity to Deliver Sustainable Quality-Assured Universal Coverage of Clinical HIV/TB Services in Lubombo Region and Provide Central Level Technical Assistance to the Eswatini National AIDS Program (ENAP) in the Kingdom of Eswatini under the President's Emergency Plan for AIDS Relief (PEPFAR)" commenced on April 1, 2015 and will end on September 30, 2020.

In line with the goals of the eNSF for HIV and AIDS (2014-2018, and 2018-2023), the Health Sector Response to HIV/AIDS Plan (HSRP), the PEPFAR blue print, and the UNAIDS 90-90-90 targets by 2020 and revised targets of 95-95-95 by 2030, the project aimed to strengthen the capacity of ENAP, the Lubombo Regional Health Management Team (RHMT), and regional health facilities to deliver sustainable quality-assured universal coverage of clinical HIV and tuberculosis (TB) services in the Lubombo region. The goal of the project was to implement activities while assisting the MOH and the Lubombo region to reduce the incidence of HIV and TB by 50% among adults and by 90% among children, and to avert 20% of deaths among children, adults, and pregnant women living with HIV (especially those with TB co-infection). Specifically, the three main project objectives (**Figure 1**) were:

1. To provide Technical Assistance (TA) to MOH and the ENAP to develop performance standards, up-to-date guidelines, standard operating procedures (SOPs), and data tools to enhance quality service delivery.
2. To build the Lubombo RHMT's capacity to employ strong stewardship and ownership role in quality

Figure 1: Project technical and resources level support



management of HIV and TB clinical services and collaborate with the quality management (QM) program and support Lubombo RHMT to improve and sustain high-quality performance in HIV/TB service delivery at the facility level.

3. To support comprehensive and integrated universal scale-up of adult and pediatric HIV and TB clinical services (including Provider-initiated HIV Testing and Counseling Services (PIHTS), Prevention of Mother-to-Child Transmission of HIV (PMTCT), TB, TB/HIV, HIV care and treatment) at all facilities and selected communities (including mines and correctional facilities) in the Lubombo region.

The project's Results Framework is provided in Annex H. In addition, URC, as the lead clinical PEPFAR partner for the Lubombo Region and ENAP, was expected during the project to:

1. Work as PEPFAR Eswatini's lead implementing partner (IP) for TA to ENAP, providing support to all HIV care and treatment-related (including HIV Testing Services (HTS) and HIV drug resistance (HIVDR)) activities at the national level as required;
2. Collaborate with MOH in the Lubombo region to rapidly expand access to a combination of PIHTS, PMTCT, TB services, and Pediatric and Adult HIV Care and Treatment services to ensure universal coverage of comprehensive and integrated clinical HIV and TB services in the region;
3. Be responsible for building the Lubombo RHMT capacity to ensure long-term sustainability of facility-level delivery of services that meet national quality performance standards; and
4. Collaborate with relevant stakeholders to expand access to TB and HIV services at the community level (including industrial sites, mines, and correctional facilities) within the Lubombo region.

Table 1: Project target population and coverage

Level	Target Audience	Coverage
National	MOH, ENAP, Nurses training colleges	Country wide including four regions
Region	RHMT, Regional SID	Lubombo region
Facility	42 health facilities; HCW, facility clients, key population	Lubombo region
Community	7 subgrantees	9 Tinkundla in Lubombo region

Project's target population and coverage

At the national level, the target audiences were the MOH Public Health programs (ENAP and National Quality Management Programme), along with NTCP, SI Department, and Pre-Service nurses training colleges. The national level scope: -Increasing health worker use of updated policies, guidelines, SOPs, and job aides on PIHTC, HIV care and treatment (including TB/HIV collaborative activities in HIV settings); improving skills among nursing students and graduates in regards to the updated policies, guidelines, SOPs, and job aides on PIHTC, and HIV care and treatment services (including TB/HIV collaborative activities in HIV settings); increasing number of health facilities that have met performance targets on HIV care and treatment services (including PITC and TB/HIV collaborative activities in HIV settings); and increasing uptake and utilization of HIV and HIVDR -related findings from pilots and quality improvement projects to inform policy and programming (**Table 1**).

At the regional level, the target audience was the Lubombo RHMT. Regional scope was: improving performance of RHMT in providing supportive supervision including mentoring to all health facilities in the region; increasing number of health facilities that meet their regionally set HIV and TB performance targets (which will be set in collaboration between MOH QM team, RHMT, other regional partners) and Regional strategic Information Department (SID).

At the health facility and community level, the project's target audience included facility and community healthcare workers, community-based HIV organizations/community sub awardees, and recipients of care and services from supported facilities and selected communities. The facility and community level scope was: increasing number of individuals who are aware of their HIV status and successfully linked to appropriate services for each demographic group of adults, adolescents, and children, respectively; increasing number of competent health personnel that are providing HIV/TB/PMTCT testing services, linkage to care and prevention, and implementing stigma and discrimination free strategies for PLHIV and key populations.

3. Evaluation Purpose and Questions

Evaluation purpose

The overall purpose of the evaluation was to assess the program performance to understand whether the intended objectives of the project were achieved at the end of year 3 and 5, respectively. Additionally, this evaluation documents lessons learned for future improvement, accountability, transparency, generating a set of clear forward-looking and actionable recommendations logically linked to the evaluation findings and conclusions.

The evaluation results will contribute towards the evidence-base for the Government of the Kingdom of Eswatini and PEPFAR/CDC, establish key recommendations for follow-on program design, effectiveness, and continuous program improvement.

A complete description of this evaluation's statement of work/approved protocol and evaluation cost is provided in Annex A and Annex G, respectively.

Evaluation objectives

The specific objectives of the evaluation were:

- To review and document the progress made by the project in supporting ENAP, the RHMT and health facilities to provide effective HIV services according to MOH standards and guidelines. Assess effectiveness, efficiency, and quality of the project at national, regional, and facility service delivery levels, identify implementation gaps and challenges and determine how well the project is achieving its goals, objectives, and performance targets;
- To document lessons learned and provide recommendations that will inform programming directions for the project and the design for the follow-on project;
- To make specific proposals for project sustainability (institutionalization and capacity/ ability to maintain the project gains) and exit plan given its current level of funding for clinic staff / human resources;
- To determine if the project has improved the quality of HIV care and treatment services in Eswatini, resulting in reduced HIV-related morbidity and mortality;
- To quantify the increase in the number of individuals who are aware of their HIV status and successfully linked to appropriate services in the Lubombo region;
- To determine if the project has contributed towards decreased HIV incidence and increased HIV population viral load suppression in the region; and
- To determine if the project has contributed towards decreased mother-to-child HIV transmission rate in the region.

Evaluation questions

The evaluation was guided by five key evaluation questions:

1. How effective was the project in achieving its goals, objectives and performance targets?
2. What were the project's strengths, weaknesses, and gaps in planning, management, service delivery, and sustainability?

3. What were the constraints to successful implementation of the project?
4. How well did the project align with PEPFAR global priorities and approaches?
5. What were the implementing partner expenditures for providing comprehensive HIV services to clients (including HIV testing, linkage to treatment, retention, and viral load suppression)?

Intended audience

The primary intended audience for this report is CDC/PEPFAR, CDC-Lubombo implementing partners (URC and her sub awardee partners), the Ministry of Health and her stakeholders at national and sub-national levels, and the Lubombo Regional Health Management Team. Other audiences include other CDC and PEPFAR implementing partners, Health Sector development partners, donors and multinational agencies, and all stakeholders involved in HIV programming in the Kingdom of Eswatini and Africa region.

4. Evaluation Design, Methods, and Limitations

Evaluation design

The evaluation was a **non-experimental descriptive, cross-sectional design** that involved a comparison of baseline results, mid-term and end-line status of project implementation. The evaluation design complied with the PEPFAR's Evaluation Standards of Practice. The evaluation used a mixed methods design incorporating both quantitative and qualitative methods. After reviewing project documents, the evaluation team collected qualitative data through Key Informant Interviews (KIIs) and Group Key informant interviews (FGDs) with project stakeholders, direct observation at sites, and interviews with project beneficiaries during the health facility survey. Quantitative data included information obtained during the health facility survey, secondary data review, and project performance data.

Evaluation methods

Evaluation approach and team

URC adopted a participatory approach to conduct the evaluation. A Lubombo Project Evaluation Reference Group composed of key country stakeholders was constituted to conceptualize and build consensus on the study approach (including the tools to be used). Extensive consultations were held with the Evaluation Reference Group to understand how it envisages the contribution of the evaluation to the larger process of implementing HIV and TB response in the country. The resultant evaluation study protocol was later submitted to and approved by the MOH Eswatini Health Research Review Board and CDC ADS.

The evaluation team included three international experts from the URC Home Office: Dr. Swati Sadaphal, (Team Leader and M&E Expert); Dr. Babatunde Sanni (HIV/TB and Health Systems Expert), and Dr. Eric Lugada, (HIV and Clinical Support Systems Expert); as well as a locally-based expert: Mr. Mandhla Mehlo (M&E and Public Health Expert). A team of six data collectors was deployed to conduct the surveys in the sampled health facilities in Lubombo region. The evaluation team received managerial, logistical and administrative support from the URC project staff based in the URC Eswatini office. Abridged bios of the evaluation team members and their conflict of interest statements are provided in **Annex E** and **Annex F**, respectively.

Evaluation sites and respondents

From the literature review of the project documents and the approved evaluation protocol, the evaluation team established a list of potential stakeholders and sites to participate in the evaluation, and in consultation with the URC project team and the ERG selected the respondents and sites to participate in the evaluation (**Table 2**). The evaluation team identified and clustered evaluation main stakeholders into the following groups:

- URC project leadership, unit leads, technical officers at national level and other project staff as relevant to the evaluation questions
- Government counterparts / ministries and institutions both at national and regional levels
- Implementing Partners – governmental and non-governmental organizations (NGOs)
- Beneficiaries/ capacity building trainees, mentorship and support supervision

Table 2: Data collection methods, number and types of participants

Data collection method	No.	Participant type
Key Informant Interviews	34	URC project and subgrantee staff- Country Director, Finance director, Technical Directors, project theme/unit leads, CDC, MOH- national and regional - RHMT members, ENAP, NTCP, Sexual and Reproductive Health Unit (SRHU), Strategic Information Department (SID), PEPFAR partners, UN agencies-UNAIDS, World Health Organization (WHO), Nursing school heads, nursing council
Focus Group Discussions	13	Health providers- Nurses, HTS counsellors, Expert clients, Lay counsellors, Mentor mothers, Teen club members
Direct Observation/ Health Facility Survey (Questionnaires)	14	Health facility site visits (30% of total project-supported)

- Health facilities and institutions that were supported by the project
- Donors and other NGOs working in the sector

Data collection methods

The data collection period was from April to June 2020. The data collection methods were as follows:

Project document review: The evaluation team reviewed the background documents provided by URC, CDC, and MOH. These included work plans, progress reports, baseline report, strategic plans, technical reviews and information, education communication materials from the project as well as PEPFAR country operational plans, progress reports, guidelines, strategies, and document related to MOH response to HIV. A retrospective desk review of program documents relating to budget allocations and expenditure reporting such as expenditure reports, annual reports, and project planning and financial reports were also conducted.

Performance data review: The evaluation team reviewed data from the project performance monitoring plan (PMP). Data was analysed to identify trends and assess performance against targets. The team also conducted secondary data analysis of the PMP, and other data provided by the project to determine whether targets were achieved (by percentage) and were disaggregated by gender, age, and risk classification when possible. A template from the PEPFAR expenditure analysis tool focusing on IP expenditure analysis for the years 1-5 of implementation were used to collect data for expenditure analysis.

Key informant interviews: The team conducted an extensive range of interviews to collect data relating to evaluation questions. Respondents were purposively selected and were contacted through email to participate for KIIs. The selection of respondent categories is described above. The criteria of respondents' selection within the respondent categories included: informants familiar with the project activities and/or project beneficiaries. Those informants who indicated their willingness to participate were interviewed by the team members through phone/Skype/Zoom on mutually agreeable time. A KII guide and note taking form was used to elicit responses from the respondents. The list of key informants interviewed is provided in Annex C.

Direct observations: Site visits were conducted by the Local Consultant along with six data collectors to purposively selected facilities and institutions (n=14)

that benefitted from URC project support. The criteria of site selection: within two hours of distance from the capital, high- patient volume (defined as more than 1,000 active ART clients), received URC project support for at least three years. The main aim of this approach was to observe and assess assistance utilization and effectiveness in the provision of services to end users of the services. A health facility survey questionnaire was developed to structure direct observations and key aspects to look at during the site visits and included qualitative questions for the facility in-charge.

Focus Group Discussions: A total of 13 FGDs (with an average of two participants per group) were conducted, including 12 FGDs among service providers and one with teen club members at the health facilities. Respondents were purposely selected, and a structured interview guide were used to elicit responses. The selection of respondent categories is described above. The criteria of respondents' selection within the respondent categories included: informants familiar with the project activities and/or project beneficiaries.

Data management

All data collection tools are presented in Annex B. Structured interview guides and survey questionnaires, standardized procedures for interviewing, and note taking ensured consistency and objectivity in interpretation of findings. Interviewer notes were prepared immediately following each KII and GKII. Primary quantitative data from health facility surveys was collected on a paper-based questionnaire and was entered into MS Excel and reviewed with the data collectors on daily bases. Summary data from quantitative survey, KIIs, FGDs, document review, and secondary data analysis were distributed among team members. Multiple team meetings were held for data triangulation and interpretation of the results.

Data analysis and validation

Qualitative data transcripts were analysed by each evaluator, first independently and then as a team, using content analysis for generating themes along the evaluation questions and project results framework. The evaluators analysed qualitative data from the interviews connecting the data to evaluating questions and focusing on relationships context, interpretations, homogeneity, and outliers in relation to key informant views on project performance.

Qualitative data was triangulated with quantitative findings derived from project reports, the PMP, and health facility survey to provide more insights and contexts than quantitative data provided. Secondary data obtained through documentary review complemented primary data (obtained through interviews and observations). MS Excel was used to analyse the quantitative, financial, and program performance data, generating graphs and tables to present the findings. At the end of data analysis, the evaluation team triangulated all sources of information to develop findings and conclusions. Following the submission of the first draft of the report, the evaluation team met with the project staff to discuss and validate the preliminary findings.

Ethical considerations

The evaluation team ensured that ethical standards of confidentiality and protection of human subjects are met. The study was approved by the Eswatini National Human and Health Research Review Board (ENHHRRB) and the CDC Associate Director for Science (ADS). Oral informed consent (read from a written document—see Annex D) was administered to inform respondents of the purpose, process, potential risks, use, and confidentiality of the information and their right to refuse to participate at any time. Health facility respondents were interviewed in private in a facility consultation room. All interviewers and local data collectors received

training in ethical protocols and data collection tools and methods to ensure that no identifying characteristics of respondents were recorded during data collection. As much as possible, all identifiers were removed to achieve a de-identified data set to protect the respondents. Respondents did not receive any form of incentive to participate in the study. All data that the evaluation team collected were kept in accordance with data security standards as agreed upon with URC and guided by URC data management policies.

Evaluation limitations

Several potential limitations to the evaluation data and findings were identified during the design and implementation of the evaluation. Most were identified early, enabling URC and the evaluation team to take effective mitigating measures.

This project evaluation is based primarily on information collected from government counterparts and implementing partners (indirect beneficiaries) rather than from project direct beneficiaries (patients or community members) for evaluation of outcome level results. The evaluation assesses achievement of the project outputs and the likelihood of results on the outcome and impact level. While this evaluation approach provided useful illustrations of changes at the beneficiary level, and examined the contributing causal mechanisms, this data is not statistically representative for the entire population of project beneficiaries. Moreover, the evaluation focused on project-supported sites and programs and does not present a true representation of the entire region and the entire national AIDS program. There are possible biases in the selection of respondents since locations and stakeholders were selected jointly by the evaluation team and URC team on a purposive non-random basis. To overcome such limitations, the evaluation team triangulated information across multiple sources and with secondary quantitative information.

The implementation of evaluation activities was affected by the coronavirus disease (COVID-19) pandemic during the period from March to June 2020. The international team members could not travel to the country to conduct in-person interviews with the key stakeholders. Initially, the availability and response rate of the key stakeholders to participate in interviews, make documentation available, and facilitate meetings and introductions affected the timeline of data collection. However, the team planned all activities considering the COVID-19 international and country regulations to engage the key stakeholders for data collection and completed all evaluation activities as per the protocol and workplan. Key respondents were contacted and interviewed remotely using phone or internet to mitigate the limitation of travel restrictions imposed due to the pandemic. A few national level MOH respondents were unable to participate in the interviews because they were responding to the pandemic. In such instances, alternate respondents familiar with the project were interviewed. Health facility survey and FGDs were conducted by a team of local data collectors under the direct supervision of the Local M&E Expert, when country was in partial lockdown with travel allowed to Lubombo region. All local COVID-19 mitigation measures were undertaken during data collection to minimize health risk to the data collection team and respondents.

To mitigate the impact of numerous respondents focusing their recollections disproportionately on the ongoing COVID-19 pandemic response in the country, survey and interview questions were designed to include project specific anchor dates and terminology. Respondents were given time to reflect before answering to mitigate potential recall bias. Survey teams were trained extensively on interviewing skills and avoidance of leading questions to mitigate social desirability bias.

5. Findings and Conclusions

5.1 Evaluation Question 1:

How effective was the project in achieving its goal, objectives, and performance targets?

Findings

A majority of key informants (more than 95%) interviewed perceived that the project has been effective in achieving its goal, objectives, and targets. Detailed evaluation findings from various data sources for each project objective are described in sections below.

Review of project's goal level or long-term outcomes

Table 3 shows a comparison of some of the project's long-term outcomes at project baseline and end line. Data from Swaziland HIV Incidence Measurement Survey (SHIMS), show that the national HIV incidence and prevalence rates among population 15 years and older has reduced by 50% and 13% respectively. Similarly, UNAIDS reports estimated that HIV incidence, HIV prevalence, AIDS-related deaths and TB-related deaths among people living with HIV/AIDS (PLHIV) have reduced over time. However, mother-to-child transmission of HIV (MTCT) rate at six weeks remained constant at about 2% nationally.

Table 3: Review of project's long-term outcomes

Long-term outcomes indicators (National)	Baseline (source)	End line (source)	Changes
HIV incidence (≥15 years)	2.4% (SHIMS-2010; 2012)	1.2% (SHIMS2-2017; 2019)	-50%
HIV incidence per 1000 population	11.31 [10.05–12.49] (UNAIDS, 2015)	4.8 [3.81–6.2] (UNAIDS, 2019)	
HIV prevalence (≥15 years)	31% (SHIMS-2010; 2012)	27% (SHIMS2-2017; 2019)	-13%
HIV prevalence (15–49) per 1000 population	28.9 [26.8–30.4] (UNAIDS, 2015)	27 [24.6–28.7] (UNAIDS, 2019)	
MTCT rate at 6 weeks	National: 2.2% (MOH, 2013) No UNAIDS estimate for 2015	National: 2% (2-3%) (UNAIDS, 2019)	No change
AIDS-related deaths (all ages)	2900 [2300–3300] (UNAIDS, 2015)	2300 [1900–2900] (UNAIDS, 2019)	-7%
TB-related deaths in PLHIV	790 [550–1100] (UNAIDS, 2015)	600 [430–810] (UNAIDS, 2017)	-24%

Objective 1. To provide TA to MOH and the ENAP to develop performance standards, up-to-date guidelines, SOPs, and data tools to enhance quality service delivery.

The project evaluation identified that the project implemented activities towards achieving Objective 1 through provision of technical assistance to the Ministry of Health (MOH) and the Eswatini National AIDS Programme (ENAP) to develop performance standards, up-to-date guidelines, Standard Operating Procedures (SOPs), data tools, and nurse training curricula to enhance quality HIV/TB service delivery. At the onset, the project developed conceptual framework and capacity building plan that defined the technical approach based on the initial baseline assessment. Furthermore, the project provided direct technical support through the ENAP Technical Working Group (TWG) to update policies, guidelines, SOPs, job aids, and other key documents in line with international standards. See **Table 4** for a summary of type of documents and trainings for which URC provided support.

In collaboration with ENAP, the National Tuberculosis Control Program (NTCP) and other PEPFAR partners, the project conducted workshops, meetings and expert reviews to integrate care and treatment services into pre-service training curriculum of the four nursing training institutions in project year 1 and 2; Good Shepherd Nursing School (GSH), Southern Africa Nazarene University (SANU), Eswatini Medical Christian University (EMCU), University of Eswatini (UNESWA) Nursing School. As a result, all nursing training institutions have a revised competency based pre-service training curriculum that includes modules on HIV care and treatment and approved by the Swaziland Nursing Council. The project also provided technical assistance to the four institutions to incorporate clinical tools for HIV service delivery in the student's logbook to improve the skills of nursing students and graduates. In project year 1 (PY1), 276 health care workers and 71 nursing students were trained on updated on HIV care and treatment guidelines, SOPs, and job aides. In project year 4, 163 nursing students and graduates were trained on Integrated Management of Adolescent and Adult Illness (IMAI) from the four institutions.

The project supported ENAP quality improvement (QI) activities through the development of National HIV Service Standards (NHSS) for continuum of HIV care and treatment as well as TB/HIV management, this promulgated by Eswatini Standards Authority (SWASA); developed and piloted National HIV Service Quality Assessment Tool in 20 facilities across all regions. Moreover, developed training materials and trained 25 National HIV Service assessors and implemented the tool to improve quality of HIV services across service settings; conducted two National HIV Semi-Annual Reviews (NaHSAR). Furthermore, the project facilitated the adoption of Regional HIV Semi-Annual Reviews (ReHSAR) performance targets at 42 facilities, conducted service delivery assessments in 16 health facilities across four regions, and the project facilitated the national collaborative learning workshops such as National Viral Load Results Utilization and Quality Improvement Collaborative.

The project implemented strategic quality improvement work to inform evidence-based programming on HIV care and treatment and HIVDR by the establishing the National HIVDR Clinical Expert Committee; development of the Early Warning Indicators (EWI) protocol; adaptation of the WHO Early Warning Indicators data collection tools for monitoring HIVDR; facilitation of the integration of HIVDR and MDR-TB management and introduction of new TB and HIV drugs; provided support to the HIVDR EWI system implementation in all regions of the country. In addition, the project strengthened the HIV testing services through the piloting of integrated universal and targeted HIV testing in the Lubombo region to inform the HTS TWG policy

decision; standardized External Quality Assurance (EQA) for HIV testing using the WHO tool; supported the production of testing panels and coordination of feedback of proficiency testing panels for 350 HIV testing sites in all four regions. Furthermore, working with ENAP and other partners in project year 4, training package was developed for the ART Dolutegravir (DTG) based regimen, and supported ENAP led trainings of 1,396 HCWs nationally.

Data from Health Facility Direct Observation and Survey showed that the updated guidelines and SOPs, and job aids on HTS, HIV prevention, HIV care and treatment were available at the surveyed health facilities. All service provider FGDs respondents reported skills improvement and use of updated policies, guidelines, SOPs, and job aids on HTS, HIV prevention, and HIV care and treatment. Some of the respondent's quotes are provided below:

"We are well-knowledgeable about the work as the project has provided training and written information." Key informant HTS counsellor

"The trainings that URC provides enable me to get knowledge on how to perform my tasks and I also get to learn about new drugs that have been introduced." Key informant mentor mother

"Trainings helps us as Expect clients to be more knowledgeable so that we can educate clients on importance of Adherence, being able to conduct index testing. Expert Clients are usually given a strategy on how to convince clients to give their indexes and do follow up." FGD expert clients

Table 4: A summary list of URC-supported products and trainings

HIV Testing Services

- SOPs for new PIHTS algorithms (2019–2020); Revised PIHTC SOP' to include — Stigma & Discrimination reduction strategies (2019–2020)
- Re-testing for Verification Guidelines, SOPs and Job Aids (2019–2020)
- HIV index testing SOPs (2019)
- Supported the National HTS Partners Meeting (2016–2020)
- Revision of Provider Initiated HTS training manual, IMAI and NARTIS training manuals according to revised 2018 guidelines (2019–2020)

HIV Management

- Drafted the National ART delivery models guidelines & SOPs (2019–2020)
- SOPs for implementing community-centered models for ART service delivery (June 2016).
- Eswatini integrated HIV management (2018)
- National policy guideline for community-centered delivery in Eswatini (2019)
- Advanced HIV management 2019–2020
- Amendment to the 2018 Eswatini integrated HIV management (2019)
- Swaziland pediatric HIV/AIDS treatment guidelines (2019–2020)
- HIV linkage case management (LCM) (May 2019)
- Sexually Transmitted Infection management protocol (2019)
- Viral load implementation plan (in collaboration with PEPFAR lab partner) (2018–2020)
- SOPs for clinical implementation of routine viral load monitoring including stepped up adherence, sample collection, handling and transportation, sample processing and result reporting, interpretation and patient follow-up

HIV/SRH/TB Integration

- SOPs for Post GBV care (2018–2020)
- Isoniazid Preventive Therapy Register (2019)
- Revised the NARTIS Training curriculum and participants' manuals (2018–2019)
- Update of Swaziland Integrated HIV Management Guidelines (2018–2019)
- Sexually Transmitted Infection management protocol (2019)

M&E Tools

Printing and distribution of the following:

- HTS register/ logbooks: HTS Register (with risk assessment), HIV Self-Test Logbook, (2016–2020)
- Index testing logbook, LCM logbook, LCM Monthly summary, HIV screening and the HTS Monthly integrated summary sheet (2018–2020)
- Revised recording and reporting tools in line with updated guidance and disseminated documents to key stakeholders (2016–2020)

Training

- Developed the ENAP capacity building plan to address organizational weaknesses highlighted in the 2015 baseline organizational capacity assessment 2016–2017
- Community Healthcare's training module for communicable diseases 2018
- A training Toolkit was developed to train national, regional and facility staff in management of the Health Information System (HIS)
- Developed a Documents and Records Management (DRM) training toolkit 2016–2020
- Trained health care workers on the updated policy guidelines 2016–2020

Health System Strengthening (HSS)

- Established the HIV Partners Coordination Forum in partnership with ENAP 2016–2019
- Facilitated the review of the ENAP annual work-plan 2017–2019
- Developed and Launch of the ENAP knowledge management portals and tools 2018–2020
  - ENAP Website
  - ENAP Resource Centre
  - ENAP Quarterly Newsletter
- SOPs for Stepped Up Adherence Counselling (SUAC) 2019
- Inter- and Intra-Facility Linkage Case Management SOPs 2019
- Central Documents Repository in the ENAP Quality unit 2018–2020
- SOPs for HIV-DR Investigation and Management. 2018–2019
- National Risk Evaluation for Presumptive HIV-DR Tool developed for HIV DR risk evaluation 2018
- National HIV Service Standards (NHSS) for continuum of HIV care and treatment
- Conducted National HIV Semi-Annual Reviews (NaHSAR) and Regional HIV Semi-Annual Reviews (ReHSAR)
- Developed and piloted National HIV Service Quality Assessment Tool
- Facilitated the national collaborative learning workshops such as National Viral Load Results Utilization and Quality Improvement Collaborative
- Provided support to the HIVDR EWI system
- Standardized External Quality Assurance (EQA) for HIV testing

The lists of the documents that benefited in the technical support over the life of the project are presented in **Annex I**.

Objective 2. To build the Lubombo RHMT's capacity to employ strong stewardship and ownership role in quality management of HIV and TB clinical services to improve and sustain high-quality performance in HIV/TB service delivery at the facility level.

Project reports review and key informant interviews data revealed that the project conducted capacity building at the regional level including dissemination of guidelines, SOPs, standards; preparation of regional work plans; conducted joint support supervision with RHMT to health facilities; facilitated ReHSARs, CDC/PEPFAR-led site improvement through monitoring of systems (SIMS) as well as training of health care workers. The project provided a well-informed capacity building by developing a capacity building plan that aligned with the RHMT terms of reference. The capacity building plan was based on the MOH capacity metric. The use of the RHMT performance score card to track performance saw performance scores among the RHMT members increasing from 25% at baseline (2015) to 85% in Year 3 (2018).

The key informants from RHMT alluded their ability to perform their duties from the TA support received from the project as the support was structured in a way that mimicked the regional MOH structure to ensure effective capacity building. KII respondents mentioned improvement in the quality of service provision and consequently improvement of key indicators related to quality improvement projects (QIPs) and viral load suppression. Moreover, based on the 2018 Annual Lubombo Regional Report, 90% (38/42) of the facilities met their performance targets.

During 2017-18, the project successfully supported the Lubombo RHMT to take the lead in the Annual National Quality Assurance Process, which utilized the Stepwise Process for Improving the quality of HIV Testing Services (SPI-HTS) checklist to assess several areas in HTS, adherence to national guidelines and SOPs, and appropriate counselling practices. As per the Project Annual Report 2018, the overall score for the region was 88%.

Health facility direct observation and survey data showed that the supervision and mentoring rates at surveyed heath facilities was, as reported by respondents, 93% (13/14), of which the RHMT was present in 70% of surveyed facilities (**Table 5**). Supervision activities improved the delivery

Table 5: Supervision and mentoring rates at surveyed health facilities

Who provided Supervision visit	Timeline	Number of facilities	Percent
Regional Matron and URC mentor	March 2020	4	31.0%
Regional Matron	Feb-Apr 2020	5	39.0%
URC mentor	Oct 2019	1	7.5%
EPI	July 2019	1	7.5%
MOH	2018	1	7.5%
Yes, no data on who provided visit	No data	1	7.5%
	Total	**13**	**100%**

(Source: Health Facility Direct Observation and Survey, May 2020)

of services at regional and health facility level as confirmed by the stakeholders interviewed. These supervision activities included site visits, use of checklist and job-aids, on-site staff mentoring.

> *"The support come in handy to build the capacity of the health care workers on issues of HIV care. For the region is almost close to reach the 95-95-95 target even though we still have a gap with man and youth. And our viral load suppression is around 93%, this achievement was as a result of continues data review and identifying the gaps which was mainly supported by URC."*
>
> Key Informant RHMT

Evidence of increased RHMT stewardship to implement and monitor the regional health work plan was showcased by recognition of the region as the best performing region in HIV/TB services during NaHSAR meeting in November 2018, and RHMT-led Cervical Cancer (CaCx) Screening scale up in Lubombo. The RHMT spearheaded the PEPFAR surge implementation with a goal to achieve 95-95-95 targets in Lubombo during the period May 2019-September 2019 (Project Annual Reports, 2019).

However, the key informants noted unavailability of sustainability strategy, resource gaps, and integration of the system into the government structure as project gaps (see details under evaluation question two findings).

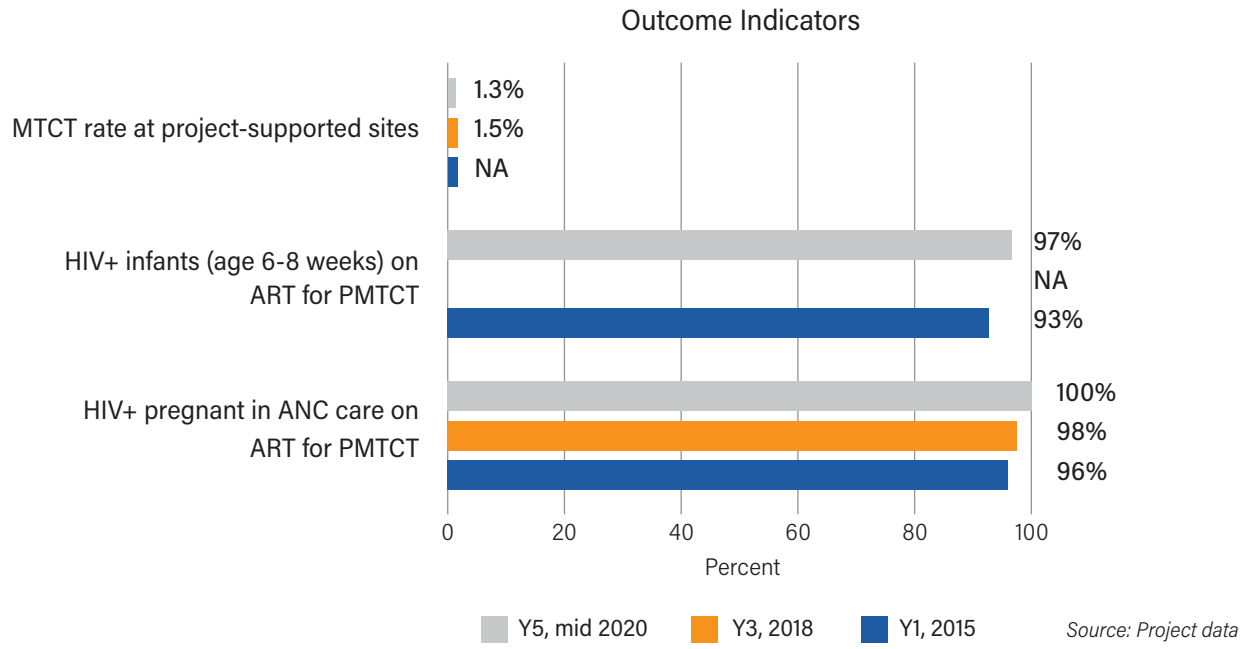
Objective 3. To support comprehensive and integrated universal scale-up of adult and pediatric HIV and TB clinical services at all facilities and selected communities in the Lubombo region.

The evaluation team found that the major project activities to achieve Objective 3 were directed towards increased competency of health personnel that were providing HTS, improved linkage to care and prevention, implementing stigma and discrimination free strategies for PLHIV and key populations; increased proportion of PLHIV in the region receiving comprehensive HIV care (integrated with non-communicable disease care); increased retention in care and treatment; increased identification of TB cases amongst HIV patients already in care; increased percent of eligible PLHIV in care who have received TB preventive therapy; increased proportion of TB patients with HIV who received ART; increased number of HIV patients that received quality-assured TB and MDR TB diagnosis and treatment services; increased proportion of mother-baby pair retained in care; and increased proportion of PLHIV that are receiving integrated SRH (FP, Cervical Cancer screening, etc.) and HIV services. The project provided assistance with recruitment, training and placement of human resources (such as lay counsellors, expert clients) in the health facilities. The project also supported infrastructure, equipment and logistical support. Examples included printing and distribution of guidelines/tools, transportation, facility repairs, building cough booths etc.

In Year 1, the project provided direct service delivery to 33 facilities in the Lubombo region, which increased to 39 in Year 2, and 42 in Years 3, 4 and 5. The project introduced standardization of practice and use of guidelines/tools/job-aids aimed at improving quality of care outcomes through training and mentoring health facility teams. Service delivery tools such as checklists and protocols were incorporated at each site. These tools covered areas of HIV care and treatment, TB-HIV and PMTCT. These tools were introduced/incorporated/ updated constantly throughout the project duration.

Review of project data (**Figure 2**) showed that MTCT rate for infant age six weeks in project-supported sites was 1.3% in year 5 as compared to the national

Figure 2: Trend analysis of PMTCT outcome indicators

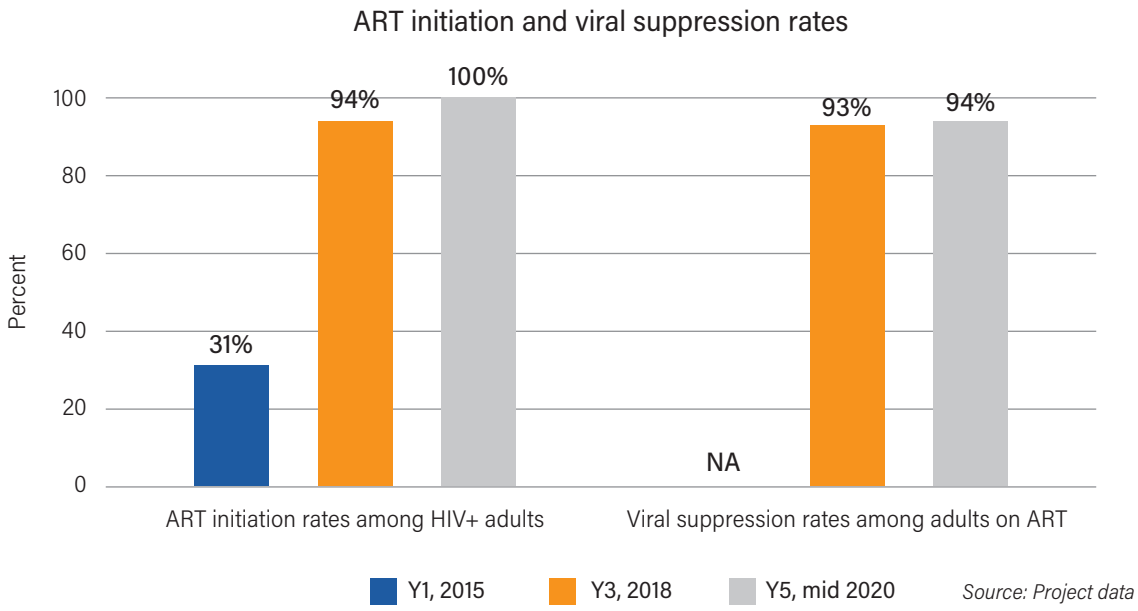


MTCT rate of 2.7% (CI 1.6-4.3) according to UNAIDS, 2018 estimates. The percentage of HIV-positive pregnant in antenatal care on ART for PMTCT in project-supported sites was 96% in Year 1, increased to 98% in Year 3, and to 100% in Year 5. According to a draft Annual Health Performance Report, 2019, this percentage is estimated at 86% for the entire Lubombo region. Percentage of HIV-positive infants (age 6-8 weeks) on ART for PMTCT was 93% in Year 1 and increased to 97% in Year 5.

The percentage of HIV-positive adults initiated of ART in project-supported sites was 31% in Year 1, increased to 94% in Year 3, and to 100% in Year 5. Percentage of HIV-positive adults on ART with viral suppression was 93% in Year 3 and 94% in Year 5 (**Figure 3**). According to SHIMS-2, 2019, viral suppression rates among adults on ART is estimated at 92% for the country. Swaziland adopted the test and start policy and began to roll out viral load (VL) monitoring systems in 2017-18. In Lubombo, the number of sites providing viral load testing increased from 28 in PY2 to 42 in PY5. According to the National ART Data Verification process conducted in 2019, which was led by the MOH, the project managed to achieve a VL testing coverage of 95% (Semi-annual project report FY2020).

Analysis of PEPFAR COP key performance indicators achievement (**Table 6**) showed that the project performed well towards achieving indicators related to HTS and PMTCT (exceeding 95% of target achievement). Key performance indicators that achieved more than 60% but less than 90% of target achievements were TB-HIV, ART initiation, and viral suppression. The TB-HIV indicators had the lowest performance with less than 60% of target achievement in Years 2, 3, and 4; there were some improvements by mid-Year 5, however. Because activities for gender-based violence (GBV), voluntary medical male circumcision (VMMC), pre-exposure prophylaxis (PrEP) for HIV prevention, and cervical cancer screening and treatment started in Year 4 and 5, these indicators were not included in performance trend analysis.

Figure 3: Trend analysis of ART initiation and viral suppression rates



Source: Project data

Table 6: Five-year performance indicators targets and results analysis

Indicator	Target					Performance					Achievement				
	FY 16	FY 17	FY 18	FY 19	FY 20*	FY 16	FY 17	FY 18	FY 19	FY 20	FY 16	FY 17	FY 18	FY 19	FY 20
HTS_TST	56825	43127	68899	21973	15577	68173	76026	90508	75435	26936	120%	176%	131%	343%	173%
HTC_POS		4395	8747	1140	1380		3430	4050	3361	1220		78%	46%	295%	88%
HTS_Index			15316		1739			2627	2821	2757			17%		159%
PMTCT_STAT N	5746	5751	5751	5224	2874	5092	5293	5243	5075	2812	89%	92%	91%	97%	98%
PMTCT_STAT_D	6049	6054	6054	5728	2874	5114	5487	5271	5075	2812	85%	91%	87%	89%	98%
PMTCT_POS	2114	1977	2043	1569	920	1899	1604	1745	1522	909	90%	81%	85%	97%	99%
PMTCT_ART	1931	1878	2044	1569	920	1821	1514	1703	1522	909	94%	81%	83%	97%	99%
PMTCT_EID	2093	1878	2043	1299	928	1842	1902	2765	2293	934	88%	101%	135%	177%	101%
TB_STAT	996	977	734	636	176	673	457	389	390	188	68%	47%	53%	61%	107%
TB_ART		678	457	524	140		287	231	244	111		42%	51%	47%	79%
TB_Prev				44422	4864				37270	5040				84%	84%
TX_TB			43154		43757			33049		28647			77%		84%
TX_NEW	5818	7379	11038	2223	2111	4254	4590	4021	3426	1291	73%	62%	36%	154%	61%
TX_CURR	28630	37,270	44422	44422	41340	34684	30481	37908	39770	36859	121%	82%	85%	90%	89%
TX_PVLS_N		24652	33316	44509	41641		272	29829	30241	31584		1%	90%	68%	76%
TX_PVLS_D				44509	41641				31621	33717				71%	81%

Target Achievement ≥ 90%
Target Achievement ≥ 60% & < 90%
Target Achievement < 60%
No Data

** Semi-annual Fiscal Year (FY) targets and results*
Source: Annual progress reports (Apr 15- Mar 16; Apr 16- Mar17; Apr 17- Mar 18; Apr 18-Sep 19) and Semi-annual progress report (Oct 19-Mar 20)

Conclusions

The triangulation of the KIIs, health facility direct observation, survey data and the desk review indicated that the project through the implementation of the activities under objective 1 achieved the following outcomes; ensured availability and improved utilization of updated guidelines, SOPs and job aids by health workers; led to the use of competency based curriculum among nursing students on HIV care and treatment services (including TB/HIV collaborative activities); and improved quality of HTS, HIV care and treatment, HIVDR programming.

The project contributed to the regional coordination of the planning process and implementation of activities through the RHMT and its various committees which eased implementation of the project and technical capacity building, mentoring and coaching support to the health facilities in the region. This further resulted in the strengthening of capacities within the RHMT to lead implementation of their respective activities, monitoring and quality improvement of services. The strategy of aligning the capacity building to the RHMT terms of reference, identification of response gaps, and embedding implementation of the project into the regional structures are likely to elicit interest and promote ownership among the target groups.

At the service delivery level, the project scaled up integrated HIV and TB services in 42 health facilities in Lubombo region. The project ensured effective and efficient implementation of site level support by promoting integrated services, quality of care, and adherence to SOPs and guidelines. The coverage of services and outcome indicators improved over time in the last 4.5 years. The project achieved most of its performance indicators, as per the COP targets, in HTS and PMTCT services, and there were partial achievements in performance indicators related to ART initiation, viral suppression, and TB-HIV services. VMMC, GBV, PrEP and Cervical Cancer services were started recently in the last two years of the project.

Overall, the project was effective in achieving its objectives and contributed towards achieving the goal of reducing HIV incidence among adults and children and reducing HIV-related morbidity and mortality nationally and in the Lubombo region.

5.2 Evaluation Question 2: *What were the project's strengths, weaknesses, and gaps in planning, management, service delivery, and sustainability?*

Findings

Project Strengths

The strengths of the project in providing technical and administrative support to strengthen HIV and TB services at the national and regional levels are highlighted below:

Respondents appreciated the project's support of highly skilled competent technical assistance staff at national and regional levels. The respondents noted that the project staff were committed and dedicated despite working in a difficult region. The staff were highly responsive to changes in national policies and focused on achieving the objectives of the project.

Another strength mentioned was the project's responsiveness to the needs of stakeholders. Project was focused on building the local capacity and systems at the national and regional levels. After the baseline assessment to understand the capacity building needs of ENAP, the assessment results were used to develop strategies and activities to address policy/tools development, training, mentorship and service delivery gaps. The project was designed and implemented to complement the national HIV program and to improve efficiency by aligning resources to deliver services where they are most

needed. ENAP respondents identified the project as the main support partner for ENAP for HIV and quality improvement and the project provided support to build the capacity and systems in line with the stated project objectives. Data reviews and quality improvement activities contributed to project performance improvement. The project built the capacity of the RHMT to understand and use data for performance monitoring and decision making. The project maintained collaborative partnerships with stakeholders through plan sharing, activity alignment, and providing regular project status updates. Involvement of relevant stakeholders in the development of annual work plans, this engendered ownership and strengthened communication among stakeholders. The project facilitated a data-driven performance improvement process at facility and regional levels. At the service delivery level, health workers specifically highlighted that the support for supply chain management at pharmacy and quality improvement and management were beneficial. The project also created male-friendly corners for HIV services to address lower utilization of HIV services by men.

The project management and leadership team had a very good handle on the project implementation cycle, from project planning and monitoring to reviewing results. The team complied with donor and contractual requirements of the project, maintained technical and financial oversight for resource efficiencies, and conducted the required monitoring, evaluation and reporting of project results based on the terms and conditions of the award and PEPFAR funding rules and regulations. The project also conducted training and capacity building for sub-grantees to enable them to produce sub-grant deliverables and conditions. Regular feedback was obtained from all program staff, using granular data analysis and meeting regularly to assess progress.

The project used an adaptive programming approach to respond to the need of the Lubombo region, the most rural region with many hard-to-reach communities. The approach included division of one regional team into three project implementation zones; each zone was given the mandate to implement services independently. This inspired healthy competition in project performance and tremendously improved services within the entire region.

In terms of human resource management, the project supported staff capacity for ENAP and health facilities by ensuring identified staff positions were occupied. This included recruitment, continued salary support, and mentoring of staff, especially where the MOH was not able to reach due to logistics and resource issues. At national level, there has been a gradual shift to where seconded staff to government have been absorbed with the help of CDC/PEPFAR and employed directly by government, thus ensuring sustainability and continuity of the program. At regional level, mentors were trained throughout the entire region. Because of the lack of health workers, several nurse managers were trained and equipped to work closely with the RHMT. The zonal approach helped because workers were allocated in the zone they were living in, thus establishing an increase of sustainable capacity within the region.

Project Weaknesses

The stakeholders reported more challenges/constraints than weaknesses. Nevertheless, a major weakness reported by respondents was the nonexistence of a sustainability and exit strategy. Respondents pointed to problems of continuation of services/activities without a clear handover of responsibility or ability to address the resource gaps within government. The continuity of project gains and target achievements will reportedly be difficult to maintain as MOH will not be able to absorb all support staff under the project. The overwhelming

majority (>95%) of stakeholders reported achievements will not be sustainable at the service delivery level. For example, RHMT used project transportation to conduct supervision visits. Health workers reported using project vehicles to transport lab samples to the referral sites. Nurses mentioned that they will not be able to handle the workload in the absence of project-supported support staff and the current level of services will decrease.

On probing, respondents agreed that the main weaknesses of the project were related to time,

> *"Project created parallel system at facility level, which have caused confusion and made health care workers have an attitude towards the rollout of the CMIS"*
>
> MOH respondent

human resources and communication. The stakeholders pointed out that was inadequate time for the implementation of individual tasks at facility level by the project TA staff. The project was implemented in the Lubombo region, but the project officers were based near the main office in Mbabane. Therefore, most of their time was spent travelling to and from facilities, with less time at facilities to mentor staff for all technical areas. Respondents also complained about the disparities in compensation between project-supported staff (who were paid at a higher salary rate), and the government-supported health facility staff. They also noted, however, that it was not possible to retain health workers with specialized skills in the region without giving them incentives.

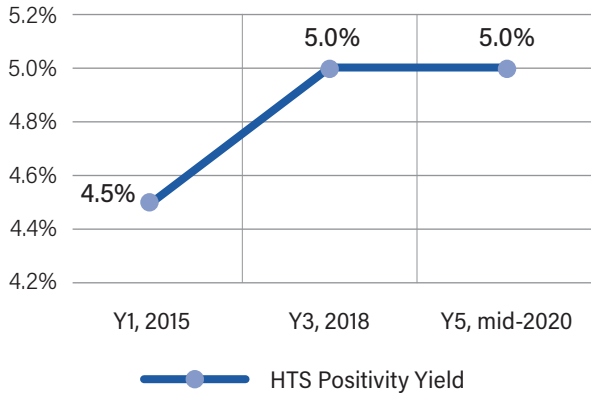
Another weakness reported was the perceived mismatch between the project work plan and the priorities /actions of the RHMT, which resulted in the project support being not fully integrated into the government structure of the RHMT. The RHMT respondent felt that the mandate of the project was not clearly explained to them, which made it difficult to guide the project effectively. Respondents particularly mentioned about the problem of creating a parallel system for data management that created duplication of work and confusion for the health workers. There were three parallel reporting systems for data: APMR, CMIS, and HMIS, which raised data quality issues. Project staff noted that it was difficult to balance who should to be involved in planning at the national, regional, and project level, as well as fostering ownership of the program. They tried to address these weaknesses through dialogue and deliberately involving all national administrative structures from ENAP and RHMTs.

Respondents identified weakness in project M&E, MCH, and SRH technical areas. However, they reported that these areas did improve over time. Sub-grantee respondents and project staff reported prolonged delays, as much as three months, in procuring funds for services from URC. This had resulted in delayed start of project-supported activities, such as VMMC and community-based ART services. A sub-grantee managed to provide some services using funds from other sources but did not report to URC during this time. When asked about whether they knew about the cause of delays, all respondents reported that there was a lot of back and forth between the URC country office and URC home office, as well as delays in URC home office and CDC approval processes. The respondents could not clearly pin-point the exact cause of the delay but thought this was due to lack of communications and inefficient internal protocols.

Project Gaps

The number of people receiving HTS services and HIV results increased over time, and target achievement was more than 100%; however, the overall HIV positivity yield for HTS services was in the range of 4.5- 5% (**Figure 4**). This rate is lower

Figure 4: Trend analysis of HTS positivity yield



than anticipated considering that the MOH HIV Annual Program Report for 2018 reported HTS positivity yield of 6.7% for the general population. For Lubombo region, it was expected to be 10%. The project implemented targeted testing modalities through index testing, self-testing, and at various entry points such as TB clinics, inpatient, outreach, and STI clinics to improve the yield. In Year 4, the yield was highest in TB clinics (31%), inpatient (17%), followed by index testing (9%). For all other sites, yield was between 1-5%.

Key informants reported sub-optimal implementation of index case testing due to lack of community sensitization and to gender and HIV stigma related issues that prevented contacts from returning for HTS services.

Health facility direct observation and survey results, KIIs, and project reports show gaps in ART retention. The gap areas were related to loss to follow-up of patients due to seasonal migration and to misinformation regarding contact details provided by patients. There was also occasional stock-out of ARVs. Care and treatment for NCDs in PLHIV and other opportunistic infections such as cryptococcal disease and cytomegalovirus retinitis were available through referral services to hospital. Health worker respondents at clinic level were not aware of any diagnostics for opportunistic infections in PLHIV other than TB.

TB in children was another gap area. The respondents reported a lack of diagnostic tools in children since most children are not able to produce sputum, lack of job aids, and drug stock-outs for pediatric TB preventive therapy dosages.

In surveyed health facilities, integration of SRH and family planning services with HIV services lagged compared to other services, notably PMTCT and TB. Respondents reported that more community awareness was needed for prevention and treatment of GBV cases since incident cases are not reported due to stigma and lack of education among community members. Another gap was the facilities did not get feedback on referred clients once the GBV cases were followed up by social workers. Nurse managers reported need for training in long-term FP methods such as IUDs insertion and removal. For cervical cancer screening and treatment, the gap noted was the community education and health worker counselling skills ensuring the safety of the procedure to the clients.

Teen clubs and other community support groups lack funding, members show up only if given incentives. Teenage pregnancy as a gap issue was noted by the respondents. PrEP services coverage was low, and gaps were in training of health workers. Respondents reported that clients preferred PrEP to be taken at home rather than at the health facility.

Another gap was coordination between partners. Project staff mentioned that the support at the regional level was by several IPs, for example, laboratory services had a different IP from URC which made it difficult to properly control laboratory services and link them to health care.

All the surveyed facilities used a schedule for sample collection by the National Sample Transport System (NSTS) to testing hubs with sample transportation

and results delivery frequency of two times per week. The project provided additional lab sample transportation support. None of the surveyed health facilities reported presence of lab information management systems or m-health based results delivery system.

Conclusions

Overall, the project was a lead PEPFAR partner for the ENAP HIV care and treatment program, as well as regional support partner to the Lubombo region. The opportunity to provide support at both levels rapidly allowed policy dissemination and implementation at the regional level. The major strengths of project were high-quality technical team, adaptive programming, responsiveness to stakeholders needs, resourcefulness, human resources management, sub-grantee capacity building, and effective project management and leadership.

One of the major weakness was the lack of a formal exit or sustainability strategy: continuity of project gains and target achievements will be difficult to maintain when the project ends. There is over-dependence of the RHMT on the project resources for their stewardship role and service delivery. Other weaknesses were the mismatch between RHMT and project action plans and priorities, multiple parallel data systems creating data quality issues, and delayed funding to project sub-grantees due to inefficient internal/approval processes.

Major gaps remaining are optimal HIV positivity yield and index testing, ART retention, TB in children, integration of SRH and FP services, care and treatment of other opportunistic infections, sustainability of teen clubs/other community support groups, and coordination between partners of delivery of services. Use of lab information management systems or m-health based lab results delivery system was non-existent.

5.3 Evaluation Question 3:

What were the constraints to successful implementation of the project?

Findings

The evaluation data reveal that there were some constraints experienced by the project during implementation which were beyond project's control. The key ones are highlighted below:

Socio-demographic constraints: According to Global Data Lab, Lubombo region is a remote area with very low socio-economic status; ranking third out of the four regions in Eswatini and ranked last (fourth out of four regions) in educational attendance percentage among children aged 6-11 years. Furthermore, the region also ranked third out of four for the Subnational Human Development Index showing its rurality (Global Data Lab, 2013-2019). Poverty and high transportation cost in the region for the patients to reach health facilities affect client access to health services. URC respondents mentioned that the higher unit costs because of the sparse population and terrain also resulted in higher expenses for the project implementation. FGDs and health facility survey data highlighted constraints due to gender disparity and HIV-related stigma that results in inadequate index testing, partner notifications and follow-up. There is high seasonal livelihood-related migration in the region to neighboring countries, thus resulting in high client loss to follow-up and challenges in ART retention. In year 2015-16, Lubombo region was hardest hit by drought, affecting the livelihood of the residents; some of project results were affected.

Human resource shortage: Almost all the respondents indicated constraints of human resource availability in the region, retention and high turnover of staff. The rurality of the region also made it difficult for staff to find appropriate accommodation in the area. During project implementation, the

RHMT staff turnover was rapid. Health care workers who were already trained had to be rapidly replaced; the new staff needed to be trained, with the result being the implementation of a continuous training cycle. However, this challenge was mitigated by the project's on-site training approach. The project directly hired service delivery staff such as Expert Clients, Lay Counsellors, Data Clerks HRH support to support health facility clinical staff to overcome the shortage in the region.

> *"We face high turnover rate, this removes trained staff and necessitates continuous capacity building, vacant position was not easily filled because of the remoteness of the Region."*
>
> Project staff

Frequent changes in Guidelines: Over the cause of the project timeline, many new guidelines were released by WHO. PEPFAR also adopted the new evidence-based approaches to improve the impact of the HIV interventions. These new approaches and guidelines included, consolidated HIV management guideline, introduced Post Exposure Prophylaxis (PEP), index testing and self-testing modalities to improve testing yield and coverage among the most at-risk population. The ENAP also updated national guidelines. Health workers needed to be retrained frequently for the revised guidelines and SOPs. However, there were lags between the release of new approach/guideline and its implementation at the facility level. For, example, the PEP Guideline rollout was impeded by the delay in updating national guideline at national level.

Inadequate infrastructure and stock-outs: There were occasional HIV testing kits and drug stock-outs for TB and ARVs, especially pediatric and child formulations at the central medical store. For example, the TLD transition to six months scripting was not possible due to stock-out of TLD. Health facilities often lack adequate infrastructure to provide comprehensive services. Some examples noted from the health facility direct observation and surveys were the following: inadequate space to provide patient counselling in private setting; absence of cough booths for safe sputum collection for TB diagnosis; and lack of transportation for patient referrals.

New epidemiological estimates: Data from SHIMS-2 estimated lower PLHIV burden in the country than earlier anticipated. This resulted in disproportionately high project performance indicator targets for Years 1, 2, and 3. The project adjusted the indicator targets for the remaining years based on the new epidemiological estimates.

Challenges with logistics, finance, and procurement: There was a sudden reduction in budget, i.e. the yearly budget dropped from 4.4 million to 3.4 million without adjustment of expected target outcomes and proposed activities. This decrease resulted in changes in training methodology, e.g. beginning onsite trainings in lieu of training workshops. Additionally, there was a delay in annual disbursement of funds from PEPFAR in Year 5 (due to the delay in finalization of the notice of award) to start implementation, and the project was obligated to spend all the funds within the short time remaining for the project fiscal year in line with the project work plan. Delays in donor approval of procurements, such as the 6-month delay for cervical cancer-related procurement, and delays in delivery of products from overseas affected timely service delivery. Restrictions at the service delivery level reduced the level of manpower at the facilities; specifically, according to respondents, a certain number of staff were required to be employed at the health facilities, but government had imposed restrictions on the number of new hires, thereby limiting human resource availability.

Community HTS provision was limited because of the intermittent presence of the community partner. PEPFAR allocated two partners to work on HIV testing services in the region. The project was mandated to carry out activities at facility, while a different PEPFAR partner was mandated to conduct community testing; the community and facility boundaries remained blurred, however, despite attempts to clarify and delineate responsibilities.

Advent of the COVID-19 pandemic: In the last year of the project, the COVID-19 pandemic led to a significant disruption of services, including complete stoppage of some services. The national lockdown and fear of contracting COVID-19 made it very difficult for the ART clients from hard-to-reach areas to access appropriate care and receive timely clinical and laboratory evaluations. Moreover, many health care workers were reallocated to join the COVID-19 mitigation team, which further decreased staff numbers to implement routine HIV services at the facility level.

Conclusions

Major constraints to successful implementation of the project focused around the socio-demography, human resources shortage, inadequate infrastructure, logistics, finance and procurement challenges, commodity stock-outs, and frequent changes in guidelines. New HIV epidemiological data released in 2018 estimated lower HIV prevalence and incidence in the country. For the initial three years, the project had based its indicator target-setting from the previous 2012 epidemiological estimates, thus the project performance showed sub-optimal results for target achievements. However, all these constraints were mitigated by implementing carefully planned interventions. The constraints did not prevent the implementation of the project except during the COVID-19 pandemic.

5.4 Evaluation Question 4: *How well did the project align with PEPFAR global priorities and approaches?*

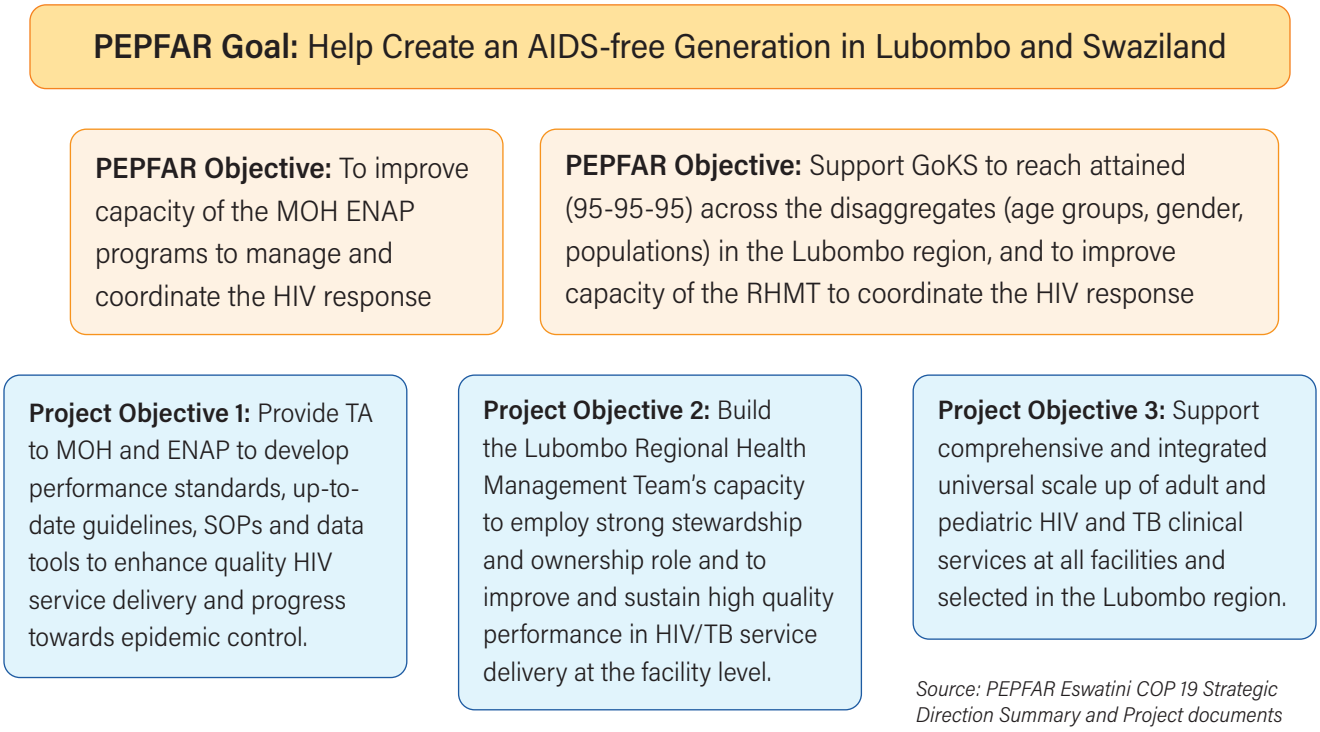
Findings

The overarching PEPFAR Goal is to 'Help Create an AIDS-free Generation'. The project goal of 'reducing HIV incidence in adults/adolescents and children and HIV related morbidity and mortality' was aligned with the overarching PEPFAR Goal. Alignment of the project objectives with the country priorities in terms of National Strategic Plan and PEPFAR priorities was seen across all project reports and other documents. The PEPFAR global priorities and approaches were annually translated into the PEPFAR Country Operational Plan (COP) of which the project been annually realigned to the PEPFAR global priorities and approaches. **Figure 5** below illustrates how the project aligned with PEPFAR global priorities and approaches.

The project started implementation under COP15. The pivot for COP15 was to achieve the UNAIDS 90/90/90 targets and epidemic control by delivering the Right Things --HIV Testing and LTC; ART; VMMC; PMTCT/Option B+; Condoms; Test and Start; PrEP-- in the Right Places, that is, focusing programs geographically and on communities with greatest need. This would have been achieved through fast track strategy and analyzing Investments in Health Systems.

Whereas the COP 16 pivot was centered on tailoring client services to reach epidemic control, UNAIDS (95/95/95) uses a client-centered approach to overcome the priority barriers to epidemic control. This strategy involved adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups. In addition, the strategy included adoption and implementation of DSD models, including six-month multi-month scripting and delivery models to improve identification and

Figure 5: Link between Project Objectives and PEPFAR Goal and Objectives



Source: PEPFAR Eswatini COP 19 Strategic Direction Summary and Project documents

ARV coverage of men and adolescents.

COP 17 focused on alignment of packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on adolescent girls in high HIV-burden areas; 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV; and children and adolescents living with HIV who require socioeconomic support, including integrated case management.

With COP 18, the focus turned to completion of TLD transition, including consideration for women of childbearing potential and adolescents, and removal of Nevirapine-based regimens. Scale-up of index testing and self-testing were included, along with enhanced pediatric and adolescent case finding, ensuring consent procedures and confidentiality are protected, and establishing monitoring of intimate partner violence. TB preventive therapy for all PLHIV was to be scaled up as an integral and routine part of the HIV clinical care package.

Following these achievements, COP19 centered on direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups. Emphasis was placed on completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including >80% access to annual viral load testing and reporting. Scale-up of unique identifiers for patients across all sites was included, along with VMMC, PrEP, and CaCX as prevention strategies.

The review of annual project reports shows that the project introduced changes to services in line with changes to annual PEPFAR COPs and aligned the program activities, project performance indicators, and targets for epidemic control in priority locations and populations each year. The project

management team respondents reported referring to the annual COPs during yearly project activities planning, budget allocation, and annual performance indicators target setting, which also included consultations with the CDC Eswatini team. The project team provided regular updates to the CDC Eswatini team and reported project performance data, details of activities implementation, challenges, and proposed remedial actions.

Conclusions

During the five-year project duration from 2015-2020, the project had fully aligned with PEPFAR goals, objectives, priorities, and approaches. Project activities, performance indicators, and targets evolved with changing PEPFAR global priorities and approaches.

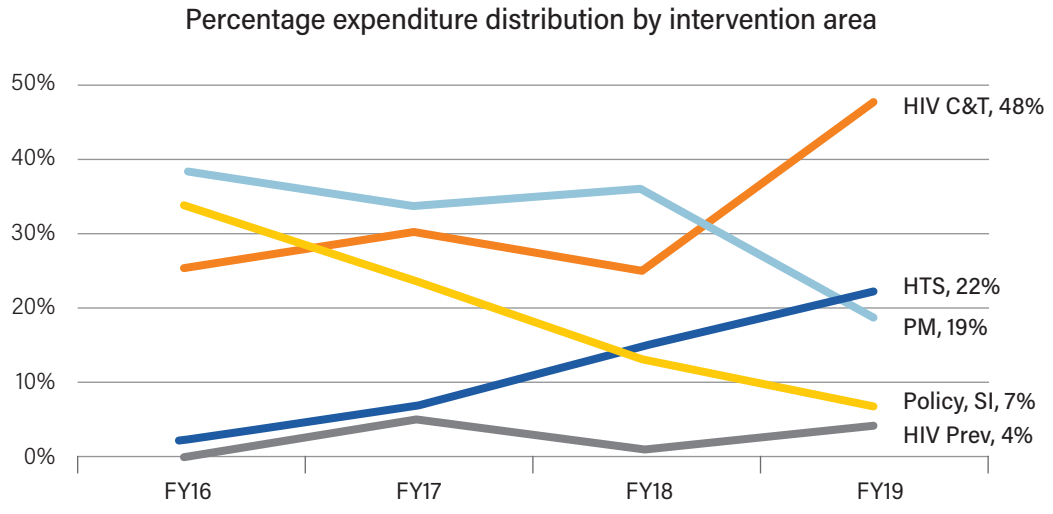
5.5 Evaluation Question 5:

What were the IP expenditures for providing comprehensive HIV services to clients (including HIV testing, linkage to treatment, retention, and viral load suppression)?

Findings

Data from the PEPFAR expenditure analysis for the years 1-4 of implementation was used to analyze project expenditure for each program area and type of expenditure categories. Program areas and sub-areas categories included: Project management (PM); HIV Testing Services (HTS); HIV care and Treatment (C&T), including PMTCT and cervical cancer services; Policy and Strategic Information (SI) support; HIV prevention services, including GBV, VMMC and Youth services. **Table 7** provides the detailed breakdown of expenditure under each program area and sub-areas. The average total expenditure per year was about $4.5 million. As seen from **Figure 6**, the Project Management expenditure, followed by Policy and Strategic Information expenditure, were highest in Year 1 (39% of total Year 1 expenditures), which gradually reduced by Year 4 (19% of total Year 4 expenditures). HTS expenditure was lowest in Year 1 (2% of total Year 1 expenditures) and gradually increased by Year 4 (22% of total Year 4 expenditures). HIV C&T expenditure was highest in Year 4 (48% of total Year 4 expenditures). HIV

Figure 6: Project expenditure distribution by intervention area, by year



Source: Expenditure Analysis Reports, 2016–2019

prevention expenditures were lowest in all years (about 0-5% of yearly expenditures).

Yearly expenditure categories (**Table 8**) included: Personnel (salaries for health care workers and salaries for other staff); Fringe benefits; Travel (international travel and domestic travel); Equipment (health equipment and non-health equipment); Supplies (pharmaceutical, health non-pharmaceutical, and other supplies), Contractual (contracted health care workers, contracted interventions, and other contracts); Construction; Training; Sub-recipients; Other (financial support for beneficiaries and all other); and indirect charges.

Year 4 expenditure analysis report shows that the highest expenditures were in Personnel (34%) and the lowest expenditures (1%) were in Health Equipment and Health Non-pharmaceutical Supplies categories. The project supported seven sub-grantees, which accounted for 12% of the Year 4 expenditures.

Key informants from CDC country leadership team and URC leadership team reported that all interventions were planned, and budget allocated for each intervention area and expenditure category during the planning at the beginning of each fiscal year. Respondents reported that the

Table 7: Summary of expenditure analysis, by year

Program Area	Sub-areas	FY16	FY17	FY18	FY19
Project Management		*$ 1,526,828 (39%)*	*$ 1,520,152 (34%)*	*$ 1,615,062 (36%)*	*$ 974,909 (19%)*
HIV Testing Services (HTS)	Service delivery (SD)	$ 73,461	$ 310,167	$ 302,853	$ 307,072
	Non SD (NSD)	$ —	$ —	$ 299,910	$ 333,751
	Male-specific SD	$ —	$ —	$ 39,959	$ 52,772
	Male-specific NSD	$ —	$ —	$ 43,230	$ 422,693
		$ 73,461 (2%)	*$ 310,167 (7%)*	*$ 685,952 (15%)*	*$ 1,116,288 (22%)*
HIV Care and Treatment	SD	$ 858,113	$ 1,003,467	$ 328,904	$ 422,693
	NSD	$ 132,022	$ 256,610	$ 1,148,137	$ 1,554,000
	PMTCT-SD	$ 32,279	$ 111,577	$ 72,687	$ 21,268
	PMTCT-NSD	$ —	$ —	$ —	$ 105,488
	Cervical cancer-SD	$ —	$ —	$ —	$ 186,648
	Cervical cancer-NSD	$ —	$ —	$ 4,220	$ 182,338
		$ 1,022,414 (26%)	*$ 1,371,654 (30%)*	*$ 1,553,948 (35%)*	*$ 2,472,435 (48%)*
Policy, Strategic information	National TA, and HR	$ 935,373	$ 572,044	$ 422,161	$ 381,472
	Strategic information (SI)	$ 388,423	$ 499,459	$ 148,125	$ —
		$ 1,373,796 (34%)	*$ 1,071,503 (24%)*	*$ 570,286 (13%)*	*$ 381,472 (7%)*
HIV Prevention	PrEP, GBV	$ —	$ 233,161	$ —	$ 63,463
	VMMC	$ —	$ —	$ —	$ 134,317
	Adolescents (Teen clubs, DREAMS)	$ —	$ —	$ 36,618	$ 35,087
		$ 0 (0%)	*$ 233,161 (5%)*	*$ 36,618 (1%)*	*$ 232,867 (4%)*
Grand Total		**$ 3,946,499 (100%)**	**$ 4,506,637 (100%)**	**$ 4,461,866 (100%)**	**$ 5,177,971 (100%)**

Source: Expenditure analysis reports (2016, 2017, 2018, and 2019)

interventions were implemented as planned in a timely manner and within allocated budget. The URC Eswatini project management team provided adequate oversight, management, and resources for management and implementation. However, there were reported delays in disbursement of funds to sub-grantees.

Conclusions

Most project interventions were implemented in a timely manner and within allocated budget approved by CDC. The project provided adequate oversight, management, and resources for management and implementation. However, the resources allocated were not equitably distributed among various aspects of HIV services. HIV prevention services received least resources. There were delays in allocation of funds to sub-grantees to carry out service delivery activities in a timely manner.

Table 8: Type of expenditure categories for Year 4

Type of Expenditure Categories	FY 19	Percent
Personnel: Salaries- Health Care Workers	$69,684	1%
Personnel: Salaries- Other Staff	$1,726,441	33%
Fringe Benefits	$816,179	16%
Travel: International Travel	$21,243	0%
Travel: Domestic Travel	$128,256	2%
Equipment: Health Equipment	$60,726	1%
Equipment: Non-Health Equipment	$102,905	2%
Supplies: Pharmaceutical	$ —	0%
Supplies: Health-Non-Pharmaceutical	$55,888	1%
Supplies: Other Supplies	$126,545	2%
Contractual: Contracted Health Care Workers	$9,171	0%
Contractual: Contracted Interventions	$136,546	3%
Contractual: Other Contracts	$391,705	8%
Construction	$ —	0%
Training	$244,084	5%
Seven Subrecipients Total	$636,740	12%
Other: Financial Support for Beneficiaries	$ —	0%
Other: Other	$ —	0%
Indirect Charges	$651,858	13%
Total Expenditures for FY19	**$5,177,971**	**100%**

Source: Expenditure analysis report (2019)

6. Recommendations

The recommendations presented below are based on the results of this evaluation. The evaluation team suggests that URC and CDC consider the following during project design and implementation of future HIV and TB programs in Eswatini.

Ensure project's sustainability strategy at the design stage

At the project design stage, ensure that the project has a sensitive sustainability and exit strategy built into the overall project implementation strategy with timelines for hand-over of the activities to the Ministry of Health. The project should work collaboratively with the MOH to facilitate its commitments and to put in place strategies that strengthen sustainability. Financial sustainability of successful project strategies such as human resources, equipment, and transportation support needs to be considered. There is a need to ensure that the service delivery models are compatible with resource-constrained contexts.

Future projects should learn from this project's successful approach of strengthening systems and building human resources capacity at the national, regional, and service delivery levels. This approach facilitated a sense of ownership for quality project implementation necessary for sustainability. The best practice of developing the leadership capacity of RHMT should be documented and rolled out to other regions if not being implemented. This practice was largely recognised as one of the success stories of the project at both the national and regional levels.

CDC could consider harmonising other donor's funds as a part of a comprehensive financing strategies for the continuation of gains of the project. This may include collaborating with other non-PEPFAR partners and MOH, with MOH-led partner coordination to avoid duplication and optimize resources in HIV programs.

Ensure equity in project resources across intervention areas

It is important to ensure balance or equity in project resources across HIV intervention areas—preventive as well as curative services. While the health and prevention benefits of ART are clear, ART alone won't be enough to end the spread of HIV, and other methods of HIV prevention are still needed.

Strengthen the implementation of index testing for HIV

Future projects should ensure the efficient and effective implementation of targeted and high yield HIV testing modalities such as Index testing and HIV self-testing. These interventions should be better aimed at reaching the most at risk and underserved populations, namely children, adolescents, men, and key populations. There is a need to strengthen the implementation of index testing and further improve the quality and capacity of index testing through training of Index Champions on motivational interview and strategies to improve community awareness about the rational and benefits of index testing. Index testing and HIV self-testing should be promoted at high-yield sites such as TB, STI, and youth clinics.

Address other identified service delivery gap areas

Several service delivery gap areas were identified by the evaluation. There is a need to include

diagnostic tools and clinical job aids to address TB in children. Efforts are needed to streamline supply management systems for medications, supplies, and HIV test kits to avoid stock-outs. More coverage of community education and awareness activities are needed to improve community knowledge about the benefits of cervical cancer screening and early treatment and gender-based violence prevention, early notification, and seeking timely interventions. Health workers should be oriented about diagnosis, treatment, and prevention of other opportunistic infections such as cryptococcal disease and non-communicable diseases affecting PLHIV.

Test and scale up context specific social protection interventions to improve ART retention and utilization of community support groups

People in resource-constrained contexts face a wide range of economic barriers such as transportation costs, income loss, and food insecurity threatening ongoing HIV care and treatment objectives. These barriers must be addressed to ensure progress toward the UNAIDS 95-95-95 goals. The project could test and include social protection interventions, such as conditional cash transfers, transportation assistance, income-generating activities, and microcredit, which have shown positive trends in other similar resource-constrained contexts.

Incorporate use of innovative tools for capacity development

Remote training is an innovative complement to traditional training methods, offering a high-frequency, cost-effective, and measurable solution for training a large scale and distributed workforce. Promote use of web-based or cell phone-based training for refresher training among service providers and mentoring support by supervisors. These remote platforms can be used to deliver the training content and measure knowledge retention and behavior change.

Low-dose, high-frequency training is an evidence-based, but relatively new best practice to improve health provider knowledge, build and retain competency, and transfer skills into practice after training. The low-dose, high-frequency training approach should be considered for expansion in Eswatini and integrated into existing in-service training programs and health system structures for lower cost and more efficiency at scale.

Optimize laboratory network systems and referral networks to improve HIV-related testing capacity and delivery of results

Mechanisms for transport of samples and results between health facilities and clinics and referral lab were limited to physical delivery methods only. Future projects could use lab information management systems or m-Health based lab results delivery systems that enable testing labs to receive all data prior to the physical specimen and report results out as soon as validated and authorized.

Ensure project reporting systems alignment with the national reporting system

The project should investigate the concern raised with regards to the parallel reporting systems existing at the facility level as an unintended consequence of the project reporting system and address this to ensure alignment with the national reporting system.

Review internal process for funds disbursement to subgrantees

The project should conduct an internal audit of its sub-grantee funding process to understand bottlenecks. Based on the results, adjust internal process and protocols to avoid the delays in sub-grantee funding and disbursement.

7. Dissemination

The report will be submitted to CDC/PEPFAR for approval and will be disseminated to the country stakeholders through in-person and virtual meetings; electronically through email; and distribution of copies of the final report. A virtual dissemination meeting is proposed for September 2020. The full report will be available for general public access on URC's website and on PEPFAR platforms.

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9. Appendices

A. Approved Evaluation SOW/Protocol

Evaluation of the Strengthening Local Capacity to Deliver Sustainable Quality-Assured Universal Coverage of Clinical HIV/TB Services in the Lubombo Region and Provision of Central-Level Technical Assistance to the Eswatini National AIDS Programme under PEPFAR

Protocol

Disclaimer
This work is supported through technical support by the United States President's Emergency Plan for AIDS Relief (PEPFAR), funded through the Centres for Disease and Prevention (CDC) under the Grants or Cooperative Agreement Number, 6 NU2GGH001399 04, managed by University Research Co., LLC (URC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC and the Department of Health and Human Services.

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
APMR	ART Patient Monitoring and Reporting System
ART	Antiretroviral Therapy
CBO	Community Community-Based Organizations
CD4	Cluster of differentiation 4
CDC	Centers for Disease Control and Prevention
CMIS	Client Management Information Systems
DSD	Differentiated Service Delivery
DST	Drug Susceptibility Testing
ENAP	Eswatini National AIDS Programme
ENSF	Extended National Strategic Framework
FOA	Funding Opportunity Announcement
FP	Family Planning
HCW	Healthcare Workers
HIV	Human Immunodeficiency Virus
HIVDR	Human Immunodeficiency Virus Drug Resistance
HMIS	Health Management Information System
HTC	HIV Testing and Counseling
HTS	HIV Testing Services
IP	Implementing Partner
IPC	TB Infection Prevention and Control
IPT	Isoniazid Preventive Therapy
MDR MDR-TB	Multi Multi-Drug resistant TB
MNCH	Maternal Neonatal Child Health
MoH	Ministry of Health
NGO	Non-Governmental organization
NQMP	National Quality Management Programme
NTCP	National Tuberculosis Control Programme
PEPFAR	President's Emergency Plan for AIDS Relief
PHU	Public Health Unit
PIHTC	Provider-Initiated HIV Testing and Counseling
PIHTS	Provider-Initiated HIV Testing Services
PLHIV	People Living with HIV
PMP	Performance Monitoring Plan
PMTCT	Prevention of Mother-to-Child Transmission of HIV
RHMT	Regional Health Management Team
SID	Strategic Information Department
SOP	Standard Operations Procedure
SRHU	Sexual and Reproductive Health Unit
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV and AIDS
URC	University Research Co., LLC
WHO	World Health Organization

Executive summary

Scope and objective

The mid and end-line evaluation of this five-year CDC-funded project *"Strengthening Local Capacity to Deliver Sustainable Quality-Assured Universal Coverage of Clinical HIV/TB Services in Lubombo Region, and Provide Central Level Technical Assistance to the Eswatini National AIDS Program (ENAP) in the Kingdom of Eswatini under the President's Emergency Plan for AIDS Relief (PEPFAR)*" project is designed to evaluate how much progress has been made at years 3 and 5 by the Implementing Partner (IP) and stakeholders towards the goal laid in the Funding opportunity announcement (FOA) CDC-RFA-GH15-1582 namely:

(1) Work as PEPFAR Eswatini lead implementing partner (IP) for technical assistance to the Eswatini National AIDS Program (ENAP) providing support to all HIV care and treatment-related (including HIV Testing and Counseling (HTC) and HIV drug resistance (HIVDR) activities at the national level as required;
(2) Collaborate with the Ministry of Health (MOH) in the Lubombo region to rapidly expand access to the combination of Provider-initiated HIV Testing and Counseling (PIHTC), Prevention of Mother-to-Child Transmission of HIV (PMTCT), Tuberculosis (TB), and Pediatric and Adult HIV Care and Treatment services to ensure universal coverage of comprehensive and integrated clinical HIV and TB services in the region;
(3) Be responsible for building the Lubombo Regional Health Management Team (RHMT) capacity to ensure long-term sustainability of facility-level delivery of services that meet national quality performance standards; and
(4) Collaborate with relevant stakeholders to expand access to TB and HIV services at the community level (including industrial sites, mines, and correctional facilities) within the Lubombo region.

The evaluation will assess the funding opportunity announcement intermediate and long-term key outcomes:

- Improved quality of HIV care and treatment services in Eswatini, resulting in reduced HIV-related morbidity and mortality;
- Improved quality management and performance standards of HIV and TB clinical services in the region;
- Increased number of individuals who are aware of their HIV status and successfully linked to appropriate services in the region;
- Decreased HIV incidence and HIV population viral load in the region;
- Decreased TB-related mortality among HIV patients in care in the region;
- Increased TB and multidrug-resistant TB (MDR-TB) treatment success rates in the region;
- Decreased mother-to-child HIV transmission rate in the region;
- Reduced unmet need for family planning (FP) among HIV-positive women in the region;
- Reduced HIV-related maternal mortality and morbidity in the region; and
- Reduced HIV-related child mortality and morbidity in the region.

Design, Methods, Limitations

This evaluation will be a non-experimental, descriptive, cross-sectional design. The evaluation will be conducted in three phases using mixed methods design incorporating both quantitative and qualitative methods including extensive review and analysis of project performance indicator data: Phase 1 will comprise a desk review of all project deliverables and results; Phase 2 will comprise collection of qualitative and quantitative data from stakeholders and participating health facilities at the end of year 3 (mid-term evaluation); Phase 3 will comprise of collection of qualitative and quantitative data from a wide range of stakeholders and beneficiaries inclusive of; ENAP, RHMT, National Tuberculosis Control Programme (NTCP), Sexual and Reproductive Health Unit (SRHU), Strategic Information Department, National Quality Management Programme (NQMP), MOH Directorate of Health and other PEPFAR/non-PEPFAR IPs and Community-Based Organizations to measure project impact and lessons learned.

A primary limitation is that the evaluation will focus on project-supported sites and programs and may not be a true representation of the entire region and the entire national AIDS program.

Evaluation questions, evaluation methods, and application areas for recommendations

	Evaluation Question	Evaluation Methods	Application or Data Use
1	How effective is the project in achieving its goals, objectives and performance targets?	□ Document and data review □ Key informant interviews □ Secondary data analysis	□ Feedback for course correction □ Recommendations for future project(s)
2	What are the project's strengths, weaknesses, and gaps in planning, management, service delivery, and sustainability?	□ Document and data review □ Key informant interviews □ Secondary data analysis	□ Feedback for course correction □ Recommendations for future project(s)
3	What are the constraints to successful implementation of this program?	□ Document and data review □ Key informant interviews □ Secondary data analysis	□ Feedback for course correction □ Recommendations for future project(s)
4	How well does the project align with PEPFAR global priorities and approaches?	□ Document and data review □ Key informant interviews	□ Feedback for course correction □ Recommendations for future
5	How well were interventions implemented in a timely manner and within allocated budget?	□ Document and data review □ Key informant interviews □ Secondary data analysis	□ Feedback for course correction □ Recommendations for future project(s)
6	Has the project provided adequate oversight, management, and resources for management and implementation	□ Document and data review □ Key informant interviews □ Secondary data analysis	□ Recommendations for future project(s)

Project Overview

Title

Evaluation of the "*Strengthening Local Capacity to Deliver Sustainable Quality-Assured Universal Coverage of Clinical HIV/TB Services in Lubombo Region and Providing Central Level Technical Assistance to ENAP in the Kingdom of Eswatini under PEPFAR"* project, subsequently referred to as the **CDC Lubombo Project**.

Background

This protocol covers the evaluation of the CDC-funded project "S*trengthening Local Capacity to Deliver Sustainable Quality-Assured Universal Coverage of Clinical HIV/TB Services in Lubombo Region and Providing Central Level Technical Assistance to ENAP in the Kingdom of Eswatini under PEPFAR*" implemented at central level Eswatini National AIDS programme (ENAP) and in the Lubombo region. The evaluation will be conducted to assess progress made in project implementation after three years of implementation from April 2015 to September 2018 against the program objectives, timelines, and the extent to which the objectives of the program continue to be consistent with beneficiaries' requirements, country needs, global priorities, and IPs' and donors' policies, to inform planning for the remaining period of the project.

Methods

This evaluation will be a non-experimental descriptive, cross-sectional design that will involve a comparison of baseline results and end line status of implementation. The evaluation will use a mixed methods design incorporating both quantitative and qualitative methods. It will be conducted in three phases. Phase 1 will be an internal review by URC and will entail a desk review of existing reports (from government, IP, PEPFAR, World Health Organization), work plans (from ENAP, RHMT, project), policies, guidelines, standard operating procedures (SOPs), data tools, job aids, performance standards, Social and Behaviour Change Communication and other strategic documents. Phase 1 will precede both Phase 2 to be conducted 18 months prior to project end (mid-term evaluation data collection analysis and reporting) and Phase 3, three months before project ends, (end line evaluation data collection and analysis and reporting).

Analysis and use

The analysis of the quantitative data will be done using STATA to determine the changes in the program performance and will be presented in a descriptive narrative, including tables, figures, and graphs. The qualitative data from in-depth interviews will be analyzed using qualitative content analysis and reported based on emerging themes. The findings and recommendations will be used to refine the program strategies and activities towards achieving the project goals and objectives.

Investigators and Roles

The evaluation will be led and implemented by URC global technical team (independent of URC Eswatini). URC Eswatini team will provide logistics support to the evaluation team; transport, technical information and other logistics for data collection, report writing, and dissemination.

Collective responsibilities for external evaluators

Review and provide inputs in the final evaluation protocol

- Assess whether the objectives of the review can be met
- Assess whether the methods are appropriate for the review
- Review and develop data collection tools

Quality and Relevance of Design

Assess the continuing appropriateness and relevance of the project design and how the project context, threats, and opportunities may have changed during the project. Assess what adjustments have been made and what further adjustments might be necessary. In particular:

- To what extent does the project respond to priority issues in the FOA?
- Is the project team planning the most appropriate strategies?

Are stakeholders passionate about the project goals?

Assess the major achievements of the project to date in relation to its stated objectives and intended results of the FOA. The external evaluators will conduct a systematic assessment of progress based on monitoring data for the planned goal, objectives and strategic activities. (Data already collected by the project's monitoring and reporting systems will provide much of the basic information).

- Assess what has been achieved, the likelihood of future achievements, and the significance/ strategic importance of the achievements
- Include also qualitative evidence, e.g., opinions on the project's effectiveness based on impressions and interviews with target groups, partners, government, etc.
- Describe any unforeseen impacts (whether positive or negative).
- Identify any exceptional experiences that should be highlighted, e.g., case-studies, stories, best practice

Efficiency of Planning and Implementation

Assess how resources are being used to deliver the project.

- To compare budget allocation and actual expenditure

Are plans being used, implemented, and adapted as necessary? For example:

- What % of activities in the work plan is being delivered?
- Is monitoring data being collected as planned, stored, and used to inform future plans
- Ensure that data analysis conforms to high standards of scientific rigor and ensure that the write-up of the results are for appropriate dissemination to maximize the evaluation report.

Impact

Assess to what extent the project is contributing to a reduction in new HIV infections, improved quality of HIV care and treatment services and reduced HIV/TB related morbidity and mortality in Eswatini.

Potential for sustainability, replication, and magnification

Assess the key factors affecting the sustainability of the project, such as:

- Which organizations could/will ensure continuity of project activities in the project area?
- Is there evidence of organizations/partners/communities that have copied, scaled up or replicated project activities beyond the immediate project area? Is such replication or magnification likely?
- Are there savings that could be made without compromising delivery?

Assess and make recommendations on the key strategic options for the future of the project, i.e., exit strategy, scale down, replication, scale-up, continuation, major modifications to strategy.

Collaborating institutions

URC	Implementing partner for the "Strengthening Local Capacity to Deliver Sustainable Quality-Assured Universal Coverage of Clinical HIV/TB Services in Lubombo Region, and Provide Central Level Technical Assistance to the Eswatini National AIDS Program (ENAP) in the Kingdom of Eswatini under the President's Emergency Plan for AIDS Relief (PEPFAR)" project
MOH/ENAP/RHMT	Holds the mandate for the provision of HIV/AIDS services and a key collaborating partner in the implementation of the project. Key custodians of the health sector responsible for strategic information, pharmaceutical/supply chain and diagnostics/laboratories
CDC/PEPFAR (funding agency)	Funding Agency and provide Technical support to the project

Evaluation sites

- MOH programmes (ENAP, NTCP, SRHU, SID, and NQMP)
- Lubombo RHMT
- PEPFAR-supported health facilities in Lubombo
- Selected communities and subgrantees supported by the project

Budget

$35,000.00	Mid-term evaluation
$35,000.00	End line evaluation

Introduction

Eswatini has an HIV prevalence of 27% translating to more than 197,000 people living with HIV (PLHIV) and the highest HIV prevalence globally [1]. The country has made remarkable progress

in its response to HIV epidemic over the years and the incidence has halved since 2011 [1]. The University research co.,LLC received a grant from the President's Emergency Plan for AIDS Relief (PEPFAR) through collaborative agreements with The United States Centers for Disease Control and Prevention (CDC) to support the provision of HIV prevention, care and treatment services in the Lubombo region of Eswatini and also provide technical support to the national AIDS programme. (. For this evaluation period, PEPFAR indicators have been enhanced to better correspond to global changes in HIV policy and to better reflect the increasing emphasis on patient outcomes. In this regard monitoring country HIV program response is critical to understand the achievements and gaps in HIV programs in National and subnational context and by population. These data are used to inform PEPFAR programs and guide PEPFAR resources at all levels [2]. This evaluation is important in informing the current CDC project on how it can improve its implementation [3]. Evaluation does not stand alone as a methodology and it is certainly not free of values or interests but, evaluation practices are firmly linked to particular social and institutional structures and practices, which influence what is done within the study itself [4]. The project established a monitoring and evaluation system to monitor progress. Literature states that an information system is the backbone of M&E and is founded on a cycle of information sharing and feedback. M&E systems address the challenge of measuring a program's success in meeting its objectives in cost-effective, practical ways. Effectively measurement of programs through M&E provides the evidence base upon which to compare and improve programs, share best practices, secure donor and community support, advocate for services or funding, and ultimately meet program goals and objectives.[2]. The evaluation will strike a balance between generating meaningful and useful information for programme managers while taking steps to ensure that data use does not worsen discrimination and stigma toward people who are HIV-positive [5].

Program evaluations are a tool to inform decision-making about sustaining, improving, or discontinuing a programme. Periodic HIV programme evaluations contribute to the generation of local and international knowledge base on HIV prevention strategy effectiveness [6]. With the new strategies for effective HIV programme management, there is growing recognition that greater investment in programme evaluation is needed to expand and solidify the evidence base for HIV prevention. The recent guidance from the United States President's Emergency Plan for AIDS Relief (PEPFAR) to focus more on evaluation is putting the issues of evidence use generated from evaluations into perspective. It is important for the HIV prevention, care and treatment, and control community to direct evaluation efforts to where they are most needed and ensure they are conducted in a way that will maximize their utility for programme improvement and for collective learning about successful HIV programme management.

Background

The University Research Co., LLC (URC) in collaboration with the Ministry of Health (MOH) in the Kingdom of Eswatini is implementing a Centers for Disease Control and Prevention (CDC) funded project to contribute to national efforts for HIV epidemic control. Eswatini is one of the HIV high-burden countries with a prevalence of 27.2% among adults aged 18-49 years (SHIMS2,

2017). In addition, the country has high tuberculosis (TB) incidence rate (of 308 TB cases per 100,000 per year), with 69% of TB patient co-infected with HIV (WHO, 2018). PEPFAR aims to contribute to immediate, comprehensive and evidence-based action to turn the tide of global HIV/AIDS including Eswatini through funding activities to prevent or control disease or injury and improve health or to improve a public health program or service. In Eswatini through the CDC, PEPFAR is funding the "*Strengthening Local Capacity to Deliver Sustainable Quality-Assured Universal Coverage of Clinical HIV/TB Services in Lubombo Region and Provide Central Level Technical Assistance to the Eswatini National AIDS Program (ENAP) in the Kingdom of Eswatini under the President's Emergency Plan for AIDS Relief (PEPFAR)"* project. The project commenced on April 1, 2015.

The goal of the project was aligned to the Extended National Strategic Framework (ENSF) and aimed to implement activities that will assist MOH and the Lubombo region to reduce the incidence of HIV and TB by 50% among adults and by 90% among children, and to avert 20% of deaths among children, adults, and pregnant women living with HIV (especially those with TB co-infection). In line with the goals of the ENSF for HIV and AIDS (2014-2018), the Health Sector Response to HIV/AIDS Plan (HSRP, 2014-2018), the PEPFAR blueprint, and the Joint United Nations Programme on HIV/AIDS (UNAIDS) 90-90-90 targets by 2020, the project objectives are:

1. To provide Technical Assistance (TA) to MOH and the Eswatini National AIDS Program (ENAP) to develop performance standards, up-to-date guidelines, standard operating procedures (SOPs), and data tools to enhance quality service delivery.
2. To build the Lubombo Regional Health Management Team's (RHMT) capacity to employ strong stewardship and ownership role in quality management of HIV and TB clinical services and collaborate with the quality management (QM) program and Lubombo RHMT to improve and sustain high-quality performance in HIV/TB service delivery at the facility level.
3. To support comprehensive and integrated universal scale-up of adult and pediatric HIV and TB clinical services (including Provider-initiated HIV Testing and Counseling (PIHTC), PMTCT, TB, TB/HIV, HIV care and treatment) at all facilities and selected communities (including mines and correctional facilities) in the Lubombo region.

   In addition, as the lead clinical PEPFAR partner for the Lubombo Region and ENAP, the implementing partner (IP) is expected, during the course of the project, to:

   1. Work as PEPFAR Eswatini's lead IP for TA to ENAP, providing support to all HIV care and treatment-related (including HIV Testing Services (HTS) and HIV drug resistance (HIVDR)) activities at the national level as required;
   2. Collaborate with MOH in the Lubombo region to rapidly expand access to a combination of Provider-Initiated HIV Testing Services (PIHTS), Prevention of Mother-to-Child Transmission of HIV (PMTCT), TB services, and Paediatric and Adult HIV Care and Treatment services to ensure universal coverage of comprehensive and integrated clinical HIV and TB services in the region;

3. Be responsible for building the Lubombo RHMT capacity to ensure long-term sustainability of facility-level delivery of services that meet national quality performance standards; and
4. Collaborate with relevant stakeholders to expand access to TB and HIV services at the community level (including industrial sites, mines, and correctional facilities) within the Lubombo region.

Three years of project implementation have elapsed with numerous lessons learned to help improve project performance in subsequent years of project implementation. Based on the project mandate, the following are the intermediate and long-term outcomes:

Project Year 3 and 4 FOA Objectives and Intermediate Outcomes

Intermediate Outcomes (3-4 Years)
Objective 1: Provide Technical Assistance (TA) to MOH and the Eswatini National AIDS Program (ENAP) to develop performance standards, up-to-date guidelines, standard operating procedures (SOPs), and data tools to enhance quality service delivery.
Increased healthcare worker's use of updated policies, guidelines, SOPs, and job aides on HIV Testing Services (HTS), Provider-Initiated HIV Testing Services PIHTS), HIV care and treatment (including tuberculosis (TB)/HIV collaborative activities in HIV settings)
Improved skills among nursing students and graduates regarding the updated policies, guidelines, SOPs, and job aids on HTS, PIHTS, and HIV care and treatment services (including TB/HIV collaborative activities in HIV settings)
Increased number of health facilities that have met performance targets on HIV care and treatment services (including PIHTS and TB/HIV collaborative activities in HIV settings)
Increased uptake and utilization of HIV and HIVDR-related findings from pilots and quality improvement projects to inform policy and programming
Objective 2: Build the Lubombo Regional Health Management Team's (RHMT) capacity to employ strong stewardship and ownership role in quality management (QM) of HIV and TB clinical services and collaborate with the QM program and Lubombo RHMT to improve and sustain high-quality performance in HIV/TB service delivery at the facility level.
Improved performance of RHMT in providing supportive supervision to all health facilities in the region (including mentoring in private health facilities)
Increased number of health facilities that meet their regionally set TB and HIV performance targets (which will be set in collaboration between MOH QM team, RHMT, regional partner, etc.)
Objective 3: Support comprehensive and integrated universal scale-up of adult and pediatric HIV and TB clinical services (including HTS, PIHTS, PMTCT, TB, TB/HIV, HIV care and treatment) at all facilities and selected communities (including mines and correctional facilities) in the Lubombo region.
HTS, PIHTS

Intermediate Outcomes (3-4 Years)
Increased number of competent healthcare personnel that are providing HTS, linkage to care and prevention, and implementing stigma and discrimination free strategies for people living with HIV (PLHIV) and key populations
HIV CARE AND TREATMENT
Increased proportion of PLHIV in the region receiving comprehensive HIV care (integrated with non-communicable disease care) for each demographic group of adults, adolescents, and children
Increased retention in care and treatment at 12, 24, and 36 months for each demographic group of adults, adolescents, and children, respectively
TB/HIV
Increased identification of TB cases amongst HIV patients already in care
Increased percent of eligible PLHIV in care who have received isoniazid preventive therapy
Increased proportion of TB patients with HIV who received antiretroviral therapy within 2weeks of diagnosis
Increased number of HIV patients that received quality-assured TB and MDR TB diagnosis and treatment services in line with the TB/HIV decentralization plan
PMTCT/MNCH
Increased proportion of mother-baby pair retained in care at 24 months post-partum
Increased proportion of PLHIV that are receiving integrated Sexual and Reproductive Health (family planning, cervical cancer screening, etc.) and HIV services

Project Year 5 FOA Objectives and Outcomes to assessed during the end of project Evaluation

Outcomes (5 Years)
Improved quality of HIV care and treatment services in Eswatini, resulting in reduced HIV related morbidity and mortality
Increased number of individuals who are aware of their HIV status and successfully linked to appropriate services in the Lubombo region
Decreased TB-related mortality among HIV patients in care in the Lubombo region
Decreased HIV incidence and HIV population viral load in the region
Increased TB and multi-drug resistant TB treatment success rates in the region
Decreased mother-to-child HIV transmission rate in the region

Justification of the evaluation

HIV programme evaluation remains a public health priority. Efforts to control the AIDS epidemic cannot succeed without effective HIV management programmes. There is no one-size-fits-all solution, but a combination of strategies that offer the best hope for successful HIV prevention and

thus for sustainable HIV treatment and management. Data shows that HIV programmes have measurable population benefits, however, at a local context, the evidence base for specific programmes is varied and incomplete. Thus, there is an urgent need to continue to accumulate credible evidence about what works and does not work to avert HIV infections in particular populations and settings, and to apply the lessons learned in programme practice. In Eswatini, significant progress has been made in providing HIV care even in primary healthcare facilities within the public health sector. HIV guidelines have continued to evolve which calls for close monitoring of guideline implementation to inform future guideline development and use. With substantial emphasis placed on rapid implementation and scale-up of these services, the country seeks to comprehensively review the longitudinal outcomes of the provision of HIV services in different settings and the effectiveness of various strategies in achieving the desired outcomes. Among PEPFAR's core agendas are impact, efficiency, sustainability, and partnerships as foundations for achieving an AIDS-Free Generation. This evaluation, therefore, complies with the PEPFAR agenda and with the Funding Opportunity Announcement (FOA) requirements to conduct programme evaluations to assess the progress made in project implementation against the program objectives and timelines.

Intended use of the evaluation findings

The evaluation is a two-stage evaluation comprising the mid-term and end-line to be conducted at 18 months and 3 years respectively prior to the expiry of the project.

The mid-term evaluation

The results of the mid-term evaluation will provide an overall assessment of project and HIV programmatic outcomes as at end of year 3. The results will be used to adjust the project implementation plan including modifying strategies, priority population groups or types of interventions to ensure program effectiveness, sustainability, and continued improvement.

End line evaluation

The overall purpose of the end-line evaluation is to understand whether the intended objectives of the project have been achieved, in line with the plan, as compared with the results of the baseline evaluation of 2015. The findings and recommendations will contribute to the evidence base for the government of the Kingdom of Eswatini and PEPFAR/CDC establish key recommendations follow-on program design, effectiveness and continuous program improvement.

Purpose of the Evaluation

The evaluation for the *"Strengthening Local Capacity to Deliver Sustainable Quality-Assured Universal Coverage of Clinical HIV/TB Services in Lubombo Region, and Provide Central Level Technical Assistance to the Eswatini National AIDS Program (ENAP) in the Kingdom of Eswatini under the President's Emergency Plan for AIDS Relief (PEPFAR)"* project is designed to serve the following purposes;

- To review and document the progress made by the CDC Lubombo project in supporting ENAP, the RHMT and health facilities to provide effective HIV services according to MOH standards and guidelines.

- Assess effectiveness, efficiency, and quality of the project at national, regional, and facility service delivery levels, identify implementation gaps and challenges and determine how well the project is achieving its goals, objectives, and performance targets (Mid-term)
- To document lessons learned and provide recommendations that will inform programming directions for the project and the design for the follow-on project (end line)
- To make specific proposals for project sustainability (institutionalization and capacity/ability to maintain the project gains) and exit plan given its current level of funding for clinic staff /human resources (end line)
- To measure if the project has improved the quality of HIV care and treatment services in Eswatini, resulting in reduced HIV-related morbidity and mortality (end line)
- Quantify the increase in the number of individuals who are aware of their HIV status and successfully linked to appropriate services in the Lubombo region (mid-term and end line)
- To measure if the project has decreased HIV incidence and HIV population viral load in the region (end line)
- To measure if the project decreased mother-to-child HIV transmission rate in the region (end line

Evaluation Questions

The evaluation will focus on how well the programme is performing and the results achieved relative to the targets of Notice of Award Ultimately, in this evaluation, we will consider the impact made by the interventions in changing the landscape of the HIV epidemic in the Lubombo region on prevalence, mortality, and morbidity. The evaluation questions will be aligned to the results chain framework and measure the results of HIV interventions (outcomes), the access and utilization of services (outputs), availability of HIV services (outputs) and type and the policies, plans and resources (inputs) committed to the programme.

Key evaluation questions

- How effective is the project in achieving its goals, objectives and performance targets?
- What are the project strengths, weaknesses, and gaps in planning, management, service delivery, and sustainability?
- What are the constraints to the successful implementation of the project?
- How well does the project align with PEPFAR global priorities and approaches?
- What were the IP expenditures of providing comprehensive HIV services to clients (including HIV testing, linkage to treatment, retention and viral load suppression)?

Other evaluation questions

Process, Inputs and output questions

1. Which interventions and programs were provided?
2. Were service delivery models appropriate for reaching the right population groups?
3. What successes and challenges related to planning and implementation were experienced?

Outcome questions

4. Was there a reduction in HIV risk behavior among people living with HIV infection (PLHIV) and high-risk HIV-negative/HIV status-unknown people?

5. Was there an increase in service access and participation in HIV prevention activities among PLHIV infection and high-risk HIV-negative/HIV status-unknown people?
6. Are collective efforts being implemented on a large-enough scale to impact the HIV epidemic (coverage)?
Impact questions
7. Was there improved quality of HIV care and treatment services in Eswatini resulting in reduced HIV-related mortality and morbidity?
8. Was there an increased number of individuals who are aware of their HIV status and successfully linked to appropriate services for each demographic group of adults, adolescents, and children, respectively?
9. Was there a reduction in HIV incidence and HIV population viral load?
10. Was there a reduction in TB-related mortality among HIV patients in care?
11. Was there an increase in TB and MDR-TB treatment success rates in the region?
12. Was there a decreased in mother-to-child HIV transmission rate in the region?
13. Was there a reduction in HIV-related maternal mortality and morbidity in the region?
14. Was there a reduction in HIV-related under 5 mortality and morbidity in the region?
15. Was there a reduction on unmet need for family planning (FP) among HIV-positive women in the region?

Specific evaluation objectives as arranged per level of intervention
Project management
To assess the extent to which the project had adequate oversight, management, and resources for ongoing project management and implementation.
National Level
To assess the extent to which technical assistance has been provided to MOH and ENAP to develop performance standards, up-to-date guidelines, SOPs, and data tools to enhance quality service delivery.
Regional level (Lubombo Region)
To assess the extent to which the Lubombo RHMT's capacity has been built by the project to employ strong stewardship and ownership role in QM of HIV and TB clinical services and
To assess the extent to which the project has assisted the national QM program to collaborate with the Lubombo RHMT to improve and sustain high-quality performance in HIV/TB service delivery at the facility level.
Health facility level
To assess the extent to which the project has supported comprehensive and integrated universal scale-up of adult and pediatric HIV and TB clinical services (including PIHTC, PMTCT, TB, TB/HIV, HIV care and treatment) at all facilities and selected communities (including mines and correctional facilities) in the Lubombo region.

Evaluation Procedures/Methods
Evaluation Design
This evaluation will be a non-experimental descriptive, cross-sectional design that will involve a comparison of baseline results, mid-term and end-line status of implementation. The evaluation is designed to comply with PEPFAR's Evaluation Standards of Practice and consistent with PEPFAR's definition of process evaluation. The evaluation will use a mixed methods design incorporating both quantitative and qualitative methods. The evaluation will be conducted by a

team of external evaluators consisting of HIV specialist, health systems specialist, monitoring and evaluation specialists drawn from the global URC technical teams assisted by local evaluators and support staff. The major components of the methodology are:

a) Document review: Evaluators will review the background documents provided by URC, CDC, and MOH. These will include work plans, progress reports, survey reports, strategic plans, technical reviews and information, education communication materials from the project as well as PEPFAR country operational plans, progress reports, guidelines and strategies, and document related to MOH response to HIV. A retrospective desk review of program documents relating to budget allocations and expenditure reporting will also be conducted. Relevant documents such as expenditure reports, annual reports, and project planning and financial reports will inform the desk review.

b) **Performance data**: Evaluators will review data from the project performance monitoring plan (PMP). The focus of analysis of the data is to contribute to answering the evaluation questions including trends and output data and assess performance against targets. We will also conduct secondary data analysis of the PMP and other data provided by the project to determine whether targets were achieved (by percentage), disaggregated by gender and by age and risk classification where possible. A template from the PEPFAR expenditure analysis tool focusing on IP expenditure analysis for the years 1-3 of implementation will be used to collect data for expenditure analysis. Categories for expenditure reporting will include the following categories: Personnel (salaries for health care workers and salaries for other staff); Fringe benefits; Travel (international travel and domestic travel); Equipment (health equipment and non-health equipment); Supplies (pharmaceutical, health non-pharmaceutical, and other supplies), Contractual (contracted health care workers, contracted interventions, and other contracts); Construction; Training; Sub-recipients; Other (financial support for beneficiaries and all other); and indirect charges.

c) Key informant interviews: The evaluators will conduct an extensive range of interviews to collect data relating to evaluation questions. Interviewers will make appointments with key informants to avoid scheduling conflicts. Informants will indicate their willingness to participate and agree on the most appropriate time for the interview to take place. Interviews will be conducted with key informants including the Country Director, Finance director, Technical Directors and other key staff for the expenditure analysis.

To determine appropriateness of selection and recruitment, the evaluation will select key informants based on their position, experience and knowledge about the project. These will be selected from PEPFAR staff, URC project staff, health authorities at national, regional, and facility level, international development partners, e.g., UNAIDS, World Health Organization (WHO), and civil society partners (community-based organizations (CBOs), non-governmental organizations (NGOs)), collaborating partners (such as national technical assistance implementing partners, both PEPFAR- and non-PEPFAR-funded) and MOH departments (such as; the ENAP, National TB Control Programme (NTCP), Strategic Information Department, Health Laboratory Services, Research Unit). All key informants will provide consent prior to interviews.

d) Analysis: The evaluators will review qualitative data from the interviews connecting the data to evaluating questions and focusing on relationships context, interpretations, homogeneity, and outliers in relation to key informant views on evaluation questions. Qualitative data will be used to substantiate quantitative findings derived from project reports, other assessments and gap analysis conducted by the project and the PMP to provide more insights and contexts that quantitative data can provide and to answer questions where other data does not exist. At the end of data collection, the evaluation team will triangulate all sources of information from document review from the PMP and from interviews to develop findings and conclusions.

e) **Project Advertisement** The project team will introduce the study, its purpose, components and voluntary nature, and to assure individuals of their anonymity if they participate. The project announcement will provide a straightforward summary that can be understood by all. Additional detailed information will be provided during the informed consent process. Even though participants will be encouraged to participate, the voluntary nature of the study will be emphasized during the announcement, and participation will be at the discretion of each individual and conflict of interest will be addressed.

Evaluation Approach

The evaluation will be conducted in three phases.

Phase 1 (Desk Review)

Phase 1 will entail the collection of all the necessary documents in preparation for external evaluators and will be conducted by the internal team of evaluators. In addition, a review of existing programmatic data, reports and other documents to assess the interventions and services provided, change of HIV landscape in the Lubombo region by comparison of baseline assessment results and current project achievements will be conducted and relevant documents prepared. The review will describe the current situation based on the available documentation. It will provide the evidence base for the field review. The output of the desk review will be data on the socioeconomic context of the Eswatini population, economy, and broad health indicators including the impact of the programme on prevalence, morbidity, mortality, trends, general and specific populations, by age and sex. The output will further provide current coverage of key interventions disaggregated by age and sex including interventions provided and inputs such as existing policies, guidelines, and human resources. The review will mostly use existing secondary data obtained and summarized through various (primary data) systems such as ART Patient Monitoring and Reporting System (APMR), programme reports, Client Management Information Systems (CMIS), routine health reporting, surveillance, population surveys, operational research, and other documented success stories. Results will be shared with a team of external evaluators who will focus on Phase 2 and bringing the two phases of the evaluation together. Annex 5 indicates the outputs and documents to be reviewed during Phase 1 (Desk Review).

Phase 2 (Field Review)

Following the desk review, a field review will be conducted by external evaluators to make on-site observations and collect information. This will build from findings of the desk review in order

to verify the findings of the desk review, seek explanations for these findings, and fill in information gaps. The field review will include technical briefings, stakeholder interviews, key informant interviews, and site visits. Phase 2 of the evaluation will collect data from PLHIV and other stakeholders who participated in ENAP capacity building, RHMT capacity building and health facilities in the Lubombo region. Qualitative data will be collected to provide feedback to learn about project participants' experiences and benefits from project interventions and services. The information will also provide a context analysis that will entail a review of existing epidemiological data and national documents to provide an understanding of Eswatini HIV landscape in the Lubombo region. Interviews with IP staff will provide information for the expenditure analysis. The context analysis will assess the availability of and access to HIV services of the general population. The data collection will seek to collect recommendations from beneficiaries on ways to improve HIV service delivery and new activities going forward.

Phase 3 (End line Evaluation)

Phase 3 constitutes the end line evaluation to measure the impact of the project on HIV epidemic control and will be conducted within 12 months of Phase 2.

Study population: The primary study target populations will be the beneficiaries of the project; patients, health care providers at project supported health facilities, staff and managers in the Lubombo region. The Lubombo region is largest region in the country and has the lowest population density of 36 when compared to the other three regions. Its boundaries are Manzini Region on the North, Shiselweni Region on the South, and Mozambique on the East and South Africa on West. The region is mainly rural with an estimated population: 212,531. Its HIV prevalence is 29.4% compared to the national prevalence of prevalence of 27%. The evaluation will also target the following; RHMT members, staff of MOH programmes supported by the project (ENAP, NTCP, the Sexual and Reproductive Health Unit, and the Strategic Information Department (SID), staff and managers of CBOs/NGOs supported by the project (sub grantees).

- The stakeholders will include PEPFAR/CDC, senior officials in the Directorate of Health Services in MOH, officials from the Eswatini National Emergency Response Council on HIV and AIDS, development partners and civil society organization.
- Implementing Partner (IP) management and technical staff.

Inclusion Criteria:

- PEPFAR/URC supported facilities in Lubombo
- Healthcare providers who work within the PEPFAR/URC-supported sites and programs
- Participants over the age of 18 who consent to be interviewed

Exclusion Criteria

- Non-PEPFAR/URC-supported facilities will not be included in the evaluation
- Healthcare workers (HCWs) who are eligible for the evaluation but are not present on the day of data collection

Sampling

The evaluation will conduct a non-probability purposive sampling with one or more specific pre-defined project beneficiaries and implementation sites. The variables to which the sample is drawn up will be linked to the evaluation questions. The sampling units (patient receiving HIV treatment and care, Health care workers and managers will be selected based on one or more predetermined characteristics (tested for HIV, on treatment, in Lubombo region) and the sample size can be as small as one (n=1). To minimize bias, the clusters of options by zones and facility types in the Lubombo region will ensure transparency in site selection. Only project sites or beneficiaries with specified characteristics will be selected such as the size of the health facilities, patient volume and whether it is a direct service delivery (DSD) or a TA site.

Programmatic data: Data for the whole region data will be assessed.

Sites: Sites will be sampled across the three geographical zones by facility ownership (mission, private, public), by levels according to MOH hierarchy of health facilities (hospitals, health centers, primary health care facilities, and public health units) and by urban/rural classification.

Quality of service: Proportional probability sampling will be used to obtain the number of charts to be reviewed for data quality, documentation, and completeness.

Chart reviews: The number of charts to be reviewed per facility will be proportionate to the total number of patients receiving HIV treatment services.

Key informant interviews

Healthcare workers: These will be selected purposively during the field site visit to ensure that all cadres involved in HIV care are selected (doctors, staff nurses, expert clients, lay counselors, and laboratory staff) for interviews.

Health facility managers: These will be selected purposively from the randomly selected sites

Stakeholders: These will be purposively selected to interview a representative from each of the major stakeholder organizations.

Beneficiaries: These will be purposively selected to interview a representative from each of the major beneficiaries.

Estimated number of participants per site

- 42 project supported health facilities in the Lubombo region
- 6 Non-project supported RHMT supervised health facilities in the Lubombo region
- 6 key informants at national level (MoH. ENAP)
- 6 key informants at regional level (RHMT)
- 48 Health Care workers in health facilities the Lubombo region
- 4 key informants in the Nursing training college
- Secondary data from 42 health facilities
- Secondary data/reports from 4 regions of the Eswatini (ENAP TA)

Enrolment

For the evaluation, participants will not be enrolled (there will be no face-to-face interaction with the patient), but charts will be selected informed by the sampling. A systematic random sampling on the n^{th} file will be applied to reach the sample required for chart review per facility. *The chart reviews will be led by an HCW at the facility who is involved in the management of the patient and the external evaluator will tally the information from the charts on evaluation tools. No identifiable data will be collected from the charts during the chart review for the assessment of the quality of service.*

Variables and interventions

For the quantitative data, variables will be collected according to the epidemic control indicators (90-90-90), the level of the indicators (output, outcome, and impact), patient-level variables (socio-demographics, HIV risks, level of immunosuppression), and health facility variables.

Variables related to HIV epidemic control

Indicators related to knowledge of HIV status (1st 90)

1. Estimated number of PLHIV by age and sex disaggregates (Based on Spectrum 2019 estimates and SHIMS 2)
2. Number of individuals tested for HIV by sex and age disaggregation and modality of testing
3. Number of HIV positives identified
4. Number of HIV-infected individual linked to antiretroviral therapy (ART)

Indicators related to ART treatment (2nd 90)

1. Number newly initiated on treatment (disaggregated by same day, within 7 days, after 7 days), place of initiation (community, facility, mobile, etc.)
2. Number of individuals on ART disaggregated by treatment regimen

Indicators related to viral load suppression and retention (3rd 90)

1. Viral load coverage
2. Viral load suppression

Variables related to the level of the indicators

Outcomes

1. **Linkage to ART:** defined as a completed first appointment with an HCW for ART provision within 30 days of HIV testing.
2. **Retention on ART:** Percentage of adults and children with HIV alive and on ART 12, 24, 36 (etc.) months after initiating treatment among patients initiating ART during a specified time period
3. **Viral suppression** defined as an HIV viral load <1,000 copies/mL
4. **Loss of follow up:** was defined as missing a clinic visit for >90 days for patients on ART
5. **Mortality** defined as all-cause deaths occurring after ART initiation but before the completion of the evaluation period. Deaths will be confirmed by hospital records.

6. **Completion of TB treatment:** defined as the number of clients who have successfully completed their treatment.

Output Indicators

1. Number of HCWs trained
2. Number of patients accessing services
3. Number of health facilities implementing an integrated NCD, TB and HIV packages (by entry point, type of clinic and model)

Patient variables

1. Age
2. Sex
3. Unique identifier
4. Date of entry in care (DD/MM/YYYY)
5. HIV diagnosis date
6. Population types (people who inject drugs, men who have sex with men, , female sex workers TB/HIV co-Infected)
7. Date ART initiated for the first time (DD/MM/YYYY)
8. Date of re-engagement in care (for patients who disengage from care)
9. Time from HIV diagnosis to ART initiation
10. Date second-line ART regimen initiated (DD/MM/YYYY)
11. Date of birth (DD/MM/YYYY)
12. Current ART regimen
13. WHO clinical stage at ART initiation
14. Viral load results (copies/mL)
15. Differentiated service delivery model or mainstream
16. Type of DSD
17. Compliance to appointment date
18. Service delivery model (case management (yes/no); multi-month prescriptions and pharmacy fast-track refills (yes/no); community client-led ART (yes/no)
19. CD4 cell count (cells/µL)
20. HIV testing modality (community- or facility-based)
21. History of pre-exposure prophylaxis
22. Pregnancy status

23. Breastfeeding status
24. Opportunistic infections or comorbidities
25. Contraceptive use

Facility variables

1. Level of care (clinic, health center, hospital, referral hospital)
2. Geographical location: (rural, urban)
3. Category of facility: MOH, faith-based organization, private, NGO
4. Number of clients active on ART
5. Number of HCWs in facility; HCW: total patient ratio
6. Laboratory services available on site: CD4+ testing, TB GeneXpert testing, HIV testing
7. Time of HIV services: Integrated, one-stop shop, referrals within (e.g., lab, pharmacy)
8. Site Improvement Through Monitoring System Scores

Data Management

The evaluation will provide procedures and standards for the management of data and information acquired during MTR and ETE, these procedures will include procedures and standards for data collection, collation, entry, analysis and report writing, address data quality issues at all the levels and phases of the evaluation.

Data collection

Quantitative data collection

Quantitative data will be collected using a data abstraction form with data values extracted from patient charts and similar sources using password-protected tablets. Data will be extracted from patient chronic care files, HTS registers, ART registers, referral, and linkage logbooks, viral load registers and electronic information systems including CMIS and APMR. Trained evaluation data collectors will be responsible for data abstraction from selected project sites in the designated departments in each health facility. Data collectors will visit the designated departments for data abstraction after services have ended for the day or when the patient load appears to be manageable to the HCWs so as not to interfere with patient care. Where possible, the facility-based focal point will assist with data collection to ensure timely data abstraction and verify for data quality. Only required data variables will be abstracted and entered into the password-protected data collection devices (computers/tablets). For CMIS sites, the patient identification numbers will be extracted from the system to facilitate tracking across service delivery points, if needed. Otherwise, other unique patient identifiers such as name and contact details of the participants will not be abstracted. For indicators where MOH Health Management Information System (HMIS) or CMIS is already collecting aggregate data, the evaluation team will request data from the SID unit. The data will then be extracted from the current databases at the HMIS and captured directly into the project database, in a password-protected computer.

Interview questionnaires, training summaries, and reports will be used to collect quantitative data from HCWs on training, services provided, satisfaction with support provided by the IP. Quantitative data on health facility-related variables will be collected. Expenditure data will be collected from expenditure reports, annual reports, and project planning and financial reports, which will feed into the expenditure analysis data extraction tool.

Qualitative data collection

Interviews will be conducted using interview guides with a comprehensive list of topics and issues to be covered during. The interviewer will subtly probe informants to elicit more information and takes elaborate notes.

Data Entry

All staff entering, accessing and analyzing data will be trained on data confidentiality, security, and data management best practices. Only selected staff will have access to data depending on their roles and responsibilities. In Step 1, data officers at PEPFAR/URC-supported facilities will enter the HIV care and treatment patient data from APMR or CMIS database and aggregate de-identified data from other forms and registers into Excel sheets. In Step 2, data is pulled out of electronic databases using standard queries. In Step 3, data cleaning is completed. A copy of the original dataset is preserved. We will create and maintain a data dictionary with the list of all variables, variables labels, and variables codes for new variables. We will carefully examine for coding errors, outliers, and inconsistencies. We will maintain a log to track any changes from the original dataset. Finally, the data from the different facilities are merged and exported into STATA for analysis.

Data Handling

All data will be entered directly into a database that will be designed specifically for the project and stored on a secure web platform (RedCap). Currently, URC uses RedCap for surveys and evaluations and this will also be used for the study. Built-in data checks will ensure that data are within a feasible range and the Redcap database is encrypted. Any outliers will be verified and identified during data cleaning. For disaggregated patient-level data, data will be extracted directly from the source document at the facility. Data will be reviewed with the facility focal point person at the site and challenges associated with incompleteness, inconsistency, and accuracy will be resolved in the field by triangulating with other data sources.

In health facilities where internet connection is a challenge, data will be temporarily stored off-line in the password-protected data collection device and subsequently transferred in an encrypted format to the web-based server routinely. To comply with ethical standards, access to data will be restricted to authorized persons, through the use of password-protected computers for electronic data, lockable cabinets will be used to store supplementary qualitative data. All staff entering, accessing and analyzing data will be trained on data confidentiality, security, and data management best practices and will sign non-disclosure agreements to ensure data confidentiality. The computers used for data capturing and analysis will be installed with back up and data recovery software to avoid data loss or corruption, additional external hardware drives will be provided to

provide additional storage for the study data. Data will be retained based on the project, CDC and MoH archiving, retention and disposal policy. A five year period for keeping the data and disposing off.

Data analysis

Quantitative data will be exported into Excel for simple analysis and STATA 14.0 for more complex analysis. For PEPFAR Monitoring, Evaluation, and Reporting (MER) indicators, we will perform descriptive analysis to examine trends and differences/similarities across age groups and sex. We will use the disaggregation categories recommended in the latest MER Indicator Reference Guide (Version 2.3). For patient-level data, we will analyze by the outcome. We will describe the data using the frequency distribution of the outcome, and covariates. Patient characteristics will be summarized using means and standard deviations, or medians and interquartile ranges for continuous variables and proportions with 95% confidence intervals for categorical variables. To compare groups, we will use Pearson chi-square for binary measures and Wilcoxon rank-sum tests, t-tests, or analysis of variance for continuous variables. The findings from the content analysis will be triangulated with different data sources to answer some of the evaluation questions. An evaluation report will be written by the team and drafts will be shared with appropriate partners MOH and PEPFAR partners and donors before finalization. For the expenditure analysis, counts will be used for various categories and compare with budget categories and variance above and below reported. Expenditure reporting within 5% of budget will be considered within budget while variances will be analyzed as over or under budget. Graphs and tables will be used to present this data.

Qualitative data will be analyzed through thematic analysis using NVivo 10. Data analysis will be based on the evaluation objectives, with all findings aligned to the evaluation questions. The analysis of qualitative data collected during the review will be in conjunction with the statistical analysis of quantitative data to provide a holistic view of the project implementation effect.

Quality control

Data collection instruments will be reviewed by both internal and external evaluators and pre-tested. Data capturing: to ensure that complete data is captured, training of data collectors on the instruments will be conducted and daily review of the scripts and database to identify incomplete data will be done.

For qualitative data, data will be reported as captured and data recorders will be used to complement handwritten notes and transcribed by hand. These data will be kept in lockable cabinets at the URC office with only access by the Evaluation coordinator assigned by the evaluation team. The data after transcription will be looked and kept until the end of the project a thereafter destroyed. Internal quality checks using checklists to conduct DQC (the 1st 50 files will be checked for data quality errors and sample 10% of subsequent files. Spot checks by the different study supervision levels during data collection, analysis and report writing. Any transcription error will be addressed at the different evaluation phases and process.

Data manipulation and transcription errors will be minimized by ensuring data quality monitoring for all data captured in the databases, checking for outliers and inconsistencies.

Ethical Considerations

The evaluation will be submitted for ethics review and approval. This protocol will be implemented after the approval by the Eswatini National Health Research Review Board (the local ethics approval will be provided to CDC upon receipt), the Associate Director of Science at CDC and URC Institutional Review Board. Permission to use CMIS/registers and HMIS data will be obtained from the Eswatini MOH. The evaluation will abide by the Declaration of Helsinki in terms of respect to autonomy and justice. The evaluation team will ensure privacy and confidentiality for all participants participating in the evaluation by using de-identified data and maintaining the anonymity of respondents in addition all data collected with be stored in lockage cabinet and computers with access codes only accessible to evaluation team. Since the evaluation will include sensitive information, interviewers will sign non-disclosure forms to protect and confidentially maintain participants' information. The evaluation is a review of programmatic aggregate data, no identifiable patient information will be included, and the findings will be used for improving programming and quality improvement.

Consent Procedures

The evaluation will analyze clinical information obtained from routine patient care as part of clinical care and widely reported through the program annual report.

This evaluation requests for waiver of written informed consent for the following reasons:

- The waiver will not adversely affect the rights and welfare of the subjects as the services provided in these clinics to be collected is routine care provided in line with national guidelines and within MOH-supported facilities. Viral load assays and proposed routine clinical blood draws are the standard of care for patients on ART. Adherence assessments are completed during routine clinical encounter and are also an important and recommended part of HIV care
- The evaluation involves no more than minimal risk to the subjects.
- The proposed data to be analyzed will be collected from national and partner tools accepted for use to improve the quality of patient care
- The data to be analyzed will not contain personal identifiers (the personal identifier will be eliminated by the MoH to ensure the personal identifiers are protected)

Informed consent will be, however, sought, from all key informants and they will be assured of their right to participate or not and to withdraw at any time during the interviews without any negative consequence. The level of English used in the IC is of an average adult who can read at a 7th to 9th grade level according to the Flesch-Kinkaid reading. The evaluation will interview representatives from key beneficiaries and stakeholders affected by the project such as member of the regional RHMT and central-level ENAP. There could be some discomfort when responding to sensitive questions. The program data used will be de-identified at data collection level. .

Human subjects training

Evaluation staff involved in this protocol or engaged in activities related to data collection, analysis, interpretation, and scientific writing will be required to complete a course and obtain certification on Good Clinical Practice.

Dissemination of findings

In accordance with the 2017 PEPFAR Evaluation Standards of Practice, approved reports will be disseminated publicly within 90 days after CDC's approval of the final evaluation report. The findings will be compiled into a formal evaluation report and disseminated to stakeholders (MOH, PEPFAR, and project staff). *:* A final evaluation report will be produced in alignment with PEPFAR Evaluation SOP requirements and posted on a public ally accessible website within 90 days of clearance

Intended use of the findings

The evaluation findings will be used to guide and improve the technical support provided to the national AIDS programme and to guide corrective measures to improve health services delivery in the Lubombo region of Eswatini. The mid-term will be used to inform better planning for the remaining period of the project. This will entail refining project strategies to meet objectives.

Evaluation findings will allow project/program staff, MOH programs, project beneficiaries, partners, donors, and other project stakeholders to learn from the experience and improve future interventions, evidence planning, and decision making. The end line and end-term evaluation findings will meet the accountability mandates to the donor and stakeholders, as well as improve project effectiveness. In addition, the MTR and End line will provide information to address the information needs for stakeholders. Such needs include HIV services coverage in the Lubombo region, Health system strengthening, health burden information and HIV infection and prevalence rates.

Timelines And budget: MTR Implementation June- September 2019; End line evaluation MAY 2020- AUGUST 2020

Main Activity	Specific activity	Unit cost/Input	Total	Timeline
Concept and proposal development and protocol approval	Proposal development & submission to CDC	$1000	$1000	**September 2018**
	Proposal development & submission to local IRC	$100	$800	**Feb/March 2019**
	Protocol approval			**June 2019**
Recruitment	Data clerks	$20 x10 days x 10	$2000	**July 2019**
	Evaluation coordinator	30 x 30 days x 2	$2000	**July 2019**
	URC external Evaluators Accommodation& P	10 days x500 x 4	$20,000	**2019 July**
	Data tool development	N/a	N/a	**July 2019**

Main Activity	Specific activity	Unit cost/Input	Total	Timeline
Tool development & training	Recruiting and training on data collection tool	$10 x 20 people	$200	**July 2019**
Data collection	Data collection – RHMT and HCW	Person time/transport	N/a	**August 2019**
	Data collection – key informant –ENAP	Person time/transport	N/a	**August 2019**
	Data collection – key informant –Training institution	Person time/transport	N/a	**August 2019**
	Data collection – site visits	Person time/transport	$1000	**August 2019**
Data analysis	Data cleaning, collation & analysis	Person time/transport	$2000	**Sept 2019**
Report writing & dissemination	Report writing	$5 x 20 x 10 days	$2000	**Sept 2019**
	Printing	$20 x 100copies	$2000	**Sept 2019**
	Dissemination	$20 x 100	$2000	**Sept 2019**
Total for Mid term			**$35,000**	
Recruitment	Consultant	$300 x 30 3	$27,000	**April 2020**
	Data clerks	$20 x10 days x 5	$1000	**April 2020**
	Evaluation coordinator	30 x 30 days x 1	$900	
Tool development & training	Data tool development	N/a	N/a	**April 2020**
	Recruiting and training on data collection tool	$5 x 20 people	$100	**April 2020**
Data collection	Data collection – RHMT and HCW	Person time/transport	N/a	**May 2020**
	Data collection – key informant –ENAP	Person time/transport	N/a	**May 2020**
	Data collection – key informant –Training institution	Person time/transport	N/a	**May 2020**
	Data collection – site visits	Person time/transport	$2000	**May 2020**

Main Activity	Specific activity	Unit cost/Input	Total	Timeline
Data analysis	Data cleaning, collation & analysis	Person time/transport	N/a	**June 2020**
Report writing & dissemination	Report writing	$5 x 20 x 10 days	$1000	**June 2020**
	Printing	$20 x 150 copies	$3000	**June 2020**
Total for End Evaluation			**$35,000**	

Evaluation Budget sharing

The total budget and annual expenditures related to the evaluation will be included in the Evaluation report. The amount will be shared with the activity manager/project office for entry into the DATIM evaluation inventory.

Monitoring implementation of the MTR and the End term Evaluation by the sponsor

"As the study sponsor, the Centers for Disease Control (CDC) may conduct monitoring or auditing of study activities to ensure the scientific integrity of the study and to ensure the rights and protection of study participants. Monitoring and auditing activities may be conducted by: CDC staff ("internal"); authorized representatives of CDC (e.g., a contracted party considered to be "external") both internal and external parties

Monitoring or auditing may be performed by means of on-site visits to the Investigator's facilities or through other communications such as telephone calls or written correspondence. The visits will be scheduled at mutually agreeable times, and the frequency of visits will be at the discretion of CDC. During the visit, any study-related materials may be reviewed and the Investigator along with study staff should be available for discussion of findings. The study may also be subject to inspection by regulatory authorities (national or foreign) as well as the IECs/Institutional Review Boards to review compliance and regulatory requirements."

Conflicts of Interest

The investigators of the study certify that all financial and material support for the conduct of this study and its preparation is clearly described in the protocol and that they have NO affiliations with or involvement in any organization or entity with any financial interest (such as honoraria; educational grants, membership, employment, or other equity interest), or non-financial interest (such as personal relationships, affiliations, knowledge or beliefs) in the subject matter or materials discussed in this research protocol.

B. Data Collection Instruments/Tools

KII Interview Guide Format

a. Name of Respondent	
b. Designation	
c. Name of Organization	
d. Gender of Respondent (Male/ Female)	
e. Date of Interview	
f. Method of Interview (Skype, Zoom, Phone, in-person, Group)	
g. Name of Interviewer	
h. Interviewer comments, if any:	

Part 1: Effectiveness (EQ1: How effective is the project in achieving its goals, objectives and performance targets?)
1.1. To what extent has the project achieved its intended results?
Probes:
Did the support reach the intended beneficiaries?
Are different beneficiaries appreciating the benefits of the URC project interventions? For example?
What are the specific indicators of project effectiveness?
What factors contributed to the effectiveness or otherwise?
What were the benefits of the program interventions?

1.2. What are the indications that the approach worked or making progress toward goals established to be achieved?
Probes:
Examples/ anecdotes which provide illustrations of positive, negative or unintended effects, or quantitative and qualitative evidence

How effective was the training on improving quality of services?

Part 2: Strengths/Weaknesses/Gaps (EQ2: What are the project's strengths, weaknesses, and gaps in planning, management, service delivery, and sustainability?)
Strengths:
2.1. What are the strengths of the project?

2.2. What do you consider to be the best practices in the implementation of the project?
2.3. Were URC interventions implemented at adequate scale to reach intended outcomes?

Weaknesses:
2.4. What are the weaknesses of the project?

2.5. How are the weaknesses being addressed?

Gaps:
2.6. What else should be done to make the project more effective?

Sustainability:
2.7. How does the URC ensure ownership and durability of its programs?
Probes:
Have project been integrated in institutional/government plans?

2.8. To what extent are the benefits likely to go beyond the project completion?

Part 3: Constraints (EQ3: What are the constraints to successful implementation of the project?)

3.1 Were there any challenges beyond project's control?

3.2 How did they affect project management, implementation and project achievements?

Part 4: Alignment with PEPAR (EQ4: How well does the project align with PEPFAR global priorities and approaches?)

4.1 Do you think the project activities align with PEPFAR global priorities and approaches ?
Probes: Why do you say so?

Part 5: Project Management (EQ5: What were the IP expenditures of providing comprehensive HIV services to clients (including HIV testing, linkage to treatment, retention and viral load suppression)?

5.1 Were interventions implemented in a timely manner and within allocated budget?

5.2 Has the project provided adequate oversight, management, and resources for management and implementation?
Probes: Why do you say so?

Part 6: Other Comments/ Follow-up:

Group KII Interview Guide Format

Beneficiary Group- Health workers/Trainee/Peer Support group

i. Name of Respondent/ Respondents participating in the group KII	
j. Designation of respondent (s)	
k. Name of Organization	
l. Gender of Respondent (Male/ Female) **Give gender distribution of GKII**	
m. Date of Interview	
n. Method of Interview (Skype, Zoom, Phone, in-person, Group)	
o. Name of Interviewer	
p. Interviewer comments, if any:	

Q. No.	Interview Questions	Responses
1	What type of support did you receive form the CDC-URC Lubombo project?	
2	Please elaborate how you have benefited from the CDC-URC Lubombo project?	
3	How effective was the support from CDC-URC Lubombo project on improving quality of services? Please elaborate.	
4	How effective was the training on improving quality of services?	
5	What were the strengths of the CDC-URC Lubombo project? Please elaborate?	
6	What were the weaknesses of the CDC-URC Lubombo project? Please elaborate?	
7	Does your facility have up-to-date guidelines, SOPs, and job aids on PIHTS, HIV care and treatment, TB/HIV?	

8	Please list the updated or new guidelines, SOPs and job aids on PIHTS, HIV care and treatment, TB/HIV developed since 2015.	
9	Were you trained on the updated guidelines, SOPs and job aids listed on question 8?	
10	Are you using the updated guidelines, SOPs and job aids listed on question 8?	
11	In your opinion what are the key barriers or challenges the Lubombo region is facing in controlling the HIV epidemic?	
12	Suggest how to strengthen HIV services: a) at health facility? b) at community level?	
13	What would you like to see in the next two years with regards to technical assistance and support to your health facility?	
14	How will the health facility maintain these project gains when the CDC-URC Lubombo project ends?	
15	Any other comments:	

Group KII Interview Guide Format

Regional TA- Lubombo RHMT

a. Name of Respondent/ Respondents participating in the group KII	
b. Designation of respondent (s)	
c. Name of Organization	
d. Gender of Respondent (Male/ Female) **Give gender distribution of GKII**	
e. Date of Interview	
f. Method of Interview (Skype, Zoom, Phone, in-person, Group)	
g. Name of Interviewer	
h. Interviewer comments, if any:	

Q. No.	Interview Questions	Responses
1	What type of support did Lubombo RHMT receive form the CDC-URC Lubombo project?	
2	Please elaborate how Lubombo region has benefited from the CDC-URC Lubombo project?	
3	Do you think the RHMT have adequate technical assistance (TA) from CDC-URC Lubombo project? Please elaborate?	
4	How effective was the support from CDC-URC Lubombo project on improving quality of services? How effective was the training on improving quality of services?	
5	What were the strengths of the CDC-URC Lubombo project? Please elaborate?	
6	What were the weaknesses of the CDC-URC Lubombo project? Please elaborate?	

7	Please list other stakeholders providing RHMT technical and other resources for HIV control? What ways these other stakeholders providing support to RHMT?	
8	Does the Lubombo region have up-to-date guidelines, SOPs, and job aids on PIHTS, HIV care and treatment, TB/HIV?	
9	Please list the updated or new guidelines, SOPs and job aids on PIHTS, HIV care and treatment, TB/HIV developed since 2015.	
10	Have the listed updated guidelines, SOPs, and tools from question 9 been disseminated to end users and healthcare workers and managers? please explain	
11	Have healthcare workers been trained on revised guidelines? How many were trained based on thematic areas by region?	
12	From your observation and facility support, Are healthcare workers using the updated guidelines, SOPs and job aids listed on question 9? How do you know that health workers are using these guidelines? Please provide evidence of use.	
13	How many health facilities received support for the CDC-URC Lubombo project?	
14	How many health facilities have set performance targets?	
15	How many health facilities are meeting their performance targets?	
16	In your opinion what are the key barriers or challenges the Lubombo region is facing in controlling the HIV epidemic?	
17	Suggest how to strengthen the technical assistance and support to improve HIV programming: a) at the national level, b) at regional level, c) at service delivery level or health facility?	
18	What would you like to see in the next two years with regards to technical assistance and support to RHMT?	
19	How will the HIV program/ Lubombo RHMT/MoH maintain these project gains when the CDC-URC Lubombo project ends?	
20	Any other comments:	

Performance Evaluation of URC CDC-Lubombo Project
Health Facility Assessment Tool

a	**Date of survey:**	
b	**Interviewer's name:**	
c	**Time started:**	
d	**Time ended:**	

0: Type of respondents:

01 Respondent (Choose applicable):	Facility manager	1	
	Nurse Manager	2	
	Senior Medical Officer/ SMO	3	
	Matron	4	
	Other Specify: ----------	5	
	Other Specify: ----------	6	

Module 1: HEALTH FACILITY IDENTIFIER

01	Facility Name		
02	Telephone no:		
03	Name of region		
04	Type of facility	Health Center Hospital Public Health Unit Community Clinic Mission Other: Specify ----------	1 2 3 4 5 6
05	Facility: public or private	Public Private Not sure/don't know	1 2 3
06	Facility: urban/rural	Urban Semi-urban Rural	1 2 3
07	How many days is this facility open to outpatients (outpatients are those who are receiving preventive or curative care abd going home the same day)	Number of days per week	___(days per week)
08	At what time do outpatient care hours open	Time open (AM/PM)	___(AM/PM)
09	At what time do outpatient care hours close	Time close (AM/PM)	___(AM/PM)
07	Does the facility provide 24 hours care	Yes No	1 2
08	Average patient visits per day	Number per day	_____
09	Average patient visits per month	Number per month	_____

Module 2: SERVICES PROVIDED

No.	Does the health facility provide the following services *on site*:	Yes	No	If No, do you refer patients to other facility	Comments/ Challenges - Distance (Km) / average travel time (Hrs)
TB-HIV services					
SP1	TB screening in Adults	1	2	3	
SP2	TB diagnosis in Adults	1	2	3	
SP3	TB treatment in Adults	1	2	3	
SP4	MDR-TB treatment in Adults	1	2	3	
SP5	IPT (TB preventive therapy) in Adults	1	2	3	
SP6	ART for Adult TB patients	1	2	3	
SP7	TB screening in Children	1	2	3	
SP8	TB diagnosis in Children	1	2	3	
SP9	TB treatment in Children	1	2	3	
SP10	MDR-TB treatment in Children	1	2	3	
SP11	IPT (TB oreventive therapy) in Children	1	2	3	
SP12	ART for Child TB patients	1	2	3	
HIV services					
SP13	HIV counselling services	1	2	3	
SP14	HIV testing services	1	2	3	

No.	Does the health facility provide the following services *on site*:	Yes	No	If No, do you refer patients to other facility	Comments/ Challenges - Distance (Km) / average travel time (Hrs)
SP15	Antiretroviral therapy (ART) in adults	1	2	3	
SP16	Antiretroviral therapy (ART) in children	1	2	3	
SP17	Viral load testing	1	2	3	
SP18	CD4 testing	1	2	3	
SP19	Sexually transmitted diseases prevention and treatment	1	2	3	
SP20	Voluntary male medical circumcision	1	2	3	
SP21	HIV other opportunistic infections treatment (Kaposi sarcoma/ cryptococcal meningitis)	1	2	3	
SP22	Post-exposure prophylaxis for HIV (PEP) for health workers	1	2	3	
PMTCT					
SP23	Antenatal care	1	2	3	
SP24	Prevention of mother to child transmission of HIV services (PMTCT)	1	2	3	
SP25	Childbirth services	1	2	3	
SP26	Post natal care, infant care	1	2	3	
SP27	Life-Long ART for Pregnant and Lactating Women	1	2	3	
SP28	Early infact diagnosis for HIV	1	2	3	
Other					
SP29	Gender based violence/ rape survior services	1	2	3	

No.	Does the health facility provide the following services *on site*:	Yes	No	If No, do you refer patients to other facility	Comments/ Challenges - Distance (Km) / average travel time (Hrs)
SP30	Family planning services	1	2	3	
SP31	Adolescent/youth serivces	1	2	3	
SP32	Cervical cancer screening services	1	2	3	
SP33	Pre-exposure prophylaxix for HIV (PrEP)	1	2	3	

Serice integration

No.	Does the health facility provide the following integrated services *on site*:	Yes	No	Comments
INT1	All these four services - HIV, TB, PMTCT, and SRH services managed are fully integrated in this facility	1	2	
INT2	HIV is integrated with: TB	1	2	
INT3	HIV is integrated with: PMTCT	1	2	
INT4	HIV is integrated with: FP or SRH	1	2	
INT5	TB is integrated with: PMTCT	1	2	
INT6	TB is integrated with: FP or SRH	1	2	
INT7	PMTCT is integrated with: TB	1	2	
INT8	PMTCT is integrated with: FP or SRH	1	2	

Module 3: INFRASTRUCTURE

	Infrastructure and Accommodation				
	Does the health facility have adequate space for:-	YES	NO	# of rooms	Comments/ Challenges
IF1	A well-ventilated area or room for patient Waiting	1	2		
IF2	Patient reception or triage area	1	2		
IF3	Separate Consultation or counselling room to maintain patient privacy	1	2		
IF4	Separate clinical examination room to maintain patient privacy	1	2		
IF5	Toilet	1	2		
IF6	Support group meetings rooms	1	2		
IF7	Filing & medical records rooms	1	2		
	Does the health facility have:-	YES	NO		Comments/ Challenges
IF8	Source of running water inside the building	1	2		
IF9	Source of electricity, including solar lamps or generator	1	2		
IF10	Emergency transportation for sick patient for referral	1	2		
IF11	Emergency communication system- eg phone	1	2		

Module 4: HUMAN RESOURCES

	Does the health facility have following HR Category:	Yes	How many currently working	How many Approved no. of posts	No	Comments/ Challenges
HR1	Doctors	1			2	
HR2	Registered nurses	1			2	
HR3	Nursing assistants	1			2	
HR4	Pharmacists	1			2	
HR5	Pharmacy technicians	1			2	
HR6	TB screening officers	1			2	
HR7	HTS counselors	1			2	
HR8	Data clerks	1			2	
HR9	Pharmacy assistants	1			2	
HR10	Cleaners	1			2	
HR11	Orderlies	1			2	
HR12	Security	1			2	
HR13	Other : specify _____	1			2	
HR14	Other : specify _____	1			2	
HR15	Other : specify _____	1			2	
HR16	Other : specify _____	1			2	

Module 5: INFECTION CONTROL

Verify the below through relevant observation or documentation

No		Yes	No	Comments (If no – Action Points)
IPC1	Is there a person responsible for infection control?	1	2	
IPC2	Is there a Facility Infection Control Committee?	1	2	

	If yes, When was the last TB risk assessment done? Month, Year	_____Month _____Year		
IPC3	Is there a Facility TB Infection Control Plan?	1	2	
	If yes, when was it developed? Month, Year	_____Month _____Year		
IPC4	Is there a system for triaging coughing patients?	1	2	
IPC5	Is there a dedicated area for sputum collection?	1	2	
IPC6	Are there N95 respirator masks for staff	1	2	
	If yes, Are all staff fit-tested?	1	2	
IPC7	Do all consulting rooms have handwashing facilities? (Check one of the consulting room for water, elbow taps, handwashing basin, soap/disinfectant, paper towel and pedal bin)	1	2	
IPC8	Water seen	1	2	
IPC9	Elbow taps seen	1	2	
IPC10	handwashing basin seen	1	2	
IPC11	soap/disinfectant seen	1	2	
IPC12	paper towel seen	1	2	
IPC13	Pedal bin seen	1	2	
IPC14	Who is responsible for responsible for screening patients in waiting area?	_____(designation of the staff)		
IPC15	How many staff members were diagnosed with TB in the past 12 months?			
IPC16	Comments on Infection control practices?			

Module 6: SUPPORT GROUPS

No		YES	NO	Comments / Challenges
SG1	Are there HIV/TB support groups for adults, pregnant women lactating adolescents and children in the area?	1	2	
	Adults	1	2	
	Pregnant woman	1	2	
	Adolescents	1	2	
	Children	1	2	
	Caregivers	1	2	
	CAGs (Community ART Groups)	1	2	If yes, how many? ____
SG2	Is there a functional support group on site? *Proof: minutes and attendance registers*	1	2	If yes, proof seen: yes or No
	If yes, What activities take place in this particular support groups (list activities)			
	If yes, What NGOs or partners are supporting the support groups at the facility?			

Module 7: CONTACT SCREENING AND TRACING LOSS TO FOLLOW UP

No.		YES	NO	
CON1	Is HIV Index testing conducted?	1	2	
CON2	Is HIV partner testing conducted?	1	2	
CON3	Is TB contact screening conducted?	1	2	
	If yes, Where is the information on contact screening recorded?	1	2	
	If yes, Who is responsible for contact screening?	1	2	
ADH1	Are patients provided with adherence support during treatment (directly observed therapy [DOT] or other)	1	2	
	TB treatment	1	2	
	ART	1	2	
	PMTCT	1	2	
LTFU1	Is there a system in place to track treatment interrupters/ loss to follow up? *(Prompt for*	1	2	If yes, Who is responsible for tracing interrupters/lost to follow up?

	ART patients under TB, HIV, and PMTCT clinics)			
	TB treatment	1	2	
	ART	1	2	
	PMTCT	1	2	

Module 8: INFORMATION, EDUCATION, AND COMMUNICATION (IEC) & Adocacy communication and social mobilization

	Are there patient education materials on:	YES, seen by interviewer	No, Never had	Yes, but could not be verified or material reported Stock out at present	Comments/ Challenges
IEC1	TB prevention and treatment	1	2	3	
IEC2	HIV prevention and treatment	1	2	3	
IEC3	PMTCT	1	2	3	
IEC4	Early infant diagnosis	1	2	3	
IEC5	Viral Load testing	1	2	3	
IEC6	ART Adherence	1	2	3	
IEC7	VMMC	1	2	3	
IEC8	Family planning	1	2	3	

Module 9: CLINICAL SERVICES

No.		Observation notes
CL1	What are the specific policies of HIV/TB-related clinical services - SOPs, job aids currently availability in this facility? Can I see a copy of it? e.g., HTS, ART, PMTCT, TB, GBV, VMMC *(Prompt if necessary: e.g. SOPs, Job aids, guidelines, note If you see a copy of the guidelines / job-aids/ SOPs)*	
	If seen, who provided these SOPs, guidelines, job-aids	

	Training and supervision			
CL2	Have you received any training on specific policies of HIV/TB-related clinical services -SOPs, guidelines, job-aids	1	2	
	If yes, who provided the training, and when was the last training session	Who: _____ When: _____		
CL3	Do you receive supervision visit from anyone or RHMT ?	1	2	
	If yes, who provided the last supervision visit, and when was the last supervision visit	Who: _____ When: _____		

	Has there been a stock out Medicines during the last 12 months? (Specify commodity and specify stock out periods)	Yes	No	If Yes, add stock outs reported and period
CL4	ART drugs	1	2	
CL5	Drug sensitive TB	1	2	
CL6	Drug-resistant TB	1	2	
CL7	PMTCT drugs	1	2	
CL8	Other (specify)……	1	2	
CL9	Other (specify)……	1	2	
CL10	Other (specify)……	1	2	
CL11	Other (specify)……	1	2	

Module 10: LABORATORY SERVICES

No.	Does the health facility provide the following lab services *on site*:	Yes	No	If No, do you refer patients to other facility	Comments/ Challenges – Distance (Km) / average travel time (Hrs.)
Lab tests					
LAB1	HIV rapid test	1	2	3	
LAB2	CD4 count	1	2	3	
LAB3	HIV- Viral load	1	2	3	

No.	Does the health facility provide the following lab services *on site*:	Yes	No	If No, do you refer patients to other facility	Comments/ Challenges – Distance (Km) / average travel time (Hrs.)
LAB4	Pap smear	1	2	3	
LAB5	Syphilis RPR	1	2	3	
LAB6	HBsAg	1	2	3	
LAB7	Hemoglobin	1	2	3	
LAB8	CMV testing	1	2	3	
LAB9	Creatinine	1	2	3	
LAB10	ALT and AST	1	2	3	
LAB11	Cryptococcal antigen (CrAg)	1	2	3	
LAB12	Sputum microscopy	1	2	3	
LAB13	GeneXpert	1	2	3	
LAB14	TB culture	1	2	3	
LAB15	TB drug sensitivity testing	1	2	3	
LAB16	Other (specify: _____)	1	2	3	
LAB17	Other (specify: _____)	1	2	3	
LAB18	Other (specify: _____)	1	2	3	
LAB19	Other (specify: _____)	1	2	3	
LAB20	Other (specify: _____)	1	2	3	
LAB21	Other (specify: _____)	1	2	3	

Laboratory policies/ guidelines

No.		Observation notes		
LP1	What are the specific policies of HIV/TB-related lab diagnostics - SOPs, job aids currently availability in this facility? Can I see a copy of it? e.g., rapid tests, point-of-care (POC) CD4, viral load, Xpert MTB/RIF *(Prompt if necessary: e.g. Lab strategic plan, Policies, Lab SOPs, Job aids, POC guidelines, note If you see a copy of the guidelines / job-aids/ SOPs)*			
	Has there been a stock out of laboratory reagents or commodities during the last 12 months? (Specify commodity and specify stock out periods)	Yes	□No	If Yes, add stock outs reported and period
LP2	Creatinine	1	2	
LP3	ALT/AST	1	2	

LP4	Hemoglobin	1	2	
LP5	HIV tests	1	2	
LP6	CD4 count	1	2	
LP7	Viral load	1	2	
LP8	Other (specify)……	1	2	
LP9	Other (specify)……	1	2	
LP10	Other (specify)……	1	2	
LP11	Other (specify)……	1	2	

Laboratory tests and lab support systems

Lab support systems				
		Yes	No	Comments
LTS1	Is there a schedule for sample collection by NSTS or other Courier to testing hubs	1	2	
	If yes, How often are samples collected for transport to lab testing hub?	_____ times per week		
		Yes	No	Comments
LTS2	Is there an Laboratory Information System-based results delivery system	1	2	
LTS3	Is there an mHealth-based results delivery system in place	1	2	
LTS4	How are results reported back to the facility?			
LTS5	Is there a person responsible for:	Yes	No	Comments
	(i) collecting results from the lab to the clinic	1	2	
	(ii) filing patient lab results	1	2	
	(iii) documentation of results requiring urgent tracking of patients	1	2	

Table 9 summarizes the evaluation questions and indicators used to analyze them.

Table 9. Project evaluation questions, indicators, data sources, sampling or selection criteria, and data analysis methods

No.	Evaluation Question	Indicators to be measured	Data Source/Collection method	Sampling or selection criteria	Data Analysis Method
1	How effective was the project in achieving its goals, objectives and performance targets?	Changes in PMP/Key performance indicators by 3 objectives (see Table A.1)-outcome and output- at short-term, intermediate and long-term over time **KPI:** • Quality of HIV prevention, care and treatment services, including PMTCT, TB • Capacity development over time • Coverage of 95-95-95 services o number of individuals who are aware of their HIV status o successfully linked to appropriate services, for each demographic group of adults, adolescents, and children o With viral load suppression • HIV risk behavior among people living with HIV infection (PLHIV) and high-risk HIV-negative/HIV status-unknown people	Data review: All KPIs- outcome and output, Data extraction from secondary sources: National HIMS, DHS, Document review: Review of annual work plans, Performance Monitoring Plans (PMPs), and budget allocations KIIs- Key CDC; URC; MOH staff-National, regional; Nursing school head; Health Facility Manager; PEPFAR partners; other donors	Projects' performance monitoring systems data (2015-2020), Secondary data sources: CMIS (2015-2020), DHS (pre 2015, current), SHIMS Report ART Data TB data Selection of KII participants: representation of national and regional level stakeholders	Quantitative analysis of KPIs trends overtime (baseline, year 3, year 5), Use of a three-point rating system (achieved , not achieved , partially achieved) at year 3 and year 5 for output/short/intermediate outcome indicators, Comparison with baseline, if available and project targets Use of a three-point rating system (positive change ,negative change ,unchanged) at year 5 for impact/long-term outcomes and Comparison with baseline, if available or obtained from secondary data sources (for 2015/2014/2013) and performance targets

No.	Evaluation Question	Indicators to be measured	Data Source/Collection method	Sampling or selection criteria	Data Analysis Method
		• service access and participation in HIV prevention activities among PLHIV infection and high-risk HIV-negative/HIV status-unknown people **Impact outcome indicators (which indicators are applicable for the whole country and which for Lubombo region only):** • HIV-related mortality and morbidity – National • HIV incidence – National & Regional • HIV population viral load-National & Regional • HIV-related maternal mortality and morbidity-National • HIV-related under 5 mortality and morbidity-National • Mother-to-child HIV transmission rate –Regional and National • TB-related mortality among HIV patients in care- National • TB treatment success rate – National & Regional	FGDs- health providers Project theme leads Regional partners	Indirect beneficiaries: health workers-nurses, doctors, counsellors Secondary Data CMIS, SHIMS Report ART Data TB data	Are collective efforts being implemented on a large-enough scale to impact the HIV epidemic (coverage)? Are the collective effort the right set of strategies to create an enabling environment for reaching the impact Correlations with implemented activities and budget inputs

No.	Evaluation Question	Indicators to be measured	Data Source/Collection method	Sampling or selection criteria	Data Analysis Method
		• MDR-TB treatment success rate – National • unmet need for family planning (FP) among HIV-positive women Perceptions of the health providers and key stakeholders about availability, access, use and quality of services, and changes over the past 5 years			
2	What were the project's strengths, weaknesses, and gaps in planning, management, service delivery, and sustainability?	Description of interventions and programs provided by the project 1. National level- technical assistance provided to MOH and ENAP to develop performance standards, up-to-date guidelines, SOPs, and data tools to enhance quality service delivery; TA to the national QM program 2. Regional level- Lubombo RHMT's capacity built by the project to employ strong stewardship and ownership role in QM of HIV and TB clinical service 3. Facility level- comprehensive and integrated universal scale-	Data review: All KPIs- outcome and output Document review: Project reports, Workplans, Expenditures KIIs- Key CDC; URC; MOH staff- National, regional; Nursing school head; Health Facility Manager; PEPFAR partners; other donors	Selection of KII participants: representation of national and regional level stakeholders (CDC- Country Director, Activity Manager, URC: CoP; Technical Lead, Finance Lead ENAP, TB, RHMT Lead)	Qualitative analysis: content analysis, themes, depth to support Analysis of four dimensions: 1) project planning; 2) project management; 3) service delivery; and 4) sustainability Data triangulation and correlation with quantitative program data: key performance indicators- outcome and output

No.	Evaluation Question	Indicators to be measured	Data Source/Collection method	Sampling or selection criteria	Data Analysis Method
		up of adult and pediatric HIV and TB clinical services (including PIHTC, PMTCT, TB, TB/HIV, HIV care and treatment) at all facilities and selected communities (including mines and correctional facilities) in the Lubombo region Service delivery models appropriate for reaching the right population groups: Y/N Description of successes and challenges related to planning and implementation were experienced # of instances and description of changes to the program management approach based on performance results # and description of cross –cutting interventions addressing gender, health policy, quality improvement, M&E system strengthening, private sector, other donor coordination	FGDs- Nursing school beneficiaries; trained health providers Site checklist/Direct observation: availability of SOPs, Job-aids, its utilization, and quality of service; HF statistics over time	Indirect beneficiaries: health workers, nursing students Site selection: High-volume HF, >3years of project support	Quantitative analysis of site checklist

No.	Evaluation Question	Indicators to be measured	Data Source/Collection method	Sampling or selection criteria	Data Analysis Method
		# and description of sustainability interventions addressing institutionalization and capacity/ability to maintain the project gains and exit plan # of instances at National and Regional level where stakeholders reported – project strength, weakness and gaps; # of instances at National and Regional level where stakeholders reported that they have capacity to maintain the project gains when project ends			
3	What were the constraints to successful implementation of the project?	Description of challenges in project reports - that project faced constraints beyond their control in the coverage and delivery of quality services # of instances and description where stakeholders believe that project faced constraints beyond project's control in the coverage and delivery of quality services	Document review: Review of annual work plans; annual reports KIIs- Key CDC; URC; MOH staff- National, regional; Nursing school head; Health Facility Manager; PEPFAR partners; other donors	Selection of KII participants: representation of national and regional level stakeholders Indirect beneficiaries: health workers, nursing students	Qualitative analysis: content analysis, themes, depth to support Data triangulation and correlation with quantitative data

No.	Evaluation Question	Indicators to be measured	Data Source/Collection method	Sampling or selection criteria	Data Analysis Method
			FGDs- Nursing school beneficiaries; trained health providers		
4	How well did the project align with PEPFAR global priorities and approaches?	Describe how project changed approaches in line with the PEPFAR COP over time (2015 to 2019) Project aligns with PEPFAR global priorities and approaches: Y/N	Document review: COP 2015 to 2019, annual work plans, annual reports KIIs: Key CDC, URC staff, other PEPFAR partners	Selection of KII participants: PEPFAR	Qualitative analysis: content analysis, themes, depth to support
5	What were the IP expenditures for providing comprehensive HIV services to clients (including HIV testing, linkage to treatment, retention, and viral load suppression)?	How well were interventions implemented in a timely manner and within allocated budget? Has the project provided adequate oversight, management, and resources for management and implementation	Document review: Project reports, Workplans, Expenditures KII: Key CDC and URC Document review: Project reports, Workplans, Expenditures KII: Key CDC and URC	Selection of KII participants: Project-related	Qualitative analysis: content analysis, themes, depth to support
				Selection of KII participants: Project-related	Qualitative analysis: content analysis, themes, depth to support

C. List of Key Informants Interviewed

S. no	Name of respondent	Affiliation	Job Title
KIIs			
1	Ms. Rejoice N. Nkambule	MOH	Deputy Director - Public health
2	Dr. Nomuthandazo Lukhele	WHO	HIV Technical Focal Person
3	Mr. Muhle Dlamini	ENAP	HIV Program Manager
4	Ms. Lenhle Dube	ENAP	HTS National Program Coordinator
5	Ms. Bonisile Nhlabatsi	SRHU	Program Manager
6	Ms. Sebentile Myeni	SID-M&E	MoH M&E Manager
7	Ms. Zanela Simelane	SID- HMIS	HMIS Manager
8	Dr. Theresa T. Ntshakala	South Afrian Narene University - SANU	Senior Lecturer
9	Mr. Adam Dlamini	Good Shepherd College	Nurse Educator
10	Ms. Khombi Nkonde	Christian Medical University	Dean, Nursing Department
11	Ms. Nathi Maphalala	Eswatini Nursing Council	Coordinator
12	Chris Makwindi	Elizabeth Glaser Pediatric AIDS Foundation	Technical Director
13	Ms. Caroline Ryan	CDC Eswatini	Country Director
14	Dr. Sikhathele Mazibuko	CDC Eswatini	Activity Manager
15	Ms. Nomsa Dlamini	Lubombo RHMT	Regional Matron
16	Ms. Gertrude Dlamini	Lubombo RHMT	Regional Pharmacist
17	Ms. Phetsile Ndzabandzaba	Lubombo RHMT	Regional M&E Officer
18	Mr. Sabelo Khoza	Lubombo RHMT	Regional AIDS Coordinator
19	Mr. Phila Lushaba	Lubombo RHMT	HMIS Officer
20	Sister Dlamini N	Sithobela Health Center	Head Nurse
21	Dr. Mudiwa	Sithobela Health Center	Head Medical Officer
22	Ms. Phumzile Dlamini	Gigal Clinic	Nurse
23	Ms. Thiya Simelane	SOS Clinic	Nurse
24	Mr. Phesheya Vilakati	Cabrini / Subgrantee	Project Director

S. no	Name of respondent	Affiliation	Job Title
25	Mr. Benedict Xaba	Amicall / Subgrantee	Project Director
26	Mr. Goodman Magagula	CHIPS / Subgrantee	Program Manager
27	Dr. Samson Haumba	URC Eswatini	Country Director
28	Ms. Normusa Musarapasi	URC Eswatini	Associate Director, Clinical Services
29	Ms. Janet Ongole	URC Eswatini	Director, Strategic Information
30	Mr. Alex Kintu	URC Eswatini	Director, Finance and Operations
31	Ms. Hloniphile Mabuza	URC Eswatini	Thematic Lead- Senior Technical Advisor HIV Treatment & Research
32	Mr. Hugben Barugaba	URC Eswatini	Thematic leader- Quality Improvement and Support Systems Advisor
33	Ms. Lindiwe Mkhatshwa	URC Eswatini	Thematic leader- HSS Director /HTS
34	Dr. Yohannes Ghebreyesus	URC Eswatini	Zonal Lead
FGDs			
1	Two participants	Sithobela Health Center	Nurses
2	Three participants	Bholi Clinic	Nurses
3	Two participants	Gilgal Clinic	Mentor Mothers
4	Two participants	Sithobela Hospital	HTS Counsellors
5	Two participants	Bholi Clinic	Lay Counsellors
6	Two participants	Gilgal Clinic	HIMS Associate and HTS Counsellor
7	Two participants	Sithobela Health Center	Mentor Mothers
8	One participant	SOS Clinic	Mentor Mother
9	Two participants	Sithobeweni Hospital	Expert Clients
10	Four participants	Bholi Clinic	Expert Clients
11	Two participants	EASO (Eswatini AIDS Support Organization) SOS (Ekutfokomeni Clinic)	Expert Client and HTS Counsellor
12	Two participants	Gilgal Clinic	Expert Clients
13	Three participants	Ndzevane Clinic	Teen Club Members

D. Informed Consent Form

Title: Evaluation of the Project Aimed at Strengthening Local Capacity to Deliver Sustainable Quality-Assured Universal Coverage of Clinical HIV/TB Services in Lubombo Region, and Providing Central-Level Technical Assistance to ENAP in the Kingdom of Eswatini under PEPFAR

Principal Investigators:

Organization: Ministry of Health (MOH) and University Research Co., LLC

Introduction

My name is [insert name], and I am working for University Research Co., LLC on the Strengthening Local Capacity to Deliver Sustainable Quality-Assured Universal Coverage of Clinical HIV/TB Services in Lubombo Region and Providing Central-Level Technical Assistance to ENAP in the Kingdom of Eswatini under PEPFAR. The project is implementing activities that will assist the MOH and the Lubombo region to reduce the incidence of HIV and TB by 50% among adults and by 90% among children, and to avert 20% of deaths among children, adults, and pregnant women living with HIV (especially those with TB co-infection).

We are conducting an evaluation to measure the extent at which the project is making an impact in the health sector in Eswatini. As I go through this information sheet with you, there may be words or ideas that you are not familiar with. Please interrupt me at any time and ask questions. If you have questions later, you can ask them of me or another evaluator involved in this evaluation.

Purpose of the evaluation

To assess the extent at which the project is making an impact in the health sector in Eswatini and make recommendation for improvements in implementation.

Participant Selection

You have been identified as someone who receives technical support and/or is working closely with the PEPFAR project. We would like to ask you some questions about your experience with this project to better understand how people perceive the project.

Methods of data collection

We will collect information using one of the following methods:

a) We will interview you using a structured questionnaire
b) We would like you to join a small group of people to talk about the project together
c) We have a short questionnaire for you to answer on your own

Voluntary Participation

Your participation in this evaluation is voluntary. It is your choice whether to participate or not. If you choose not to participate, there will be no negative consequences to you. If you decide to

participate, you may change your mind and withdraw from the evaluation at any time. Withdrawing from the evaluation procedures will not impact the support you are receiving.

Procedures

a) We will ask you questions and document your responses in the questionnaire. You are free not to answer any question you do not feel comfortable answering.
b) You will answer the questionnaire in a private area and write your responses in the allocated spaces. If you have any questions as you go, I am happy to help.

Duration

The interview will take about 45 minutes

Risks and Benefits

The risks of participating in this are minimal. Your answers will not be connected to any identifying information (including your name or where you work) and I will keep all information completely confidential. The survey is about the project and we will not ask about personal matters. Although you will not receive direct benefit from participating in this evaluation, your participation is likely to help us improve the support the project gives this health facility or unit.

Reimbursements

You will not be provided any incentive to take part in this evaluation.

Confidentiality

(*For interview/questionnaire participants)* Although we have asked for your signature for this consent form, it will not be connected to your responses and for the questionnaire we will not collect any identifying information about you.

Sharing the Results

We will be compiling the answers from all participants and analysing them based on our evaluation questions. The results will be shared with the Ministry of Health and other stakeholders. We also hope to publish these findings in peer reviewed journals to contribute global learning so others may learn from our experience. The information that you and other participants provide will not be traced back to you. Neither your name nor identifying information will be used in any reports, publications, or meetings held where findings of this evaluation is discussed.

Right to Refuse or Withdraw

You do not have to take part in this evaluation if you do not wish to do so. Your choosing not to participate will not affect your relations now or in the future. You may stop the participation at any time that you wish without any negative impact to you.

Who to Contact

This proposal has been reviewed and approved by Eswatini National Health Research Review Board which is a committee whose task it is to make sure that research participants are protected from harm. This evaluation has also been reviewed by the Institutional Review Board of URC. If you have questions about the evaluation or would like to know more, please contact the Principal Investigator, Dr Samson Haumba: Tel# 24047154/5/6 or the Eswatini National Health Research review board secretariat at +268 2404 9505.

You can ask me any more questions about any part of this evaluation. Do you have any questions?

CERTIFICATE OF CONSENT

I have been invited to take part in CDC Lubombo/ENAP HIV project Mid Term Evaluation (MTR) I have read the information above, or it has been read to me. I have been able to ask questions about it. I am happy that my questions have been answered. I am freely agreeing to take part in this evaluation.

Print Name of Participant: _____

Signature of Participant: _____

Date (Day/month/year):_____

Statement by the evaluator taking consent

I have read the information sheet to the individual. I have done my best to help the individual understand this form. I confirm that the individual could ask questions about the evaluation, and I did my best to answer these. I confirm that the individual has not been forced into giving consent but that it was given freely.

A copy of this form has been provided to the individual. _____

Print Name of evaluator taking the consent; _____

Signature of evaluator taking the consent; _____

Date: Day/month/year _____

E. Abridged Bios of the Evaluation Team Members

Composition of External Investigators

Name and qualifications	Position/experience	Roles
Dr. Swati Sadaphal **MBBS, DVD, MHS**	Is a medical doctor, public health specialist with over 20 years of experience in Adult and Paediatric HIV/AIDS, STIs, TB management, project management, capacity building, quality improvement, and monitoring and evaluation. She is currently working as Senior Technical Advisor, Monitoring, Evaluation & Learning (MEL) at URC HQ.	Lead Evaluator and M&E/ QI/QA Lead
Dr. Babatunde Sanni **MD MPH**	Is a medical doctor with over 18 years' experience in managing international and national health programs on TB, HIV, Maternal and Child Health and Non-Communicable Diseases. He is currently working as Senior Technical Advisor, at URC HQ.	HIV/TB, Health Systems Expert
Dr. Eric Lugada **MD**	Is a public health expert with extensive experience in Health Systems Strengthening, HIV/AIDS Services, Supply Chain Management for Health Commodities, Capacity Building, Monitoring & Evaluation, Operations Research, Financial Management, QA/QI and clinical systems mentoring. He is currently working as Chief of Party for DHAPP HIV/TB care and treatment program in Uganda.	HIV/TB, HIV Clinical Support Systems Expert
Mr. Mandla Mehlo **MSc, MSc , BA, BSc**	Is an M&E specialist and analyst with 15 years' experience in Public health , community health systems, Gender equality, Sexual Reproductive Health and Rights (SRHR), evaluation, Operations Research in Southern Africa(Eswatini) with bilateral and international donors organizations and Government entities (Ministry of Health, DPM's Office, etc.) and International and Local. He is currently working as in independent Monitoring and Evaluation expert.	Local Monitoring and Evaluation Expert

Composition of Internal Investigators

The internal evaluators led the design of the evaluation protocol, facilitate Institutional Review Board approvals, prepared documentation for desk review and planned logistics for successful evaluation.

Name	Designation	Role and responsibilities
Dr. Samson Haumba	URC Eswatini Country Director	• Provided leadership in the design of the evaluation protocol and standards • Sought approval from the URC Institutional Review Boards, the CDC Center for Global Health Associate Director for Science and that of the National Health Research Review Board of Eswatini • Ensured that the execution of the evaluation follow the plan described in the protocol and to high standards of scientific rigor • Oversaw the overall implementation, financing and technical components of the end line review and coordination of the review logistics. • Further national and global learning agenda while being responsive to the needs of the Ministry of Health, Eswatini National AIDS Program, and other stakeholders
Ms. Janet Ongole	Director Monitoring & Evaluation	
Dr. Arnold Mafukidze	Technical Director	
Ms. Lindiwe L.P. Mkhatshwa	HTC Director	
Mr. Alex Kintu	Finance Director	
Dr. Yohannes Ghebreyesus	Associate Director Clinical	

F. Conflict of Interest Statement

The evaluators of the study certify that they have reviewed the evaluation research protocol and to the best of their knowledge they have disclosed any actual or potential conflicts of interest that they may have in regard to the program/projects being evaluated. In addition, prior to participation as an evaluator, each agreed to disclose any actual or perceived conflicts of interest to the Team Leader to assure that he/she is not placed in a position to review and evaluate project that may present the appearance of partiality.

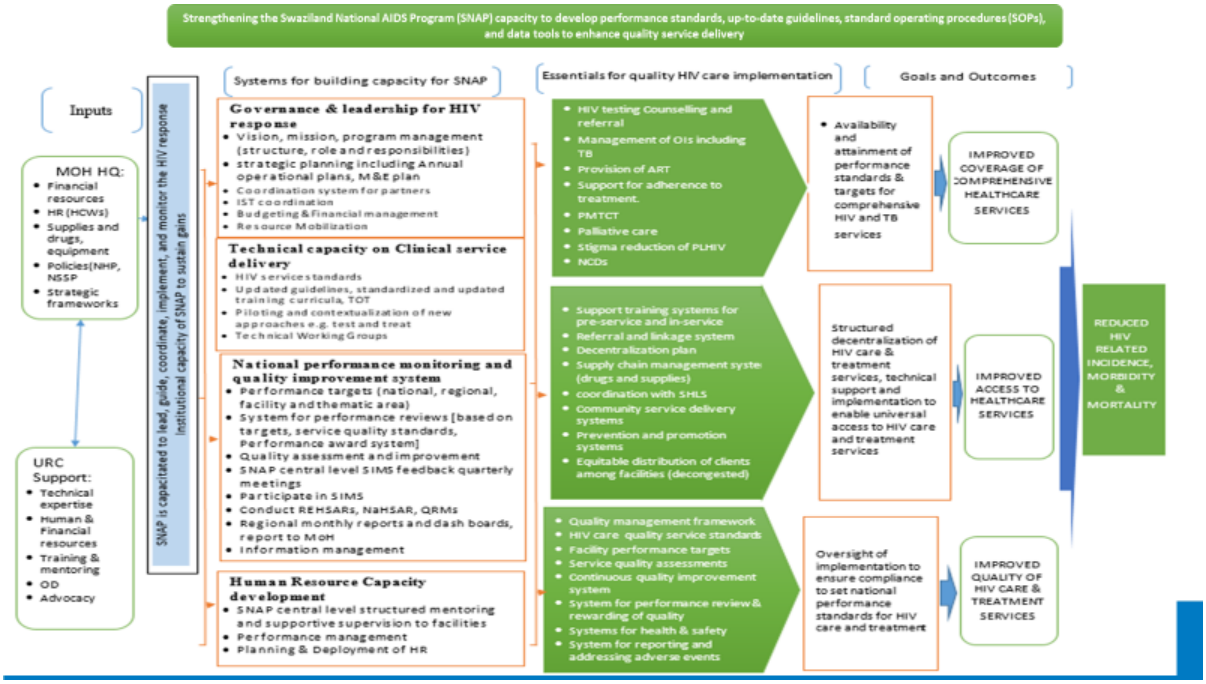
G. Evaluation Costs

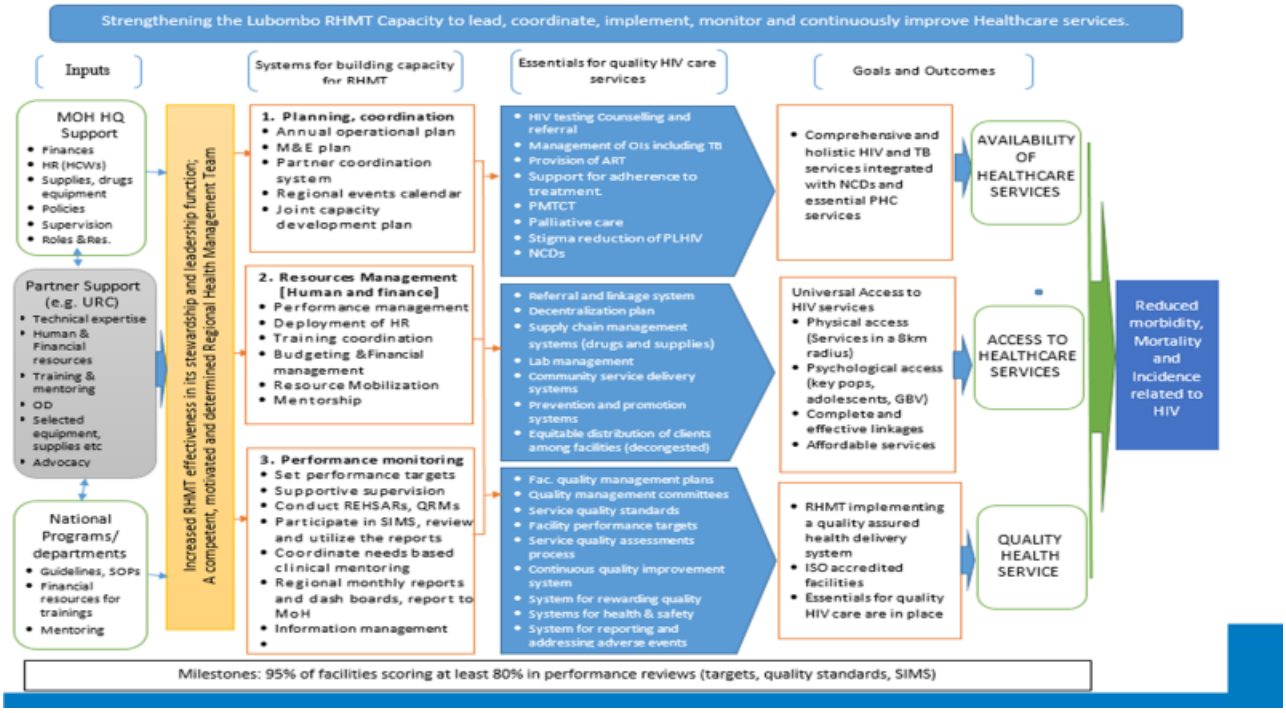
The total annual expenditures related to the evaluation were as follows:

Activity	Year	Total Expenditure
Project Evaluation	FY2019	$35,000
Project Evaluation	FY2020	$35,000

The costs will be shared with the activity manager/project office for entry into the DATIM evaluation inventory.

H. Project Results Framework or Logical Framework





I. Project Products/Deliverables 2015-2020

Project Year One April 2015 – March 2016

PROJECT DELIVERABLE FOLIO NUMBER	ITEM TITLE	CATEGORY (Manuals, standards, guidelines, SOPs, BCC materials, publications, R&R Tools and job aids)	PERIOD	OWNER	DESCRIPTION OF SUPPORT / STATUS AT THE TIME OF REPORTING
1.	HIV/TB Baseline Assessment Report	Baseline Report	September 2015	Project, ENAP, Lubombo RHMT	Printed, disseminated and distributed
2.	Guidelines for community - centered models of Antiretroviral Therapy service delivery (CommART) in Swaziland 2016	Guidelines	March 2016	ENAP	Printed, disseminated and distributed
3.	GBV Guidelines	Guidelines	November 2015	ENAP	Printed, disseminated and distributed
4.	QA/QI framework	Guidelines	February 2016	ENAP, QMP	Printed, disseminated and distributed
5.	Compendium for Performance Targets for Lubombo region and health facilities, 2016	Performance Standards	March 2016	ENAP, QMP / Lubombo RHMT and health facilities	Printed, disseminated and distributed
6.	Revised RHMT organizational structure and TORs in alignment with the NHSSP11 and eNSF goals	Standards	November 2015	Lubombo, RHMT	Printed, disseminated and distributed
7.	Standard Operating Procedure for implementing community-centred models of Antiretroviral Therapy service delivery (CommART) in Swaziland 2016	Standard Operating Procedure	March 2016	ENAP	Printed, disseminated and distributed
8.	Standard Operating Procedures (SOPs) - new HTC algorithm	Standard Operating Procedure	December 2015	ENAP	Printed, disseminated and distributed
9.	Referral and linkage SOP	Standard Operating Procedure	January 2016	ENAP	Printed, disseminated and distributed
10.	National GBV training curriculum and SOP's	SOPs and Manual	January 2016	ENAP	Printed, disseminated and distributed
11.	Initiation of a community-based guide for provision of NCD	Guide /SOP	March 2016	ENAP	Printed, disseminated and distributed

PROJECT DELIVERABLE FOLIO NUMBER	ITEM TITLE	CATEGORY (Manuals, standards, guidelines, SOPs, BCC materials, publications, R&R Tools and job aids)	PERIOD	OWNER	DESCRIPTION OF SUPPORT / STATUS AT THE TIME OF REPORTING
12.	SNAP Documents Control and Knowledge Management Guide	Guide /SOP	January 2016	ENAP	Final Draft
13.	Regional Documents control and records management Guide	Guide/SOP	February 2016	Lubombo RHMT	Final Draft
14.	SNAP Consolidated Work plan 2016- 2017	Work plan	February 2016	RHMT	Printed, disseminated and distributed
15.	Health Sector Response Plan- M&E Plan	M&E Plan	December 2015	ENAP	Printed, disseminated and distributed
16.	Regional Health Management Team (RHMT) capacity building plan (CBP)	Capacity Building Plan	February 2016	Lubombo RHMT	Printed, disseminated and distributed
17.	Lubombo Region Health Work plan (LRHWP)	Work Plan	2016-2017	Lubombo RHMT	Printed, disseminated and distributed
18.	Infection prevention and control (IPC) plans for 30 facilities	IPC Plans	October 2015 - March 2016	Facilities	Printed, disseminated and distributed
19.	Contingency plan to monitor the drought conditions in the Lubombo region	Drought contingency plan	January – March 2016	Project, Lubombo RHMT	Printed, disseminated and distributed
20.	Clinical mentoring tools incorporating gender mainstreaming at facility level	R&R Tools	December 2015	Lubombo region	Printed, disseminated and distributed
21.	M&E, SI support supervision and mentoring checklist	R&R Tool	December 2015	Lubombo-RHMT(SID)	Printed, disseminated and distributed
22.	Updated HTC registers	R&R Tools	December 2015-	MoH, ENAP	Printed, disseminated and distributed
23.	SNAP- led Stepwise Process Improvement for HTS - checklist	R&R Tool	December 2015-	MoH, ENAP	Printed, disseminated and distributed
24.	MoH In-service Training Calendar October - December 2015	IST calendar	October 2015	MoH, ENAP	Printed, disseminated and distributed
25.	Quarterly IST calendar for SNAP for period January – March 2016	IST Calendar	March 2016	MoH, ENAP	Printed, disseminated and distributed
26.	MoH In-service Training Calendar April - June 2016	IST calendar		MoH, ENAP	Printed, disseminated and distributed
27.	SNAP directory of trainers for each of the thematic areas	Database	November 2015	ENAP	In use
28.	Communicable Diseases Module (community health care worker training curriculum)	curriculum	November 2015	Nursing colleges	Final Draft

PROJECT DELIVERABLE FOLIO NUMBER	ITEM TITLE	CATEGORY (Manuals, standards, guidelines, SOPs, BCC materials, publications, R&R Tools and job aids)	PERIOD	OWNER	DESCRIPTION OF SUPPORT / STATUS AT THE TIME OF REPORTING
29.	Integrated Nursing training Curriculum incorporating HIV/AIDS and TB	curriculum	November 2015	Nursing colleges	Final Draft
30. '	Non-research determination protocol entitled: ***'what is the magnitude of HIV positive status misclassification in patients about to initiate on ART in Swaziland?'***	Research protocol	June to October 2016	SNAP	Printed, disseminated and distributed
31.	PIHTS Training of Trainers	Report and training manuals	February 2016	ENAP	Training manual was reviewed and printed
32.	Quality Assurance / Quality Improvement (QA/QI) Training report	Report, toolkit, training modules, training slides		ENAP	Printed, disseminated and distributed
33.	Regional HIV Semi-annual Review (ReHSAR) Data analysis tool kit	Data analysis Tool kit	February 2016	Lubombo RHMT	Printed, disseminated and distributed
34.	Viral load monitoring refresher training report and toolkit	Report and toolkit	October 2015	ENAP	Printed, disseminated and distributed
35.	Viral Load Monitoring • Viral load onsite training report – Cabrini 28th October, 2015 • VL Provider Training toolkit 27.10.15	Report and toolkit	October 2015	ENAP	Printed, disseminated and distributed
36.	QI Assessment toolkit and report (NaHSAR Presentation, QIP Assessment tool, scorecard and story board posters	Report and toolkit	November 2015	SNAP, QMP, Project	TA and resources
37.	Data Quality Management Training report and toolkit for Health Facilities	Training Report	February 2016	Lubombo RHMT	Printed, disseminated and distributed
38.	Routine Data Quality Assessment Reports	Data assessment Reports	March 2016	Project	Printed, disseminated and distributed
39.	Health facility and Regional Strategic Information Department (SID) Training	SI Training Report	February 2016	Lubombo RHMT	Printed, disseminated and distributed
40.	Lubombo ReHSAR 5 Report	Review Report	October 2015	Lubombo RHMT	Disseminated
41.	Lubombo REHSAR 6 Report	Review Report	March 2016	Lubombo RHMT	Disseminated

PROJECT DELIVERABLE FOLIO NUMBER	ITEM TITLE	CATEGORY (Manuals, standards, guidelines, SOPs, BCC materials, publications, R&R Tools and job aids)	PERIOD	OWNER	DESCRIPTION OF SUPPORT / STATUS AT THE TIME OF REPORTING
42.	NaHSAR 11 Report	Review Report	June 2015	ENAP	Disseminated
43.	NaHSAR 12 Report	Review Report	November 2015	ENAP	Disseminated
44.	Semi-annual report to CDC Swaziland of performance data analysis	Progress Report	March 2016	Project	Printed, disseminated and distributed
45.	Annual report to CDC Swaziland of performance data analysis	Progress Report	October 2015	Project	Printed, disseminated and distributed
46.	Quarterly report to PEPFAR through the DATIM	Progress Report	July-September 2015	Project	
47.	Semi-annual report to PEPFAR through the DATIM	Progress Report	October 2015-March 2016	Project	Printed, disseminated and distributed
48.	Basic IMAI training report	Training Report	February 2016	Project	Printed, disseminated and distributed
49.	National NARTIS Training of Trainers report	ToT Training Report	December 2015	Project	Printed, disseminated and distributed
50.	Regional NARTIS Training Report	Training Report	March 2016	Project	Printed, disseminated and distributed
51.	Regional TB/HIV Training for nurses report	Training Report	February 2016	ENAP	Printed, disseminated and distributed
52.	SNAP program review report	Review Report	January 2016	ENAP	Printed, disseminated and distributed
53.	Lubombo Region Health Work planning (LRHWP) workshops reports	Planning Report	January 2016	ENAP	Printed, disseminated and distributed
54.	Induction and orientation of newly deployed nurse managers in Lubombo Region report	Orientation Report	January 2016	ENAP	Printed, disseminated and distributed
55.	CDC led SIMS assessment reports	SIMS assessment Reports	January 2016	ENAP	Printed, disseminated and distributed
56.	Facilities Assessment of provision for food support for PLHIV on treatment - Report	Assessment Report	January 2016	ENAP	Printed, disseminated and distributed
57.	ART site accreditation assessment - Ikwezi Clinic report	Site Accreditation Report	January 2016	ENAP	Printed, disseminated and distributed
58.	ART site accreditation assessment - SOS Siteki Clinic report	Site Assessment Report	November 2015	ENAP	Printed, disseminated and distributed
59.	Monthly Teen Club Meeting Reports	Reports	October 2015 – March 2016	Project	Printed, disseminated and distributed

PROJECT DELIVERABLE FOLIO NUMBER	ITEM TITLE	CATEGORY (Manuals, standards, guidelines, SOPs, BCC materials, publications, R&R Tools and job aids)	PERIOD	OWNER	DESCRIPTION OF SUPPORT / STATUS AT THE TIME OF REPORTING
60.	Onsite training on Therapeutic Support groups at Sitsatsaweni Nazarene Clinic report	Onsite training Report	March 2016	Project	Printed, disseminated and distributed
61.	HTC couples testing month report	HIV Communication Report	February 2016	Project	Printed, disseminated and distributed
62.	TB accreditation assessments to a TB basic management unit (BMU) report	TB accreditation Report	October 2015 – March 2016	Project	Printed, disseminated and distributed
63.	Infection prevention and control (IPC) assessments reports for 38 facilities	IPC assessment Reports	October 2015 - March 2016	Project	Printed, disseminated and distributed
64.	World TB day commemoration in the Lubombo region publication	Publication	March 2016	Lubombo RHMT	Printed, disseminated and distributed
65.	World AIDS Day publication	Publication	December 2015	SNAP	Printed, disseminated and distributed
66.	URC monthly newsletters	Publications	October 2015 – March 2016	Project	Printed, disseminated and distributed
67.	Technical monthly updates	Publications	October 2015 – March 2016	Project	Printed, disseminated and distributed
68.	Success Story ***– 'Setting performance targets for health facilities towards meeting the 90-90- 90 UNAIDS targets by 2010'***	Publication	March 2016	Lubombo RHMT	Printed, disseminated and distributed
69.	Success Story – ***'Improving Viral Load Monitoring at Cabrini'***	Publication	October 2015	Cabrini clinic, Lubombo	Printed, disseminated and distributed
70.	Success Story – ***'Development of BCC Materials for the Deaf'***	Publication	March 2016	Lubombo RHMT	Printed, disseminated and distributed
71.	Success story - ***Partnership With Cabrini Ministries Mobile Outreach Clinic To Create Access To HIV/TB Services In The Rural Areas Of Lubombo Region, Swaziland***	Publication	March 2016	Cabrini clinic, Lubombo	Printed, disseminated and distributed
72.	Success story - ***Improving on-time pill-pick up rates for patients on ART at Siteki Nazarene Clinic, Lubombo region, Swaziland.***	Publication	March 2016	Siteki Nazarene, Lubombo	Printed, disseminated and distributed

Project Year Two April 2016 – March 2017

PROJECT DELIVERABLE FOLIO NUMBER	ITEM TITLE	CATEGORY (Manuals, standards, guidelines, SOPs, BCC materials, publications, R&R Tools and job aids)	PERIOD	OWNER	DESCRIPTION OF SUPPORT / STATUS AT THE TIME OF REPORTING
73.	ACSM Strategy	Strategy Document	23 May-2016	ENAP	Draft awaiting input from the situational analysis
74.	Lubombo Referral Hospital IPC Training Report	Report	30 November 2016	Lubombo Referral Hospital / Project	Finalized and shared
75.	URC Newsletters	Publications	April 2016 – March 2017	Project	Shared
76.	World AIDS Campaign December 2016	Report	December 2016	Project	Shared
77.	Communications Plan revised	Plan	1 June 2016	Project	Draft
78.	Drug & Supply Chain Management Training Report - Shewula Clinic	Report	25 June 2016	Shewula Clinic / Project	Finalized and shared
79.	Final submission PY2 CDC ENAP/Lubombo TA work plan	Work Plan	20 April 2016	Project	Shared
80.	Technical Monthly Updates	Publications	April 2016 – March 2017	Project	Shared
81.	Health Care Risk Waste Collection Training for Waste Collecting Drivers and Incinerator Operators	Report	06 – 08 April 2016	RHMTs / Project	Finalized and shared
82.	In-Service Training Guidelines 2015	Guidelines	November 2015	MoH	Printed and shared
83.	Doctors Training on Community ART Models	Report	29 April – 01 May 2016	ENAP	Finalized and shared
84.	Lubombo Health Care Workers Training on Comprehensive Post GBV Care	Report	11 - 13 May 2016	RHMT	Finalized and shared
85.	Lubombo Multi-facility SES template	Template	5 May 2016	RHMT	Shared
86.	Maloma Mine lessons learned	Publication	01 June 2016	Maloma Mine / Project	Shared
87.	MoH In-service Training Calendar	Calendar	April 2016 - March 2017	MoH	Shared
88.	Lubombo Targets	Compilation of targets	April 2016 - March 2017	RHMT	Finalized and shared
89.	Lubombo Nurses Regional Training on Palliative Care	Report	28 November - 02 December 2016	RHMT / ENAP / Project	Finalized and shared
90.	Hlane Clinic Test and Start Training	Report	22 November 2016	Hlane Clinic / Project	Finalized and shared
91.	Second URC Sub Recipients Collaborative Learning Session	Report	15 December 2016	Project	Finalized and shared
92.	PY2 CDC ENAP_LUBOMBO TA work plan - implementation status and performance measure template	Form / Template	April 2016 - March 2017	Project	Shared
93.	QI Project Success Story for Siteki Nazarene Clinic	Publication	June 2016	Siteki Nazarene Clinic / Project	Shared
94.	Tabankulu World AIDS Day Commemoration	Report	26 November 2016	Tabankulu Clinic / Project	Finalized and shared
95.	QRM Workshop evaluation form	Form / Template	May 2016	Project	Finalized and shared
96.	Quality Assurance and Safety in HIV testing Services	Presentation	19-04-16	ENAP / Project	Shared
97.	Semi Annual Performance Report _Narrative Submitted	Report	Oct-Mar FY16	Project	Shared

PROJECT DELIVERABLE FOLIO NUMBER	ITEM TITLE	CATEGORY (Manuals, standards, guidelines, SOPs, BCC materials, publications, R&R Tools and job aids)	PERIOD	OWNER	DESCRIPTION OF SUPPORT / STATUS AT THE TIME OF REPORTING
98.	ENAP GEN F001 v0.1 Information needs assessment questionnaire	Form / Questionnaire	July 2016	ENAP	Finalized and shared with ENAP Quality Office
99.	ENAP Monthly Status Update Template	Template	April 2016 – March 2017	ENAP	Shared
100.	ENAP Resource Centre Set up and Management Plan	Work plan	13 November 2016	ENAP	Finalized and shared with ENAP Quality Office
101.	ENAP Website	Proposal	April 2016 – March 2017	ENAP	Draft 90% complete
102.	Standard Format for Documentation of Quality Improvement Interventions in Swaziland	Form / Template	May 2016	MoH	Shared
103.	Standard Operating Procedure for the Reception	SOP	April 2016	Project	Finalized and shared
104.	Success Story - Target setting workshop	Publication	March 2016	Project	Shared internally
105.	Training database	Electronic Database	FY16 (20 April 2016)	Project	In the custody of the M&E team
106.	Lomahasha Clinic On-site Training on QA/QI	Report	12th July 2016	Lomahasha Clinic / Project	Finalized and shared
107.	URC PACT meeting minutes			Project	Shared
108.	Viral load scale up checklist for site readiness assessment revised	Recording and Reporting Tool		ENAP	Shared
109.	IMPaC Training	Report	10th to 14th October 2016	Project	Finalized and shared
110.	Strengthening HIV and Tuberculosis (TB) clinical service delivery by integrating HIV and Tuberculosis (TB) training modules in the Pre-service nurse training curriculum in Swaziland.	Abstract	12 - 14 July 2016	ENAP	Submitted
111.	Completion and Reasons for Non-completion of Isoniazid Preventive Therapy among HIV Infected Patients in Swaziland	Abstract	12 - 14 July 2016	ENAP	Submitted
112.	Decentralization of clinical HIV care and treatment services requires the decentralization and integration of other enhancing systems (M&E and pharmacy systems)	Abstract	12 - 14 July 2016	ENAP / Project	Submitted
113.	High rates of Silicosis, Tuberculosis and occupational related disabilities among ex-miners in Swaziland	Abstract	12 - 14 July 2016	Project	Submitted
114.	Inadvertent Resistance Amplification through Treatment of Isoniazid Mono- and Poly-Resistant Strains of Tuberculosis in Swaziland	Abstract	12 - 14 July 2016	Project	Submitted
115.	Profile of the aging population of People living with HIV (PLHIV) on antiretroviral therapy (ART) at Good Shepherd Hospital (GSH)	Abstract	12 - 14 July 2016	Project	Submitted
116.	Healthcare Workers (HCW) Knowledge Base in fighting TB	Abstract	12 - 14 July 2016	Project	Submitted
117.	Provision of HIV testing services during the International Trade Fair- identifying successes and barriers to linkage to care	Abstract	12 - 14 July 2016	Project	Submitted
118.	Shewula Nazarene Clinic	Report	07 September 2016	Project	Finalized and shared

PROJECT DELIVERABLE FOLIO NUMBER	ITEM TITLE	CATEGORY (Manuals, standards, guidelines, SOPs, BCC materials, publications, R&R Tools and job aids)	PERIOD	OWNER	DESCRIPTION OF SUPPORT / STATUS AT THE TIME OF REPORTING
	QA/QI Onsite Training Report				
119.	Nkalashane Clinic QA/QI Onsite Training Report	Report	07 September 2016	Nkalashane Clinic	Finalized and shared
120.	Performance COP15_FY16	Poster	Oct 2015 - Sept 2016	Project	Shared
121.	Decentralization of clinical HIV care and treatment services	Poster	July 12-14, 2016	Project	Printed
122.	Provision of HIV services at Trade Fair	Poster		Project	Printed
123.	Shewula QIP	Poster	24 September 2016	Shewula Clinic / Project	Printed
124.	IPT uptake at Sitsatsaweni Nazarene clinic	Story Board	23 September 2016	Sitsatsaweni Nazarene clinic / Project	Printed
125.	LLAPLa uptake at Gilgal Clinic	Story Board	24 September 2016	Gilgal Clinic / Project	Printed
126.	Improving Linkage uptake at Bholi Clinic	Story Board	March to September 2016	Bholi Clinic / Project	Printed
127.	On time pill pick up at Siteki Nazarene Clinic	Story Board	23 September 2016	Siteki Nazarene Clinic / Project	Printed
128.	Onsite Orientation on Test and Start at Bholi Clinic	Report	20 October 2016	Bholi Clinic / Project	Finalized and shared
129.	Onsite Orientation on Test and Start at Cabrini Ministries Clinic	Report	25 October 2016	Cabrini Ministries Clinic / Project	Finalized and shared
130.	Onsite Orientation on Test and Start at Lubuli Clinic	Report	18 October 2016	Lubuli Clinic / Project	Finalized and shared
131.	Onsite Orientation on Test and Start at Sigcaweni Nazarene Clinic	Report	18 October 2016	Sigcaweni Nazarene Clinic / Project	Finalized and shared
132.	Onsite Orientation on Test and Start at Sitsatsaweni Nazarene Clinic	Report	26 October 2016	Sitsatsaweni Nazarene Clinic / Project	Finalized and shared
133.	Onsite orientation on Test and Start at Ubombo Hospital	Report	25 October 2016	Ubombo Hospital / Project	Finalized and shared
134.	SOP for Implementing CommART in Swaziland	SOP	June 2016	ENAP	Finalized and shared
135.	National Policy Guidelines for CommART in Swaziland	Policy	June 2016	ENAP	Finalized and shared
136.	URC Staff QRM Handbook	Handbook	November 2016	Project	Finalized and shared
137.	ReHSAR 7 Report	Report	27 – 30 September 2016	Lubombo RHMT / Project	Finalized and shared
138.	Quality Management Training Report	Report	02 - 04 November 2016	Lubombo RHMT / Project	Finalized and shared

PROJECT DELIVERABLE FOLIO NUMBER	ITEM TITLE	CATEGORY (Manuals, standards, guidelines, SOPs, BCC materials, publications, R&R Tools and job aids)	PERIOD	OWNER	DESCRIPTION OF SUPPORT / STATUS AT THE TIME OF REPORTING
139.	47th International Union Conference on Lung Health	Report	25 – 30 October 2016	Project	Finalized and shared
140.	Gucuka Clinic Onsite Training on Establishment of Teen Clubs	Report	22 November 2016	Gucuka Clinic / Project	Finalized and shared
141.	Onsite Refresher Training on Couples Testing and PIHTC - Cabrini Ministries	Report	19 - 23 Sept 2016	Cabrini Ministries / Project	Finalized and shared
142.	PIHTC Training Report for Good Shepherd Hospital	Report	13 - 14 January 2016	Good Shepherd Hospital / Project	Finalized and shared
143.	HTS Lay Counselors Training on Adherence and Psychosocial Support including Stigma and Discrimination	Report	10 - 12 August 2016	ENAP	Finalized and shared
144.	National PIHTC Trainers of Trainers Training on Adherence and Psychosocial Support including Stigma and Discrimination	Report	27 - 29 June 2016	ENAP	Finalized and shared
145.	Training for Trainers (TOT) on PIHTC and Couples Testing	Report	02 - 06 November 2015	ENAP	Finalized and shared
146.	Regional Test and Start Orientation Workshop for Lay HTS Counselors	Report	25 - 28 October 2016	ENAP	Finalized and shared
147.	Advanced IMAI Training for Doctors	Report	03 - 07 October 2016	ENAP	Finalized and shared
148.	Basic IMAI Training for Nurses	Report	15 - 19 February 2016	ENAP	Finalized and shared
149.	Sensitization of Lubombo Nurse Managers on RHMs Guidelines	Report	02 December 2016	Lubombo RHMT / Project	Finalized and shared
150.	Mentors' Training on CommART	Report	13 – 15 April 2016	ENAP	Finalized and shared
151.	NARTIS Training for Nurses in the Lubombo Region	Report	07 - 11 March 2016	ENAP	Finalized and shared
152.	Ebenezer Wesleyan Clinic Test and Start Training	Report	26 October 2016	Ebenezer Wesleyan Clinic / Project	Finalized and shared
153.	Nkalashane Clinic Test and Start Training	Report	24 October 2016	Nkalashane Clinic / Project	Finalized and shared
154.	Sub Recipients Infection Prevention and Control Training	Report	24 November 2016	Project	Finalized and shared
155.	Standard Operating Procedures for Isoniazid Preventive Therapy	SOP	December 2016	ENAP	Finalized and shared
156.	Standard Operating Procedures for the use of viral load test for ART patient monitoring	SOP	December 2016	ENAP	Finalized and shared
157.	Wellness Day Commemoration at Phocweni Army Barracks	Report	09 December 2016	Phocweni Army Barracks	Finalized and shared
158.	RSSC Clinics: Simunye, Ngomane and Mhlume Viral Load Onsite Training	Report	07 December 2016	RSSC Clinics: Simunye, Ngomane and Mhlume / Project	Finalized and shared
159.	Shewula Clinic Viral Load Training	Report	06 December 2016	Shewula Clinic / Project	Finalized and shared

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160.	Gucuka Clinic QA.QI Training	Report	21 November 2016	Gucuka Clinic / Project	Finalized and shared
161.	Onsite Training on QA.QI at Ndzevane Clinic	Report	01 November 2016	Ndzevane Clinic / Project	Finalized and shared
162.	RSSC Wellness Clinics VIA Onsite Training	Report	02 November 2016	RSSC Wellness Clinics / Project	Finalized and shared
163.	Gucuka Clinic Viral Load Onsite Training	Report	12 December 2016	Gucuka Clinic / Project	Finalized and shared
164.	Onsite training on Viral Load Monitoring at Bholi Clinic	Report	23 November 2016	Bholi Clinic / Project	Finalized and shared
165.	Onsite training on Viral Load Monitoring at Lubuli Clinic	Report	16 November 2016	Lubuli Clinic / Project	Finalized and shared
166.	Onsite Training on Viral Load Monitoring at Sitsatsaweni Nazarene Clinic	Report	21 November 2016	Sitsatsaweni Nazarene Clinic / Project	Finalized and shared
167.	Onsite Training on QA/QI at Lubuli Clinic	Report	13 December 2016	Lubuli Clinic / Project	Finalized and shared
168.	Onsite Training on TB Management at Sitsatsaweni Nazarene Clinic	Report	12 December 2016	Sitsatsaweni Nazarene Clinic / Project	Finalized and shared
169.	Facility Document Master File	SOPs	February 2017	Lubombo facilities / Project	Finalized and shared
170.	Lomahasha Clinic On-site Training on Viral Load Monitoring	Report	25 October 2016	Lomahasha Clinic / Project	Finalized and shared
171.	Lomahasha Clinic On-site Training on Test and Start	Report	19 October 2016	Lomahasha Clinic / Project	Finalized and shared
172.	Lomahasha Clinic On-site Training Report on QA.QI	Report	12th July 2016	ENAP	Finalized and shared
173.	2017 Desktop Calendar	Calendar	2017	Project	Finalized and shared
174.	Onsite Training in Viral Load at Tambuti Clinic	Report	22 February 2017	Tambuti Clinic	Finalized and shared
175.	Onsite Training in Viral Load at Ndzevane Clinic	Report	24 January 2017	Ndzevane Clinic	Finalized and shared
176.	Durban Drivers Retreat Training	Report	02 - 05 March 2017	Project	Finalized and shared
177.	Maphiveni Community Dialogue	Report	10 March 2017	Project	Finalized and shared
178.	Second URC Sub Recipients Collaborative Learning Session Report	Report	15 December 2016	Project	Finalized and shared
179.	ENAP QA F002 HIV Assessment Summary Sheet	Toolkit	2016	ENAP	Finalized and shared
180.	Clinic Manual Template	Manual Template	October 2016	ENAP	Finalized and shared
181.	ENAP Document and Records Management SOP	SOP	December 2016	ENAP	Finalized and shared
182.	ENAP Monthly Reporting Template	Form	2016	ENAP	Finalized and shared
183.	ENAP Quarterly Reporting Template	Form	2016	ENAP	Finalized and shared
184.	SOP for Completing the HTS Register	SOP	January 2017	ENAP	Finalized and shared
185.	Index Testing	Presentation	15 March 2017	ENAP	Finalized and shared

PROJECT DELIVERABLE FOLIO NUMBER	ITEM TITLE	CATEGORY (Manuals, standards, guidelines, SOPs, BCC materials, publications, R&R Tools and job aids)	PERIOD	OWNER	DESCRIPTION OF SUPPORT / STATUS AT THE TIME OF REPORTING
186.	HIV Assessment Tools	Toolkit	March 2017	ENAP	Finalized and shared
187.	Refresher Presentation on IST	Toolkit	10 March 2017	Project	Finalized and shared
188.	ENAP Presentation Template	Template	March 2017	ENAP	Finalized and shared
189.	Zonal Collaborative Learning Sessions Report	Report	7-10 Feb 2017	RHMT	Finalized and shared
190.	MoH Documents and Records Management Training Toolkit	Toolkit	2017	ENAP / Project	Finalized and shared
191.	Lubombo RHMT Terms of Reference	Terms of Reference	October 2016	RHMT	Final Draft Shared
192.	Male Engagement Re Strategy Meeting	Meeting Minutes	20 March 2017	Project	Finalized and shared
193.	FAST Meeting in Cape Town	Trip Report	13 - 15 March 2016	Project	Finalized and shared
194.	Couple Testing Events Report: Hosanna Church and Ebenezer Community Events	Report	February 2017	RHMT	Finalized and shared
195.	CQuIN Learning Network Launch in Durban	Trip Report	26 – 28 March 2017		Finalized and shared
196.	Knowledge Management Project Year II Activities	Booklet	April 2016- March 2017	Project	Finalized and shared
197.	TB QRM	Report	22 – 24 March 2017	Health facilities	Finalized and shared
198.	ART Literacy Brochure	Brochure	March 2017	ENAP	Shared
199.	HIV Assessment Training	Report	22 - 24 February 2017	ENAP	Mandzisi needs to insert information in the last section
200.	Knowledge Management Project Year 2 Report	Report	Apr 2016 – Mar 2017	Project	Finalized and shared
201.	HTS Stakeholders' Meeting Report	Report	15 March 2017	ENAP	Finalized and shared
202.	Success Story Booklet	Booklet	April 2016 – March 2017	Project	Finalized and shared
203.	ENAP Newsletter	Publication	January – March 2017	ENAP	Finalized and shared
204.	Viral Load Flier	Brochure	2017	ENAP	Finalized and shared
205.	NaHSAR	Report	November 2016	ENAP	Finalized and shared
206.	Trip Report: 1st National Conference on Violence Prevention	Report	22 August 2016	Project	Finalized and shared

Project Year Three April 2017 – March 2018

PROJECT DELIVERABLE FOLIO NUMBER	ITEM TITLE	CATEGORY (Manuals, standards, guidelines, SOPs, BCC materials, publications, R&R Tools and job aids)	PERIOD	OWNER	DESCRIPTION OF SUPPORT / STATUS AT THE TIME OF REPORTING
207.	URC Newsletters	Publications	April 2017 – March 2018	Project	Shared
208.	Technical Monthly Updates	Publications	April 2017 – March 2018	Project	Shared
209.	MoH In-service Training Calendars	Calendar	April 2017 - March 2018	MoH	Shared
210.	ENAP Resource Centre Monthly Reports	Reports	July 2017 – March 2018	ENAP	Finalized and shared
211.	Human Resource for Health Work Plan for 2017 and Reporting Template	Work plan and Reporting Template	April 2017		Shared
212.	Approval for the Pilot of the HTS Retesting Register and Invitation Slip	Memo	06 April 2017	ENAP	Shared
213.	TB/HIV/PMTCT Mid-Term Review	Report	May 2017	ENAP	Shared
214.	Human Resource for Health Work Plan for 2017 and Reporting Template	Work plan and Reporting Template	April 2017		Finalized and shared
215.	ENAP Newsletters	Publications	April – September 2017	ENAP	Finalized and shared
216.	ENAP Capacity Building Plan 2016-2018	Plan	July 2016	ENAP	Finalized and shared
217.	Quarterly Review Meetings	Information Packs, Reports	April 2017 -March 2017	Project	Finalized and shared
218.	Onsite trainings on Stigma and Discrimination reduction at Sinceni and Tikhuba Clinics	Report	22-23 May 2017	Facilities	Finalized and shared
219.	Onsite trainings on Stigma and Discrimination Reduction at Vuvulane, Malindza and Siphofaneni Clinics	Report	16-18 May 2017	Facilities	Finalized and shared
220.	Lubombo RHMT Meeting – Work plan 2017 - 2018 and annual report dissemination	Technical Brief	9 June 2017	RHMT	Finalized and shared
221.	15th NaHSAR	Compilation of all presentations	June 2017	ENAP	Finalized and shared
222.	The Executive Leadership Forum (TELF) 2017	Report	09 June 2017	Project	Finalized and shared
223.	Lubombo Region Quarterly Events Calendar	Calendar	July - September, 2017	RHMT	Finalized and shared
224.	Continuing Medical Education for Doctors on Management of ART Failure Clients	Report	05 August 2017	ENAP	Finalized and shared
225.	ENAP Annual Work Plan	Work Plan	April 2017 – March 2018	ENAP	Finalized and shared
226.	HTS Eligibility Screening Form for Healthcare Facilities	Form	December 2017	Project	Finalized and shared
227.	IPT Pilot Feedback	Meeting Report	April - June 2017	Project	Finalized and shared
228.	Lubombo Referral Hospital ART Accreditation Meeting	Meeting Minutes	05 September 2017	Lubombo Referral hospital	Finalized and shared
229.	ReHSAR 9	Report, Agenda	25 – 27 September 2017	Lubombo REHMT	Finalized and shared

PROJECT DELIVERABLE FOLIO NUMBER	ITEM TITLE	CATEGORY (Manuals, standards, guidelines, SOPs, BCC materials, publications, R&R Tools and job aids)	PERIOD	OWNER	DESCRIPTION OF SUPPORT / STATUS AT THE TIME OF REPORTING
230.	Lay Cadre Performance Tracking Workshop – Southern Zone	Report	11 August 2017	Project	Finalized and shared
231.	Updated Chronic Care File	Chronic Care File	2017	ENAP	Finalized and printed
232.	Health Facility Management Curriculum Development Workshop	Report	25 - 27 September 2017	MoH training unit, RHMT	Finalized and shared
233.	Lay Cadre Performance Tracking Workshop – Northern zone	Report	15 September 2017	Project	Finalized and shared
234.	HIV Viral Load Regional Workshop	Report	23 – 25 October 2017	ENAP, RHMT, Project	Finalized and shared
235.	Swaziland National HIV Test and Start Communication Strategy	Strategy	2016-2020	ENAP	Finalized and shared
236.	Stepped-Up Adherence Counselling for Clients with a High Viral Load	Toolkit	2017	ENAP	Dr Nomthie to provide finalized document
237.	Supply Chain Management Training at Gucuka Clinic	Report	15 August 2017		Finalized and shared
238.	Adolescent Health Day at Siteki Nazarene High School	Report	09 August 2017	Siteki Nazarene clinic	Finalized and shared
239.	Lubombo Outreach	Report	August 2017	Lubombo RHMT	Finalized and shared
240.	Birth Testing Training at Good Shepherd Hospital Maternity Ward	Report	07 -08 August 2017	Project, RHMT	Finalized and shared
241.	First Sub Recipients Collaborative Learning Forum Report	Report	04 - 05 December 2017	Project, RHMT	Finalized and shared
242.	**Success Story:** Establishing feasibility of integrating HIV care into existing PHU outreaches	Publication	2018	Project	Finalized and shared
243.	Swaziland International Trade Fair	Report	2017	Project	Finalized and shared
244.	National Stakeholder Workshop on SHIMS Implications for HIV Programming	Report	28 September 2017	MOH	Finalized and shared
245.	World Mental Health Day Commemoration at Siteki hotel	Report	18 October 2017	Project	Finalized and shared
246.	Early Warning Signs of Childhood Cancer Training	Report	02 – 03 October 2017	Project	Finalized and shared
247.	Orientation on CommART for HIV Support Group Networks	Report	14 November 2017	ENAP, Project	Finalized and shared
248.	Bholi Clinic Facility Health Semi – Annual Review (FaHSAR) Workshop	Report	17 November 2017	Bholi Clinic, RHMT, Project	Finalized and shared
249.	NARTIS Training for Nurses in the Lubombo Region	Report	13 - 17 November 2017	ENAP, RHMT, Project	Finalized and shared
250.	Orientation on Recording & Reporting tools at Ubombo Sugar Hospital	Report	20 December 2017	RHMT, Project	Finalized and shared
251.	Project Performance Review and Annual Planning Meeting	Report	01 - 3rd November 2017	Project	Finalized and shared
252.	Supply Chain Management Training at Mambane Clinic	Report	20 February 2018	RHMT, Project	Finalized and shared
253.	URC-Sithobela RHC Managers Technical Meeting	Meeting Minutes	21st February 2018	RHMT, Project	Finalized and shared
254.	CQUIN DSD: Partnering to Advance Differentiated Service Delivery	Trip Report	12 to 16 February 2018	Project	Finalized and shared
255.	Malindza Refugee Camp Clinic Children's Day	Report	17 March 2018	RHMT, Project	Finalized and shared
256.	New Thulwane Clinic Sexual Reproductive Health Day	Report	23 March 2018	RHMT, Project	Finalized and shared
257.	Health Workforce Assessment	Report	2017	MoH	Finalized and shared

PROJECT DELIVERABLE FOLIO NUMBER	ITEM TITLE	CATEGORY (Manuals, standards, guidelines, SOPs, BCC materials, publications, R&R Tools and job aids)	PERIOD	OWNER	DESCRIPTION OF SUPPORT / STATUS AT THE TIME OF REPORTING
258.	Test and Start Information for HCWs		March 2018	ENAP	Finalized and shared
259.	HIV NSF 2018 -2022 Care and Treatment Section	National Strategic Framework	March 2018	ENAP	Finalized and shared
260.	Hlane Buganu Marula Festival	Report	09 - 10 March 2018		Finalized and shared
261.	Quality Improvement Projects				

Project Year Four April 2018 – March 2019

PROJECT DELIVERABLE FOLIO NUMBER	ITEM TITLE	CATEGORY (Manuals, standards, guidelines, SOPs, BCC materials, publications, R&R Tools and job aids)	PERIOD	OWNER	DESCRIPTION OF SUPPORT / STATUS AT THE TIME OF REPORTING
262.	URC Newsletters	Publications	April 2018 – March 2019	Project	Shared
263.	Technical Monthly Updates	Publications	April 2018 – March 2019	Project	Shared
264.	MoH In-service Training Calendar	Calendar	April 2017 - March 2018	MoH	Shared
265.	ENAP Newsletters	Publications	April – September 2018	ENAP	Finalized and shared
266.	Lubombo Region Health Work Plan Development Workshop Report	Report	09 – 12 April 2018	Lubombo RHMT	Finalized and shared
267.	URC Staff QRMs	Reports, presentations and associated documents	April 2018 – March 2019	Project	Shared
268.	Acceleration towards HIV Epidemic Control in Lubombo Region, Swaziland: URC Programmatic Shifts Effective April 2018	Workplan	April 2018	Project	Finalized and shared
269.	ReHSARs	Report	May 2018	Lubombo RHMT	Finalized and sahred
270.	Training in Facility Documents & Records Management	Report and Toolkit	03 May 2018	ENAP / Project	Finalized and shared
271.	NaHSARs	Report			
272.	Facility Factsheet Booklet	Publication	May 2018	Project / RHMT	Finalized and shared
273.	HIV Self-Testing Information	PowerPoint Presentation, SOP, Tools	May 2018	ENAP / Project	Finalized and shared
274.	ENAP Resource Centre Reports	Reports	May 2018 – March 2019	ENAP	Finalized and shared
275.	HIV Active Case Finding Tools	Communication Strips, Index testing log	May 2018	Project	Finalized and shared
276.	Orientation of the Lubombo RHMT on the 2018 HIV Management Guidelines and Programmatic Shifts to Achieve FY 17 Targets	Report	06-07 June 2018	ENAP / Project	Finalized and shared
277.	MER 2 0 Indicator Reference Guide V 2 2	Tools	2 Oct 2017		Finalized and shared
278.	Quality Improvement Projects	QIP Journals, PowerPoint Presentations	April 2018 – March 2019	Project / RHMT	
279.	ENAP Above Site SIMS Assessment Report	Report	09 August 2018	Project	Finalized and shared
280.	HIV Risk assessment tools	R&R Tools	21 May 2018	Project	Finalized and shared
281.	TLD Phase in	Memos, algorithm, factsheet, presentation	Aug to Sept 2018	ENAP	Finalized and shared
282.	Quality Management Section of the Health Sector Response to HIV (2018 – 2023)	Strategic Plan	24 -27 Sep 2018	ENAP	Finalized and shared
283.	KM III Airport Clinic Health and Wellness Day	Agenda, report	29 October 2018	Lubombo RHMT/ Project	Finalized and shared
284.	APR18 Narrative_URC_01 October 2017 to 30 September 2018	Report	22 October 2018	Project	Shared
285.	Facility QIP Auditing Tool	QIP Auditing Tool	'November 2018	ENAP	Finalized and shared

Project Year Five April 2019- March 2020

PROJECT DELIVERABLE FOLIO NUMBER	ITEM TITLE	CATEGORY (Manuals, standards, guidelines, SOPs, BCC materials, publications, R&R Tools and job aids)	PERIOD	OWNER	DESCRIPTION OF SUPPORT / STATUS AT THE TIME OF REPORTING
286.	Easter Monday Commemoration in Siphofaneni	Report	22 April 2019	URC / Siphofaneni	Shared
287.	URC Newsletters	Publications	April 2019- March 2020	Project	Shared
288.	Technical Monthly Updates	Publications	April 2019- March 2020	Project	Shared
289.	ENAP Newsletters	Publications	April 2019-March 2020	ENAP	Shared
290.	Symposium for Improving TB Preventive Therapy Uptake and Completion among People Living with HIV and child contacts of patients with active TB in the Lubombo Region	Report, Presentations	06 - 07 May 2019	RHMT / URC	Shared
291.	ENAP Planning Workshop	Report	28 Feb - 01 Mar 2019	ENAP / URC	Shared
292.	TB Preventive Therapy (TPT) Posters	Posters	May 2019	URC	Shared
293.	TB IEC Development Workshop	Participant's report	13 - 17 May 2019	URC	Shared
294.	Men's Health Planning Meeting	Participant's notes	21 May 2019	URC	Shared
295.	Expert Client Training	Report	04 - 07 June 2019	URC	Shared
296.	NARTIS Feedback Workshop	Report	07 June 2019	URC	Shared
297.	5th HIV Health Sector Partners' Coordination Forum	Report	23 May 2019	URC	Shared
298.	**Publication:** Human Resources Support of Volunteers/Lay Cadre by URC	Publication	June 2019	URC	Shared
299.	World Blood Donor Day Commemoration	Report	14 June 2019	URC	Shared
300.	Orientation of health care workers from Gilgal Clinic, Mpolonjeni Clinic, Ebenezer Clinic and Siteki Public Health Unit (PHU) on the Surge activities and orientation of health care workers at Ebenezer Clinic on PrEP	Report	July 2019	URC	Shared
301.	Onsite trainings on the amendment to the 2018 Eswatini Integrated HIV Management Guidelines	Reports, amendment, memo	02 July 2019	URC	Shared
302.	Global Accelerated Action for the Health of Adolescents (AA-HA!)	Report	18 July 2019	URC	Shared
303.	Teen Club	Reports	2019	URC	Shared

PROJECT DELIVERABLE FOLIO NUMBER	ITEM TITLE	CATEGORY (Manuals, standards, guidelines, SOPs, BCC materials, publications, R&R Tools and job aids)	PERIOD	OWNER	DESCRIPTION OF SUPPORT / STATUS AT THE TIME OF REPORTING
304.	Sithobela Health Centre Facility Health Semi-Annual Review (FaHSAR)	Report	31 July 2019	Sithobela / URC	Shared
305.	Orientation of Health Care Workers on HIV Pre-Exposure prophylaxis (PrEP)	Reports	2019	URC	Shared
306.	Good Shepherd Hospital Facility HIV Semi-Annual Review (FaHSAR)	Report	03 August 2019	GSH	Shared
307.	Amendment to the 2018 Integrated HIV Management Guidelines	Addendum	2019	SNAP	Shared
308.	National Training of Mentors & Implementing Partners Workshop on HTS modalities: Index Testing & OPD HTS Optimization	Report	09 -12 April 2019	SNAP	Shared
309.	Integrated management of adolescent and adult illnesses (IMAI) Training (Training for exiting nursing students from University of Eswatini (UNESWA) and Eswatini Medical Christian University (EMCU))	Report	12 to 16 August 2019	SNAP	Shared
310.	Lubombo Regional Training on Cervical Cancer (CaCx) Screening	Report	15 to 18 July 2019	RHMT/URC	Shared
311.	Lubombo Region Cervical Cancer (CaCx) Screening Feedback Workshop	Report	10 to 11 August 2019	RHMT/URC	Shared
312.	Cervical Cancer (CaCx) Project Collaborative Learning & Sharing Workshop	Report	13 September 2019	RHMT/URC	Shared
313.	Lubombo Doctors HIV-DR Meeting	Meeting Minutes	21 September 2019	RHMT/URC	Shared
314.	Lubombo Annual Health performance Report 2018	Report	2018	RHMT/URC	Shared
315.	Q4_APR Narratives CDC/Lubombo	Report	2018 - 2019	URC	Shared
316.	HIV Drug Resistance (DR) documents	SOPs, Tools and High VL Register	September 2019	SNAP	Shared
317.	Easter Monday Commemoration in Siphofaneni	Report	22 April 2019	URC / Siphofaneni	Shared
318.	Symposium for Improving TB Preventive Therapy Uptake and Completion among People Living with HIV and child contacts of patients with active TB in the Lubombo Region	Report, Presentations	06 - 07 May 2019	RHMT / URC	Shared
319.	ENAP Planning Workshop	Report	28 Feb - 01 Mar 2019	ENAP / URC	Shared

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