End-Term Evaluation of the Strategic Scale-Up of Community-Based HIV Testing and Counseling (CBHTC) and Linkage to Treatment to Optimize Response for Epidemic Control (SCORE Project) in Eswatini under the President's Emergency Plan for AIDS Relief (PEPFAR) Project

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
AGYW	Adolescent Girls and Young Women
APMR	ART Patient Management Record
ARROWS	ART Referral, Retention, and Ongoing Wellness Support
ART	Antiretroviral Treatment
AWP	Annual Work Plans
CBHTC	Community-Based HIV Testing and Counseling
CDC	Centers for Disease Control and Prevention
CI	Confidence interval
CMIS	Client Management Information System
CommART	Community ART initiation
COP	Country Operational Plan
CSO	Civil Society Organizations
DATIM	Data for Accountability, Transparency and Impact Monitoring
DHIS2	District Health Information Software 2
DREAMS	Determined, Resilient, Empowered, AIDS-Free, Mentored & Safe
EC	Expert Clients
ENAP	Eswatini National AIDS Program
EPHC	Eswatini Population and Housing Census
FBO	Faith-Based Organization
FCI	Faith and Community Initiative
FGDs	Focus Group Discussions
GBV	Gender-Based Violence
GKIIs	Group Key Informant Interviews
GoKE	Government of the Kingdom of Eswatini
GNI	Gross National Income
GNP	Gross National Product
GU	Georgetown University
HCW	Health Care Workers

HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HTS	HIV Testing Services
ICAP	International Centre for AIDS Programs
IP	Implementing Partners
IPC	Interpersonal Communication
IRB	Institutional Review Board
ITP	Isoniazid-based TB Preventive Therapy
KIIs	Key Informant Interviews
LCM	Linkage Case Management
LL	Litsemba Letfu Men's Clinic
LMIC	lower middle-income country
M&E	Monitoring and Evaluation
MoH	Ministry of Health
NARTIS	Nurse-let ART Initiation in Swaziland (Eswatini)
NSF	National Multisectoral HIV and AIDS Strategic Framework
NERCHA	National Emergency Response Council on HIV and AIDS
NGO	Non-Governmental Organization
NSC	New Start Clinic
NVIVO	A qualitative data analysis computer software package produced by QSR International
OVC	Orphan and Vulnerable Children
OPD	Out Patient Department
PEP	Post-Exposure Prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PMP	Performance Monitoring Plan
POC	Point of Care
PrEP	Pre-exposure prophylaxis

PSI	Population Services International
PSI MIS	Population Services International Management Information System
TPT	TB preventive therapy
RHMT	Regional Health Management Team
SCORE	Strategic Scale-up of Community-Based HIV Testing and Counseling (CBHTC) and Linkage to Treatment to Optimize Response for Epidemic Control (SCORE Project) in Eswatini
SHIMS	Eswatini HIV Incidence Measurement Survey
SOPs	Standard Operating Procedures
SPSS	Statistical Package for Social Sciences
STATA	Software for data science
STI	Sexually Transmitted Infection
TASP	Treatment as Prevention
TB	Tuberculosis
TLD	Tenofovir, Lamivudine and Dolutegravir
UNAIDS	United Nations Programme on HIV/AIDS
VAC	Eswatini Violence Against Children and Youth Survey
VCT	Voluntary Counseling and Testing
VL	Viral Load
VLS	Viral Load Suppression
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

Executive Summary

HIV is one of the greatest challenges faced by the Kingdom of Eswatini where an estimated 220,000 out of 1,100,000 people are living with HIV (PLHIV), constituting 20 percent of the total population (UNAIDS, 2021). The SHIMS3 (2021) revealed the HIV prevalence rate as 23.7% among those aged 15-49 years and 24.8% among people aged 15 and older. The country has adopted the UNAIDS treatment cascade targets to ensure that 95% of PLHIV know their status, 95% are enrolled on treatment and that 95% of those on antiretroviral treatment (ART) have suppressed virally loads (UNAIDS, 2014). The targets were expanded from 90-90-90 by 2020 called Fast Track targets to 95-95-95 by 2025 called the Last Mile. The SHIMS3 revealed that the country was at 94-97-96 of the conditional cascade, indicating that Eswatini had achieved the last two targets as 97.3% of PLHIV older than 15 years who were aware of their status were on ART and 96.2% of those of ART had suppressed viral loads. However, population viral load suppression (VLS) rates revealed that 88.6% of PLHIV 15 and older had suppressed viral loads, among more women than men (90.1% versus 86.1%). Population VLS rates were lowest among adolescents and young women (AGYW) aged 15-24 years at 76.1% and men aged 25-34 years at 62.9%. (SHIMS3, 2021).

Brief description of the SCORE project

The SCORE project (Linkage to Treatment to Optimize Response for Epidemic Control) came through support from the US Centers for Disease Control and Prevention (CDC), to scale-up CommLink for community and peer-delivered linkage case management (LCM). SCORE leveraged on the CommLink foundation and rolled out community-based HIV testing and counseling approaches (CBHTC) for case finding and improved linkages to HIV prevention and treatment service. In FY19, the project was scaled down from four to two regions - Manzini and Lubombo. The package of services included targeted HIV testing services (HTS) in communities and outpatient departments (OPD) in health facilities, index testing, HIV self-testing, recency testing, active contact tracing and linkages to HIV prevention and treatment. In FY21, the project was enhanced with complimentary activities including voluntary medical male circumcision (VMMC), the Determined, Resilient, Empowered, AIDS-free, Mentored and Safe (DREAMS)

program targeting AGYW and the Faith and Community Initiative (FCI) partnership with churches and pharmacies.

SCORE end of term evaluation

Population Services International Eswatini (PSI/Es) solicited the services of an independent consultancy firm, Sacala Consulting and Management Services, to conduct an end-of-term evaluation of the SCORE project. The evaluation was guided by the SCORE project end-of-term Evaluation protocol that was approved by the Eswatini Health and Human Research Review Board (EHHRRB), Centers for Disease Control and Prevention's Office Division of Global HIV and TB Office of the Associate Director for Science (CDC ADS), and PSI Research Ethics Board (REB).

The evaluation reviewed performance in financial years FY20, FY21, and FY22 (Q1-Q3) to assess whether project activities (specifically HTS, linkage to case management, VMMC, DREAMS, and FCI) had translated into outcome-level changes. Mixed approaches using quantitative and qualitative data elements were used to assess the relevance and validity of design, program effectiveness, efficiency and sustainability of programs. The evaluation performed secondary data analysis of program data in PSI's Management Information System (PSI MIS), PEPFAR's Data for Accountability Transparency and Impact Monitoring (DATIM), MoH's Client Management Information System (CMIS), New Start Clinic patient tracker and Litsemba Letfu clinic attendance registers. Primary qualitative data was obtained through key informant interviews (KIIs) and focus group discussions (FGDs) with implementing partners (IPs), PSI program staff, clinical service providers, project beneficiaries and HIV stakeholders. Direct observations (DO) of client-to-provider interactions in five project sites were also undertaken.

Evaluation findings

HTS: In FY20, PSI tested 11,240 individuals for HIV. From those tested 1,900 (16.9%) people were diagnosed with HIV. Sixty-one percent (n=1,177) of them were diagnosed through the index testing modality. In FY21, PSI introduced facility testing in OPD which was able to diagnose 50.3% (n=1,071) of overall positives for the year and had a yield of 24.2%. Index testing achieved the highest yield of 31.6% for FY21. In FY22 (Q1-Q3), 5,801 individuals were tested and 1,150 (7.2%) were diagnosed with HIV. Forty-eight percent (N=2,480) were tested in OPD where 22.0%

(n=546) were diagnosed with HIV. Achieving a yield of 20.2%, index testing contributed to diagnosing 32.9% (n=378) of all positives identified in FY22 (Q1-Q3). Throughout FY20-FY22 (Q1-Q3), the largest number of positives were among people aged 20-39 years in FY20, 20-44 years in FY21 and 15-34 years in FY22 (Q1-Q3). Females constituted 56.5% (n=2,926) of total PLHIV diagnosed in FY20-FY22 (Q1-Q3). SCORE demonstrated a marked increase in the identification of adolescents, with a 10-fold increase in 10-14 year olds and a 3-fold increase in 15-19 year olds between FY20 and FY22. Among adolescents and young people aged 15 to 24 years, the number of females diagnosed was four times that of same aged males (n=1,015 vs n=247). However, males make up more positives starting from age 30.

Recency testing: PSI rolled out recency testing in Q4 of FY19. In FY20, PSI performed rapid test for recent infection (RTRI) on specimens from 771 of the 1,885 people older than 14 years that were newly diagnosed HIV positive during the year. Ten percent (n=79) of the specimens were identified as recent infections and the remainder (n=692) were long term. Virological testing using the recent infection testing algorithm (RITA) showed that 32 patients (40.5%) had HIV RNA ≥1000 copies/mL, giving a RITA recent of 4.2%. In FY21, the RTRI was performed on specimens from 2,053 (99.5%) newly diagnosed PLHIV and identified 5.4% (n=111) as RTRI recent infections. Using the RITA algorithm, 46.2% (42/91) patients had HIV RNA≥1000 copies/mL, henceforth a RITA recent of 2.1% (42/2033). In FY22 (Q1-Q3), the RTRI recent infections were at 4.9% (n=50) of 1,024 newly diagnosed PLHIV. The RITA recent was 2.6% (26/1017) since 26 of the 43 patients tested for HIV RNA had ≥1000 copies/mL.

Linkage to HIV treatment: During FY20- FY22 (Q1-Q3), the Linkage Case Management (LCM) model linked 4,644 out of 5,140 (90.3%) newly identified PLHIV to HIV treatment and care. The linkage rate increased from 86.3% (n= 1,640) in FY20, to 90.5% (n=1,894) in FY21 and 96.8% (n=1,110) in FY22 (Q1-Q3). This was an improvement from a 75% average linkage rate recorded during the SCORE mid-term review in FY19. On average, 95% of clients were linked within 14 days of diagnosis. Same day initiations improved from 62.5% (N=1,640) in FY20 to 81.0% (N=1894) in FY21 and 93.0% (N=1,110) in FY22 (Q1-Q3). By the end of June 2022, PSI had 2,354 active patients on the ART registered at New Start Clinic through a net increase of 681 patients since FY19. Fifty-four percent of them were female. A majority of patients were between

the ages 20 – 44 years. At the end of June 2022, almost all (98.9%) patients at New Start Clinic had attained viral load suppression (VLS).

Tuberculosis (TB) screening among ART patients increased from 86.9% (n=1,718) in FY20 to 88.4% (n= 1,985) in FY21 and 98.7% (n= 2,324) in FY22 (Q1-Q3). The number of patients who had their specimen sent for bacteriologic investigation increased from 19 patients in FY20 to 109 in FY22 (Q1-Q3). In FY20, 3 out of the 19 samples came back reactive for TB, 9.1% (n=6) were reactive in FY21 and 5.5% (n=7) in FY22 (Q1-Q3). All TB/HIV co-infected patients were started on TB treatment. All female PLHIV over 15 years that were enrolled at New Start Clinic were screened for cervical cancer at least once every two years. In FY20, cervical cancer screening was conducted on 37.5% (n=379) female PLHIV aged 20-49, of whom 62 (16.4%) were found with abnormal cervical lesions and all received treatment. In FY21, screening was provided to 47.6% (n=551) women and 12.0% (n=66) were found to with abnormal cervical lesions. All but one received treatment. In FY (Q1-Q3), 25.7% (n=309) women were screened for cervical cancer, of whom 10.0% (n=31) were found to have cancer lesions and received treatment.

Linkage to prevention: During FY20-FY2022 (Q1-Q3), PSI initiated PrEP on 1,216 people out of 32,006 people (3.8%) that had tested negative at HTS, DREAMS, FCI and STI sites. Over the implementation period, the number of individuals initiated on PrEP annually progressively increased. Further, as national and PEPFAR guidance placed a greater emphasis on PrEP for AGYW and PSI began implementing the DREAMS program, the proportionate contribution of females taking PrEP also increased. In FY20, 134 people were initiated on PrEP, only 21% (n=39) of whom were female. In FY21, 469 people were initiated on PrEP, of whom 153 (33%) were HIV negative AGYW. During the FY, PrEP was also rolled out to community HTS sites and resulted in 140 people being initiated. In FY22 (Q1-Q3), a total of 613 people were initiated on PrEP and more than half (53.0%) were female. The mode age group was 20-24 among females and 20-29 years and 35-39 years among males.

VMMC: A total of 2,451 men were circumcised at Litsemba Letfu clinic between FY20 and FY22 (Q1-Q3), comprised of 907 males in FY20, 805 in FY21 and 739 at the end of June 2022. This reflects an achievement against annual targets of 42.0% in FY20, 57.1% in FY21 and 72.7% by the end of the third quarter of FY22. Sixty-five percent of those circumcised were within the

targeted ages of 15-29 years. No boys aged 10-14 were circumcised in FY21 and FY22 (Q1-Q3) as the approach shifted to prioritize males older than15 years, in line with PEPFAR guidelines.

DREAMS: The program began in FY21 with the enrollment of 5,601 AGYW from Kukhanyeni, Mafutseni and Lugongolweni Tinkhundla, to receive a primary package of services that included social asset-building skills, school, or community-based HIV and violence prevention education, condom education, skills or commodities, HTS screening, PrEP information or enrolment, financial literacy, and contraceptive mix (counseling or commodity). By the end of June 2022, a total of 3,756 (62.4%) of AGYW had completed the primary package of DREAMS services. Thirty-eight percent (n=2,264) AGYW completed both primary and parts of the secondary package. In FY21, 284 (29.2%) were found to be eligible for testing and 277 (97.5%) were tested for HIV, which revealed a majority (97.5%) as HIV negative. Only 2.5% (n=7) AGYW were diagnosed HIV positive and all were initiated on ART. However, less than half (49.4%) of those who tested negative were initiated on PrEP. In FY22 (Q1-Q3), 958 AGYW were reached in communities. All were screened for HIV risk and 457 (47.7%) were found to be eligible and tested for HIV. Ninety-eight percent (n=454) of those tested were found to be HIV negative and only three (0.7%) were HIV positive. All three AGYW diagnosed with HIV were initiated on ART. Only 39.9% (n= 181) of those who tested negative were initiated on PrEP.

FCI: Through the FCI project which began in FY21, PSI educated faith leaders with up-to-date scientific information about HIV prevention, care, and treatment and distributed HIVST kits via eleven pharmacies and community carers. A total of 120 faith leaders from 23 churches were trained to disseminate messages of hope to congregants comprised of the youth (n=236) who constituted 44.2% of congregants who received messages, followed by 67 couples (25.4%), women's faith groups (16.3%) and men's faith groups (13.3%).

A total of 2,142 HIVST kits were distributed to 1,500 people through participating pharmacies in FY21. Sixteen percent (n=237) of those who collected kits had their last HIV test over a year ago, 42.8% (312 females and 330 males) more than three months ago and 2.1% (12 females and 19 male) had never tested. Fifty people returned for confirmatory testing after self-testing. Thirty-four

(68%) of them received confirmatory testing and 27 (80%) were diagnosed as HIV positive. Twenty-five (92.3%) were linked to ART.

Discussion

The evaluation found that the HTS approaches employed by PSI have contributed to the national target to identify 95% of PLHIV and enroll them on ART. PSI's facility OPD and index testing produced highest yields and contributed to case finding for 75.1% (n=3,889) of all newly diagnosed PLHIV during FY20-FY22 (Q1-Q3). The shift in testing approaches from a focus on community to facility-based approaches caused PSI to fail to meet the target for CBHTS to contribute at least 95% of total PLHIV identified. While the shift improved case finding among women, it resulted in a 10% decrease in the proportion of males identified. This is concerning in light of SHIMS3 findings which demonstrate that the vast majority of unidentified cases are men.

While HIVST did not contribute much to case finding, the design of the pharmacy distribution model offers potential for individuals with high-risk exposure to access HTS. The consideration to offer kits to pharmacy clients who may have had high-risk exposures (clients seeking emergency contraceptive and presenting with STI symptoms) is an ingenious contribution and best practice for the future of case finding in Eswatini. This is because more people who collected kits were among women aged 15-29 years and men aged 25-34 years, both of whom are target populations for case finding based on SHIMS3 data. Moreover, this approach enabled testing to higher risk populations who may not present through other entry points as demonstrated by the finding that 2.1% of female and 3.4% of male HIVST clients in pharmacies had never previously tested for HIV.

Against a target to improve linkage of identified PLHIV to ART facilities to 95%, by the end of June 2022, PSI's LCM coupled with CommART had enabled 96.8% of newly diagnosed PLHIV to link to ART. This is comparable to the SHIMS3 value that 97.3% of adult PLHIV who are aware of their status, are on ART. Almost all (98.9%) ART patients were virally suppressed, inferring strong adherence practices. The complimentary services for TB and cervical cancer ensured that more PLHIV remain healthy.

PSI's VMMC approaches were able to exceed the target to link 80% of HIV-negative males aged 15 or older to VMMC by FY22 (Q1-Q3), as 82.3% males who were registered were circumcised. The retargeting of men aged 15-29 offered an opportunity for immediate gains in HIV prevention as more persons in this age group are presumptively sexually active than those below 15 years, given that the median age of sexual debut is 18 years for males in Eswatini (SDHS,2006/07).

The FCI provided a platform for discussions about HIV within churches. The church-based messages of hope were identified as most sustainable beyond the PSI project, since all participating churches had mainstreamed them as part of their information package. There was no data available on GBV cases and/or how those were managed. Therefore, the evaluation was unable to determine whether the objective to reduce violence against children 9-14 years was achieved.

The evaluation found a generally weak emphasis on HIV prevention. Systematic referral to prevention services beyond VMMC involving both sexes was only initiated during the later years of implementation. While for VMMC a clear referral system was in place, through vouchers redeemed at Litsemba Letfu Clinic, there was no linkages system to follow up clients who were offered PrEP. This is demonstrated by the low uptake of PrEP by 1,216 (3.8%) out of 32,006 persons who tested negative at HTS sites. However, even within VMMC, only 69 men (2.8%) of those circumcised) came through referral from HTS, DREAMS, FCI and the STI programs. Based on the feedback from key informants, this was because a prevention linkages cascade had not been defined and this is reflected by the lack of emphasis in tracking referrals. This was a missed opportunity since risky behaviour and exposure to HIV had been established through the HTS screening and risk tools.

Another observation by evaluators was a lack of investment in strengthening community and health systems. The project relied on PSI supported human resources even in areas where existing cadres had the capacity to provide the service. Similarly, there is no evidence of collaboration between project and non-project teams, i.e. expert clients with PLHIV support groups, and PSI-lay counsellors at OPD with OPD nurses.

Recommendations

1. Give equal priority to preventing new HIV infections as to initiating newly identified PLHIV on treatment. Design a referral and linkages model for at-risk HIV-negative persons from HTS to PrEP and VMMC services, including setting performance targets for accountability.
2. Leverage on the acceptance of PSI index, HIVST and LCM approaches to build strong community systems and activate the role PLHIV networks in providing peer support as a cost-effective method for sustaining the gains.
3. HTS approaches must maintain a community component in order to target more males, especially those 25-34 years old. Facility approaches tend to miss healthier untested males who, without falling sick, will not have a reason to present to health facilities.
4. Build the capacity for pre-and prost counselling, including LCM referral, among pharmacies and community carers.
5. Incorporate Litsemba Letfu's VMMC approach including service quality into the national VMMC program to enable other sites to adopt and improve the quality of services or attractiveness of VMMC.
6. Expedite the immediate rollout of HIVST distribution in pharmacies as a targeted case finding approach for populations with risk factors who are not likely to present at health facilities.
7. Resuscitate or reengage facilities to conduct outreach services using their regular staff as a transition measure to sustain the community footprint.

CHAPTER 1: BACKGROUND

1.1. Country Context

The Kingdom of Eswatini is located in the Southern African region and has a total land area of 17,364 square kilometers. It has a population of 1.1 million, with females constituting 51.4% of the population. (Eswatini Population and Housing Census, 2017). The country is divided into four administrative regions: Hhohho, Manzini, Lubombo and Shiselweni. The population distribution varies across the regions, with Manzini having the highest proportion (32.6%), followed by Hhohho (29.3%), Lubombo (19.4%) and Shiselweni (18.7%). Eswatini has a youthful population where 73.4% is under the age of 35, adolescents and young people aged 15-24 constitute 20.7% of the population and 39.6% are under 15 years. (EPHC, 2017)

Eswatini is classified as a lower middle-income country (LMIC) with a real Gross Domestic Product (GDP) per capita of USD 3,962 in 2021. Despite the classification, Eswatini's economy is experiencing its weakest performance due to a persistent recession attributed to slow economic growth, rising unemployment and a weak fiscal position due to increasing public expenditures against a few volatile sources of revenue. Additionally, the government's public-sector wage bill has increased over the years within the context of declining revenues, threatening overall fiscal sustainability. Gross National Product (GNP) contracted by 1.9% in 2020 due to COVID-19 amid a persistent drought, currency depreciation, and weak regional economic conditions. Growth was expected to rebound by 5.9 percent in 2021, underpinned by modest post-COVID-19 recovery in all sectors (MoF, 2022). However, the recurrence of COVID-19 waves and the unprecedented civil unrest threaten prospects for higher growth. In terms of the Human Development Index (HDI)[1] Eswatini's index, which had slightly decreased from 0.548 to 0.541 between 1990 and 2015, has increased to 0.597 in 2021. This is due to increases in life expectancy to 57 years, increased mean years of schooling by two years and increased Gross National Income (GNI) by 13.2%.

According to the Household Income and Expenditure Survey (2016/17), the poverty rate is 58.9% and much higher in rural areas (70.1%) than in urban areas (19.6%). An estimated 39.7% of the population is living below the international poverty line of $1.90 per day. The country also has

[1] Human Development Index (HDI) is a summary measure of average achievement in three dimensions of human development: life expectancy at birth, being knowledgeable and standard of living as measured by gross national income per capita.

high inequality as demonstrated by a high Gini coefficient of 49.3%, making Eswatini to be within the top 20 most unequal countries in the world. An estimated 39.8% of the population faces severe food insecurity and only 24.4% are food secure. Chronic food insecurity is higher (82.0%) in rural areas than in urban areas (56.2%). The emergence of HIV in the 1980s and its devastating effects led to more children being orphaned or vulnerable, and elderly persons and children becoming heads of households with little income to care for rearranged families.

The total fertility rate is estimated to be 3.3 births per woman, reflecting declining fertility from 6.4 and 3.8 in 1986 and 2006/7, respectively. The adolescent birth rate is 87 per 1,000 among women aged 15-19. The neonatal mortality rate per 100 live births is 21.4, the under-five mortality rate is 70.4 per 1000 live births and maternal mortality is estimated at 389 per 100,000 live births. Contraceptive use using modern methods is estimated to be 66.1% among women 15-49 years (MICS, 2014).

1.2. Overview of HIV and AIDS

1.2.1. Epidemiology of HIV and AIDS

HIV is one of the greatest challenges faced by the Kingdom of Eswatini, where an estimated 220,000 out of 1,100,000 people are living with HIV (PLHIV). PLHIV make up 20% of the total population (UNAIDS, 2021). The SHIMS3 (2021) revealed an annual HIV incidence rate of 0.77 among those aged 15-49 years and 0.62% among persons who are 15 years and older which corresponds to approximately 4,000 new cases of HIV per year. HIV incidence among those who are 15 and older is higher (1.11%) among women than men (0.17%). SHIMS3 (2021). HIV prevalence rate is 23.7% among those aged 15-49 years and 24.8% among those aged 15 and older. Significant variations in HIV prevalence exist by sex and age. Prevalence is generally higher among women and among older than younger populations. At 31.6%, HIV prevalence among women aged 15-49 is twice that of same aged men (15.6%). Substantial variations occur within the ages 20-24 and 25-29 years where prevalence for women is five-fold higher than that of men of the same ages, at 17.2% vs 3.9% and 30.3% vs 5.4%, respectively. HIV prevalence peaks at 57.2% among women within the ages 40-44 years and at 49.2% in men within the ages 50-54. SHIMS3 (2021). HIV is the leading cause of morbidity and mortality among adults.

Population viral load suppression (VLS) rates reveal that 88.6% of PLHIV that are 15 and older have suppressed viral loads, higher among women (90.1%) than men (86.1%). Viral load suppression is highest among PLHIV who are on ART where 95.9% and 96.7% of women and men aged 15 years and older, respectively, have suppressed viral loads. Population VLS rates are lowest among young women aged 15-24 years at 72.9% and men aged 25-34 years at 62.5%. Breaking down the clinical cascade for these subpopulations, 16% of women aged 15-24 years do not know their status and 9.6% of those on ART are not virally suppressed. Among men aged 25-34 years, 25% do not know their status and of those who know their status, 13% are not on ART (SHIMS3, 2021).

The SHIMS3 (2021) reveals that 94% of adults 15 years and older living with HIV are aware of their status, 97% of those aware of their status are on ART and 96% of those on ART have achieved viral suppression. This is an improvement from the SHIMS2 (2016-2017) results of 87-89-91. Women achieved 95–98–96 while men reached 92-96-97, reflecting that women have achieved all three targets and the last two by men. This indicates that Eswatini is well within reach of epidemic control.

The country has a high tuberculosis (TB) incidence rate of 308 TB cases per 100,000 per year, with 69% of TB patients being co-infected with HIV (WHO, 2021). According to the National TB Annual Report (2019), the TB/HIV case fatality rate is 11% for susceptible TB and 15% for drug-resistant TB patients.

1.2.2. HIV policy framework

Commitment to the response has been sustained at the highest political levels and the country currently works towards a target to End AIDS as a public health threat by 2030. The National Emergency Response Council on HIV and AIDS (NERCHA) has coordinated the HIV response since 2001 and works closely with the MoH's Eswatini National AIDS Programme (ENAP), civil society organizations (CSO) and development partners.

Over the years, Eswatini has developed a dynamic multi-sectoral response guided by a series of national strategic plans for reducing new infections, AIDS deaths, and HIV-related stigma and

discrimination. The current National Multisectoral HIV and AIDS Strategic Framework (NSF 2018-2023) was benchmarked on the "Umgubudla HIV Investment Case," which recommended fast-track targets for effective combination prevention and comprehensive HIV treatment for PLHIV. The NSF prioritizes a mix of biomedical and non-biomedical approaches that have proven efficacy for direct and non-direct prevention of HIV and for expanding the lifespan of PLHIV. HIV prevention programs include voluntary medical male circumcision (VMMC), condom promotion and distribution, prevention of mother-to-child transmission (PMTCT), pre and post exposure prophylaxis (PrEP and PEP), prevention and treatment of sexually transmitted infections (STIs), STIs and behavioral interventions for risk reduction. For HIV treatment, a package of services has been designed to identify PLHIV through HTS, enroll and retain PLHIV on ART, and manage co-morbidities and non-communicable diseases. NSF programs are enhanced with strategies to reduce structural vulnerabilities and create an enabling environment.

Since 2014, the country has adopted the UNAIDS 90-90-90 treatment cascade targets (UNAIDS, 2014). The targets were expanded to 95-95-95 by 2025, also called the Last Mile. These were guided by growing evidence that early ART initiation offers primary health benefits to PLHIV and reduces morbidity and mortality, including suppressing patients' viral loads. VLS in turn offers secondary benefits of reducing the potential for onward transmission to uninfected persons due to reduced infectivity of PLHIV, a concept called using "HIV Treatment as Prevention."

1.2.3. Resources for HIV response

Expansive resources have been invested in the multisectoral response to HIV to correspond with its spread. According to the National AIDS Spending Assessment for FY (2018/19), total HIV spending amounted to SZL1.85 billion (US$ 137.6 million) in FY2018/19, which is equivalent of 6.0% of GNP. The majority of funders comprise of the government of Eswatini (GoKE) which contributes 40% of total resources and international sources such as the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), European Union, Médecins Sans Frontières (MSF) and other multilateral partners who contribute an average of 59%. As shown in table 1 below, HIV care and treatment consumes the largest portion (31.4%) with ART being the major cost driver taking up 68% of all expenditures for care and treatment.

Table 1: HIV Expenditure by Program Area, FY2016/17- FY2018/19

	FY 2016/17 in SZL	FY 2017/18in SZL	FY 2018/19 in SZL	% Average of total
HIV Prevention	254,403,351	283,916,102	293,050,061	14.2%
HIV testing and counseling	37,068,339	60,019,273	110,294,863	3.5%
Care and Treatment	514,324,363	653,022,233	674,577,580	31.4%
Social protection and economic support	413,668,482	407,188,777	303,355,366	19.1%
Social enablers	2,526,738	2,286,416	10,461,278	0.3%
Program enablers and Health System Strengthening	700,673,016	640,357,043	453,535,550	30.6%
Development Synergies	1,986,797	8,487,087	208,916	0.2%
Research	31,194,817	8,260,398	7,879,970	0.8%
Total	**1,955,845,903**	**2,063,537,329**	**1,853,363,584**	**100%**

Source: NASA, 2019

1.2.4. Current program performance

HIV treatment was initiated in 2003 and 199,947 (93.6%) PLHIV were enrolled in treatment by December 2021 (MoH, 2022). The recent headlines from the SHIMS3 (2021) reveal that at 94-97-96, Eswatini has achieved the last two 95s. This is an improvement from 85-87-92 revealed in 2016-17 (SHIMS2). The SHIMS3 (2021) cascade results are 84-96-90 among young women aged 15-24 years, SHIMS3 compared to 76-84-81 in SHIMS2. Among young men of the same age, the cascade is 91-96-87 in SHIMS3 compared to 60-92-58 in SHIMS2.

The successes in treatment are largely due to Eswatini's adoption of the World Health Organization (WHO) guidelines that recommended rapid expansions in the eligibility criteria, up to the prevailing test and start where all persons who are diagnosed HIV positive are eligible for ART initiation. The guidelines align to the UNAIDS treatment cascade. Successes are also attributed to the country's innovations in HTS and linkages which have scaled up innovative and targeted health facility and community-based HIV testing strategies to align with the country's epidemiology and provide ART coverage. Facility-based testing is provided in several service points using the provider-initiated testing and counseling (PITC) approach at the outpatient

department (OPD), antenatal care (ANC) under prevention of mother to child transmission (PMTCT), STI services, TB services, VMMC programs and in-patient department (IPD). Community HTS is provided using both provider and client-initiated approaches at outreach campaigns, mobile HTS and static voluntary counseling and testing (VCT) centers. In the past five years, the country has intensified targeted HTS, and linkages to HIV prevention and treatment services, with an emphasis on scaling up efficient and effective case-finding strategies such as optimization of HTS in OPDs, index case testing, and HIV self-testing (HIVST). In 2019, the country introduced Linkages Case Management (LCM) to scale up ART initiation through peer-delivered mobilization at facilities or communities, treatment optimization and provide differentiated service delivery, including community ART initiation (CommART).

Despite the significant progress made in all stages of the HIV cascade, the uptake of HIV prevention services remains challenging. For example, the uptake of VMMC (27.0%), PrEP and PEP is lower than the required targets to prevent new HIV infection (Umgubudla, 2015).

1.3. Overview of the SCORE Project

Through support from PEPFAR, the US Centers for Disease Control and Prevention (CDC) awarded Population Services International Eswatini (PSI/Es) a five-year grant for 2017 -2022 to scale-up and expand the previously successful CommLink pilot demonstration project for community-based mobile HIV-care and peer-delivered LCM. CommLink, which was designed to deliver a comprehensive package of linkage services that would motivate PLHIV to initiate ART within 90 days of diagnosis, achieved early-enrollment and linkage to ART for 96.5% newly diagnosed clients, from a baseline of 38.2% in 2016 (MacKeller et al., 2018).

The SCORE project (Linkage to Treatment to Optimize Response for Epidemic Control) leveraged on the foundation of CommLink and rolled out a community-based HIV testing and counseling approach (CBHTC) to identify HIV-positive individuals. The SCORE project aimed to improve the volume of cases from CBHTS, improve the linkages to ART facilities for at least 95% of newly identified PLHIV and improve the linkages of HIV-negative males aged 15 years and older to VMMC services.

During the first year (FY17), the project was implemented in all four regions to focus on strengthening community relationships and increasing case detection. The package of services included VCT sites in each region, an additional site at the New Start Clinic in Matsapha in the Manzini region, and mobile HIV testing services in all of Eswatini's 55 Tinkhundla (municipalities). Services provided included HTS, ART adherence counseling and active linkage services including ART initiation. The New Start Clinic site supplemented these with follow-up services including viral load monitoring, step-up adherence services for ART clients, and TB screening and treatment services. During the second year (FY18), emphasis was placed on increasing index testing and expansion of HIV self-testing (HIVST). New Start Clinic services were separated from Litsemba Letfu (LL) men's clinic services in Matsapha which provided male-friendly healthcare and HTS, including VMMC and sexual health counseling. In year three (FY19), targeted index testing was introduced to offer HTS to partners and families of newly diagnosed people - called index contacts- and roll out of community ART (CommART) distribution to improve linkage to treatment.

In year four (FY20), the project was scaled down to Manzini and Lubombo regions as guided by PEPFAR/CDC's regions' IPs allocation between USAID and CDC partners. As part of the overall HIV epidemic control strategy, the package of services changed from primarily community-based testing to include facility-based testing at OPD in 27 facilities (later revised to 25 facilities) as the scope changed to targeted HTS, recency testing, index testing services, active contact tracing and linkages to treatment services using the LCM model.

SCORE project was enhanced with complimentary projects such as;

- Comprehensive HIV and TB services at New Start Clinic in Matsapha, where HTS, ART initiation, viral load monitoring, adherence, and step-up adherence services, TB services, ANC, including PMTCT and PrEP, and PEP services were provided under the LCM.
- Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) project which provided targeted services to adolescent girls and young women (AGYW) aged 10-29 years. DREAMS services included HTS, PrEP, STI, sexual and reproductive health (SRH) and other clinical services, in addition to economic empowerment opportunities to

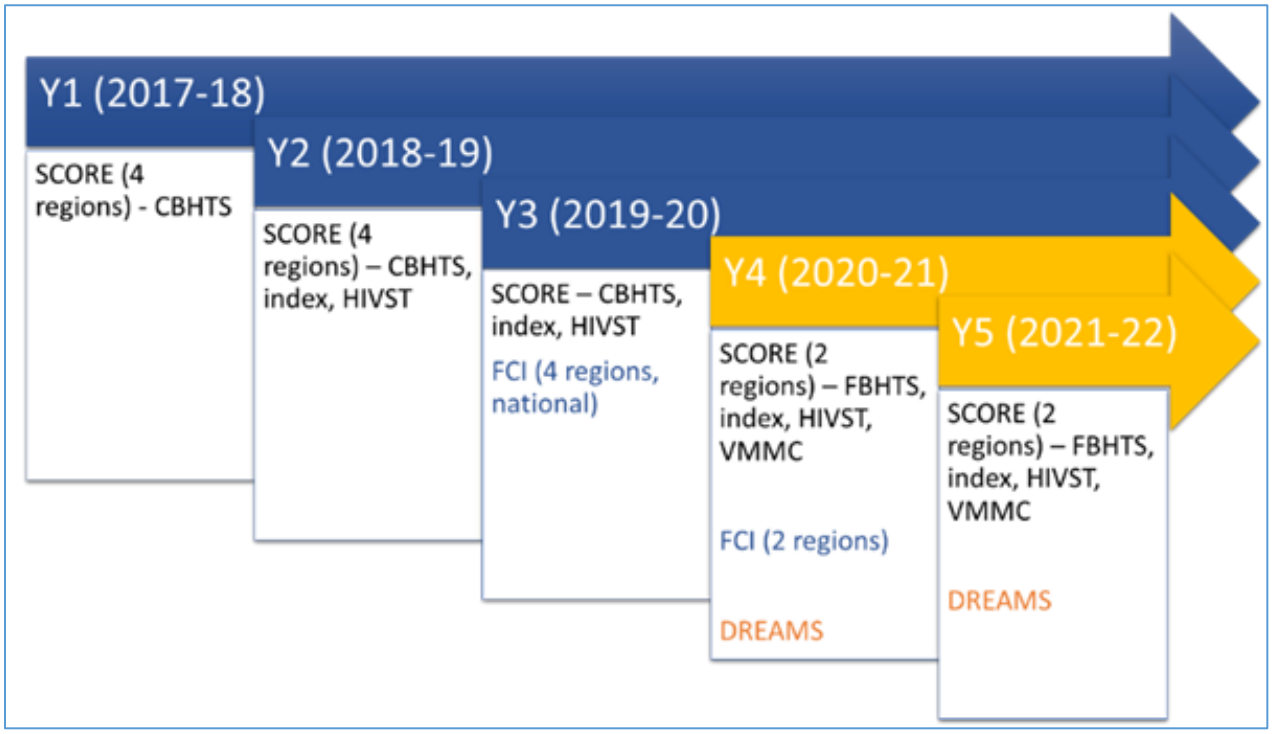
reduce their vulnerability to high-risk behavior, and a fully staffed DREAMS-on-Wheels mobile clinic.

- VMMC at Litsemba Letfu clinic to connect HIV-negative males to voluntary medical male circumcision and other health services. The males came as referrals from HTS sites in OPD, Index testing, DREAMS and FCI.
- Faith and Community Initiative (FCI) partnership between PSI and faith based communities under the Church Forum, to reach men, women, and children with HIV prevention, HTS and treatment services. FCI aimed to (1) to find undiagnosed men and youth and children living with HIV to support them with prompt linkage to treatment, and (2) to prevent sexual violence toward children and accelerate justice for children who are victims of violence.
- Facility-based testing in selected facilities and entry points.

In FY20 and FY21, programing was negatively affected by the COVID-19 pandemic and subsequent national lockdowns, combined with political and civil unrest in June 2021, which restricted the movement of people and caused abrupt interruption of services. Affected programs were all community interventions for VMMC, DREAMS, FCI, index testing and active follow-up of contacts, trainings, and mentorship visits to facilities and communities.

Figure 2 below depicts the migration of SCORE from FY17 to FY22 (Q1-Q3).

Figure 1: Evolution of the SCORE project migration from FY2017 to FY2021



Source: PSI Annual Work Plans, 2017-2021

CHAPTER 2: SCORE PROJECT END-OF-TERM EVALUATION

In August 2022, PSI Eswatini solicited the services of an independent consultancy firm – Sacala Consulting and Management Services – to conduct a rigorous end-of-term evaluation of the SCORE project. The evaluation sought to assess and identify pathways through which project activities (specifically HTS, linkage to case management, VMMC, DREAMS, and FCI) had translated to outcome-level changes.

The end-term outcome evaluation focused on the last three years of implementation, FY20, FY21 and FY22 (Q1-Q3), to determine the extent to which project objectives were achieved. It also sought to assess the influence of the adapted projects based on the findings and recommendations of the mid-term evaluation that was conducted in 2021. The evidence emerging from the evaluation sought to identify successes, weaknesses, and lessons learned in order to lay the foundation for future HTS and linkage programming strategies at PSI, CDC and national level through MoH.

2.1.Objectives of the SCORE Project End-of-Term Evaluation

The overall objective of the evaluation was to determine the extent to which SCORE (specifically HTS, LCM, VMMC, DREAMS, and FCI projects) achieved planned outcomes during FY20 to FY22 (Q1-Q3), based on a Theory of Change to achieve the following project outcomes;

SCORE:

Mid-term (intermediate) outcomes

I. Improved timeliness of linkage to care and treatment services in health facilities for PLHIV who were identified through CBHTS.
II. Improved timeliness of linkage to VMMC services for HIV-negative males aged 15 or older who received HIV testing through CBHTS.

End-term outcomes

I. Increased knowledge of HIV status among the population of Eswatini.
II. Increased number of people newly initiated on ART.
III. Increased viral suppression of PLHIV retained in care and treatment.

VMMC:

I. Improve the linkage of HIV-negative males aged 15 or older to VMMC services.

DREAMS:

I. Reduce HIV infection among AGYW aged 10-29 years
II. Reduced HIV and sexual violence among AGYWs 15-29 years.
III. Increased reporting and referral of gender-based violence (GBV) cases among AGYWs 15-29 years.
IV. Increased access to AGYW friendly clinical services
V. Improved social protection among AGYWs 15-29 years.

FCI:

I. Reduced HIV and sexual violence against children 09-14 years.
II. Increased access to HIV prevention services among men and women.
III. Increased access to HIV testing and treatment services among children, women and men.

The outcomes were quantified through the following measurable indicators and targets to be achieved by FY22 (Q1-Q3).

SCORE:

1) *Increase identification of all PLHIV to 90% or greater*
2) *Improve the volume of newly detected HIV-positive cases from CBHTS to 95%*
3) *Improve linkage of identified PLHIV to ART facilities to 95%*
4) *Identify and link individuals to HIV prevention services*

VMMC:

1) *Improve the linkage of HIV-negative males aged 15 or older to VMMC services to 80%*

Specifically, the evaluation had four (4) specific objectives to:

1) Evaluate the extent to which core objectives of SCORE (HTS, LCM, Linkage to prevention), VMMC, DREAMS, and FCI were as implemented by PSI Eswatini.

2) Compile information to determine if aspects of the project were successful at improving case detection rates and linkage to care and treatment.
3) Evaluate the implementation processes for different activities and compile information about successful innovations, good practices, application of recommendations from the mid-term evaluation, challenges and lessons learned through an independent assessment of findings.
4) Make recommendations to improve the strategic orientation and implementation of future HTS and linkage programming strategies at PSI, CDC and the national level through MoH.

In assessing the contribution by SCORE, the evaluation assessed whether an optimized and targeted testing approach in OPD settings, including index and recency testing, improved case detection and linkage to treatment and prevention; whether the LCM model improved early initiation of ART among newly diagnosed patients, retention in care and viral suppression; the effectiveness of the VMMC program; whether DREAMS clinical services met the health needs of AGYW in the community; if HIVST contributed to case findings, and if there were improvements in the reporting of GBV cases in faith based communities.

In alignment with the evaluation objectives, the evaluation questions for each area are described in Table 2 below.

Table 2: SCORE project areas and associated evaluation objectives and questions

SCORE ACTIVITIES	KEY AREAS BEING EVALUATED	EVALUATION OBJECTIVES	EVALUATION QUESTIONS
HIV Testing Services (HTS)	1. OPD facility testing 2. Index Testing 3. Recency Testing: 4. HIV self-testing distribution	1. To assess if an optimized and targeted testing approach in OPD settings, including index and recency testing, improved detection of HIV cases, and linkage to treatment and prevention between 2020 and 2022.	1) To what extent has the program implemented recency testing to identify recent HIV cases? 2) To what extent has the program utilized recency data to improve case finding among populations with the highest risk of recent infections? 3) To what extent has implementing an optimized and targeted testing approach in OPD settings contributed to case finding? 4) To what extent has the HIVST distribution contributed to case finding for HIV through index testing and facility-based distribution?
Linkage Case management (LCM)	1. Linkage to ART 2. ART initiation 3. Viral Load Testing 4. Management of opportunistic infections (OIs)	1. To assess the extent to which the LCM model improved early initiation of ART among newly HIV-diagnosed clients and retention in care and viral suppression between 2020 and 2022.	1) To what extent has the program improved linkages of men aged 20-34 and females aged 15-30 to prevention and treatment services? 2) To what extent has the SCORE program referred newly identified PLHIV for ART enrolment and retention?

Voluntary Medical Male Circumcision (VMMC) at Litsemba Letfu Men's Clinic	1. Medical male circumcision	1.To determine the extent to which the VMMC program was effective at providing VMMC services to eligible men between 2020 and 2022	1) How effective has the VMMC program been in providing VMMC services to eligible men in the two Tinkhundla of implementation?
DREAMS	1. Clinical services offered to AGYW	1. To determine if DREAMS clinical services met the health needs of AGYW in the community between 2020 and 2022 2. To assess the first 18 months of implementation including successes, failures, operational lessons learned, and the strategy/approach for implementation	1) What were the start-up implementation lessons from the new DREAMS program? What successes or challenges were experienced by the implementing partner? 2) What have been the implementation lessons from offering mobile clinical services through Dreams-on-Wheels? 3) How helpful has the clinical aspect of DREAMS been to AGYW in the 3 Tinkhundla?
FCI	1. Distribution of HIV self-testing 2. Messages of Hope 3. Disclosures on GBV	1. To determine if the uptake of HIV self-test kits (HIVST) contributed to HIV case findings between 2020 and 2021. 2. To assess the change in the reporting of GBV cases following the	1) To what extent has HIVST distribution under the FCI project improved access to and uptake of HIV testing as well as case identification for targeted populations?

		implementation of the project between 2020 and 2021.	3) How successful were faith-based and community structures in distributing HIVST kits? What contributed to success (or lack thereof)? 4) What was the experience of PSI in implementing the evidence-based interventions in the various church denominations? 5) How effective were the structured trainings in building the capacity of faith leaders on effective messaging around HIV knowledge?

2.2.Evaluation Design, Methods, and Limitations

2.2.1. Evaluation scope

The consultancy adopted participatory evaluation approaches and used qualitative and quantitative research methods to gather responses for casual contribution and attribution based on project relevance, the validity of the design, effectiveness, efficiency, impact, and sustainability. This involved comparing program results at mid-term (FY19) with end of term (FY22 (Q1-Q3)) results, and gathering the perspectives of stakeholders, implementers and beneficiaries.

The evaluation was descriptive, cross-sectional and non-experimental, designed to review planning, implementation, and achievement of results at output and outcome levels using mixed approaches with quantitative and qualitative data elements. The evaluation reflected on project successes, lessons, failures, threats, and opportunities for improvement in future HIV programming.

The evaluation was guided by the SCORE project end-of-term evaluation Protocol that was approved by the Eswatini Health and Human Research Review Board (EHHRRB), Centers for Disease Control and Prevention's Office of the Associate Director for Science (CDC ODS) and PSI Research Ethics Board (REB). The protocol provided the scope, evaluation questions, sampling frame, data collection tools, forms for consent to participation, guidelines for interviews, focus group discussions (FGDs), direct observation (DO) and analysis. The independent evaluation team did not make any changes to approved data collection tools. The independent evaluation team developed an inception report, which detailed the scope and approaches to be used, including a detailed work plan. PSI and CDC approved the report prior to the commencement of fieldwork.

Project oversight was provided by a project evaluation team comprised of CDC and PSI technical teams, who held weekly feedback sessions with evaluators to track progress and troubleshoot areas that required their support. The independence criteria of the evaluation was observed throughout the process, by ensuring that no officer from neither PSI nor CDC attended any consultation meeting, FGD or site observation together with the evaluators.

Preliminary findings and headlines were presented to CDC and PSI at the end of September 2022. Further refinements were made in all draft reports leading up to this final evaluation report.

This report has been produced based on the evidence of quantitative and qualitative data, triangulation with other sources as well as technical guidance and parameters. The discussions and recommendations presented in Chapters 5 and 6 are based on the perspective of the independent evaluators, are supported by evidence including triangulation of data and information provided by key respondents and through direct observation. They have been contextualized for the demographic, epidemiologic and sociopolitical situation of Eswatini.

2.2.2. Composition of the independent Evaluation team

Sacala Consulting and Management Services, who was awarded the contract to undertake the evaluation, a constituted a team comprised of two main consultants, one Lead Consultant and one Associate Consultant. Four data collectors/research assistants were recruited to support data collection at FGD's, DO's and to transcribe qualitative data. In August 2022, data collectors received training on the SCORE evaluation tools and research ethics. Data collection tools were piloted at the New Start Clinic to ensure their appropriateness, reliability in meeting evaluation objectives and respect for the human rights of all persons interacting with the process.

All independent evaluation staff signed confidentiality agreements (Annex 3) which specified the confidentiality of study, appropriate use of all information collected and non-disclosure. The abridged biographies of members of the evaluation team are provided in Annex A.

2.2.3. Stakeholder analysis, ethical considerations and informed consent

The evaluation consulted primary and secondary stakeholders. Primary stakeholders included project beneficiaries/clients and SCORE implementing partners – PSI Eswatini, MoH OPD facilities, Litsemba Letfu and New Start Clinics, FCI participating pharmacies, DREAMS teams, Church Forum and faith leaders, and the CDC which provided an oversight role. Secondary stakeholders constituted multisectoral partners that had a non-direct role, comprised of NERCHA, PACT, ICAP, Georgetown University (GU), other PEPFAR partners and development partners (WHO and UNAIDS).

Throughout the evaluation, evaluators upheld ethical considerations for involving human subjects by integrating crosscutting issues of human rights, non-discrimination, gender equality, equity in health and inclusivity of beneficiaries. Ethical clearance was obtained from the EHHRRB, CDC ODS and PSI REB.

The evaluators requested signed consent from all persons who interacted with the evaluation. Before the start of each interview or group discussion, respondents were informed of the purpose of the evaluation, that participation was voluntary, use of information and confidentiality of their response. Respondents were also informed of their right to refuse participation or withdraw at any time during the discussion. Signed individual consent forms were obtained using Annexes 1, 2, 4, 5, 6 and 26, which were customized for different audiences. Privacy and confidentiality was maintained during analysis and report writing by presenting data along common themes rather than specifying individual persons, groups or institutions.

2.2.4. Evaluation Methods for data collection

A. Desk reviews of documents

The evaluation undertook an extensive review of documents comprised of the SCORE project narrative proposal, SCORE Mid-Term evaluation report, annual country operational plans (COP) for PEPFAR and PSI quarterly and annual reports as well as PSI annual work plans (AWPs). Other critical documents that were referenced for triangulation included the National Multisectoral HIV and AIDS Strategic Framework (NSF 2018-2023), Umgubudla HIV Investment Case (2015), National Health Sector Strategic Plan (NHSSP III 2018-2023), and MoH standard operational procedures (SOP) guide for health care workers (at facilities and HIV testing community partners).

A. Quantitative data collection and analysis

Guided by the evaluation protocol, the evaluation did not collect quantitative data but performed secondary analyses using existing program data from the PSI MIS, DATIM, MoH's CMIS, DREAMS database at PACT, New Start Clinic patient tracker, Litsemba Letfu clinic attendance registries and PSI progress reports to CDC/PEPFAR. This provided data relating to all performance indicators, allowing the establishment of trends and determination of achievement through comparison of targets, mid-term and end of term performance. In that way, quantitative

data was used for program evaluation to assess the contribution of SCORE projects to key outcomes between 2020 and 2022.

B. Qualitative data collection and analysis

This involved primary data collection from key respondents, comprised of project stakeholders and beneficiaries/clients including, implementing partners (IPs), PSI program staff, and clinical service providers through key informant interviews (KIIs) and focus group discussions (FGDs). This also included undertaking direct observations (DO) of client-provider interactions in service sites.

Table 3 below describes the persons that were met and the interaction method that was used.

Table 3: Sampling frame for qualitative data collection

Interaction method	**Number of respondents**	**Persons**
Key informant interviews (KII)	31	• PSI staff involved in SCORE, DREAMS, FCI implementation • PEPFAR implementing partners • MOH • NERCHA • CDC • Clinical providers (DREAMS/HTS) • Community leader / pastor / community carer • FCI participating Pharmacists • Project beneficiaries • Males accessing VMMC aged 20-34
Focus Group Discussions (FGD)	11 groups consisting of 8-10 participants per group	• DREAMS beneficiaries (3 FGDs) • DREAMS clinical team (1FGD) • Community leaders (1 FGD) • Service providers (3 FGDs) • MoH/ENAP program staff (1 FGD) • FCI implementers (2 FGD)
Direct observations	5 sites	• 3 DREAMS clinical sites • 1 New start Clinic • 1 Index testing site

Thirty-one key informants (KIs) were interviewed, who were purposively sampled based on their institution and knowledge of the SCORE project. All KIs consented to participation by signing consent forms. Respondents who participated through virtual meetings were emailed consent forms for signing before commencement of interviews. The structure of interviews was guided by semi-structured interview guides that were customized for different categories of SCORE stakeholders, implementing partners, DREAMS, pharmacies, and faith leaders. The guides are referenced Annexes 9, 15, 16, and 17, respectively. Three VMMC clients were purposively included as KIs to compensate for the absence of a FGD for the VMMC program. These were identified through convenience sampling using clinical records at Litsemba Letfu Clinic for men who were due to return for post-MC checkup during the data collection period.

Eleven FGDs were conducted with HTS/PSI services providers in health facilities and outreach, PSI clinical staff involved in SCORE, ENAP, DREAMS clinical teams, HTS beneficiaries, DREAMS beneficiaries, community leaders, FCI participating pharmacies and church administrators. Each FGD had between 8-10 participants who were purposively and conveniently sampled from existing program databases and/or identified through their work function and institution. All participants signed consent forms. DREAMS beneficiaries signed assents and their parents and/or guardians of AGYW that were under the age of 18 were required to consent for their participation. A moderator's guide (Annex 7) was used to facilitate discussions in both English and SiSwati as preferred by discussants. FGD were conducted using semi-structured guides - Annexes 11, 12, 13 and 14 - for HTS beneficiaries, AGYW (DREAMS), AGYW clinical team, and community carers (FCI), respectively.

Direct observations were conducted in five sites: New Start Clinic, Kukhanyeni, Mafutseni and Lugongolweni Tinkhundla under DREAMS and index testing in the Mafutseni community. A standard checklist was used for service delivery assessment, Annex 10.. The DO for index testing was delayed due to time constraints and repeated returns until an index contact consented to testing. The DO was finally conducted just before project closure. In case the DO could not happen, the evaluation team mitigated by probing index information from HTS beneficiaries.

The purpose of collecting qualitative data was to obtain in-depth information on implementation processes, project successes, and identify the lessons, and challenges through the perspective of stakeholders, implementers, and beneficiaries. This was done to guide future project implementation through systematic recommendations. The data also enabled a process evaluation to explore ideas and further explain the quantitative results for effectiveness efficiency and sustainability.

2.2.5. Data management

The handling of all data for the evaluation followed PSI data management procedures as prescribed in the approved evaluation protocol. *Quantitative data* was extracted for specified variables according to the guidance in ANNEX 8, and managed in a PSI MIS before importing to SPSS statistical software for secondary analysis. The data abstraction process was centralized at PSI to ensure that the evaluation team received de-identified data to protect clients' identities. Evaluation consultants performed data cleaning to minimize potential errors that could occur when transferring data from the different databases. Fifteen percent of the data was examined for errors and logical consistency among inter-related variables. Data was extracted from the databases and exported to excel where the de-duplication process was performed by sorting and removing identical records and assigning unique IDs of dates of birth. The de-duplication process is outlined in the SCORE project's existing standard operating procedures (SOP). None of the data sets were found to have inconsistencies.

Qualitative data was collected using semi structured guides and audio recordings. All filled in questionnaires were stored in a double locked cabinet within the physical offices of the consultancy firm. Audio recordings were encrypted and only accessible by a passcode known by evaluators. These were also stored in a hard drive and backed up to cloud.

All evaluation data and information remained the property of PSI and was not disseminated to any party. This includes all KI responses, analysis outputs and reports. All materials were handed over to PSI at the completion of the assignment.

To ensure data integrity, the CDC and Principal investigator at PSI provided oversight and monitoring through weekly updates.

2.2.6. Data analysis

Data analyses for the end-term evaluation was guided by the evaluation questions to address aspects of effectiveness, relevance, efficiency, and results. The analysis of quantitative data for clients and beneficiaries was performed using SPSS to generate frequencies and cross tabulations by sex, age groups, region and modality. Microsoft Excel was used to generate figures and tables presented in this report.

Qualitative data from KIIs and FGDs was analyzed using textual analysis software NVIVO and guided by content and thematic analysis frameworks. Annex 20: SCORE Key informant interview/FGD Transcription Guideline was referenced for transcribing data collected from FGDs. Audio recordings were transcribed into *verbatim*, and those conducted in SiSwati were first translated into English. Coders used a three-step process to generate a codebook using emerging themes by importing transcripts into NVIVO, code transcripts and calculate a kappa statistic. Themes were identified using the thematic approach (Guest et al., 2012) and summaries were developed for each theme, with representative quotes selected.

All major findings expressed in this report were verified through triangulation with alternative related data sources and further consultations as required. This was done to develop concrete, reliable findings and conclusions.

2.2.7. Limitations, risks and mitigation measures

As it is typical of many evaluations the SCORE evaluation had some limitations and some of them received mitigation action as described in table 4 below.

Table 4: Limitations, risks and mitigation measures

AREA	LIMITATION OR RISK	MITIGATION PLAN
Quantitative data	Quantitative data was largely secondary data; as a result, consultants had no way of verifying the data from the source.	Triangulation techniques were used to qualify the data against other reliable sources.

Qualitative data	The purposive and non-random sampling technique can compromise generalization of results.	The evaluation team including CDC and PSI would continuously identify information that required further probing.
DREAMS project	Implementation commenced only at year 4/ FY 20. Due to the short implementation period, the evaluation could not observe real change in outcomes.	None.
VMMC	No FGD was allocated for VMMC beneficiaries. This did not allow evaluation to gather group interactive variable responses.	3 VMMC clients were included as key informants.
Reporting bias by subjects (especially beneficiaries)	Beneficiaries appeared to be afraid to express their honest reflection, fearing repercussions by funder (PSI Eswatini). The use of recorders may have intimidated some informants/discussants who suspected that their anonymity would be compromised.	The use of independent consultants minimized this bias. Evaluators assured participants that their responses were confidential, de-identified, and of the value of their feedback. Guidelines allowed for opting out of recording. All informants were informed that recording was solely for the purpose of evaluators recall during analysis. No PSI or CDC staff were present during the interviews,

		discussions, and field observations.
Interpretation of qualitative data by evaluators	Potential bias of the evaluation team towards their preferred interpretation of qualitative data.	Records and detailed notes including recordings were archived and can be used to verify findings. PSI and CDC performed data verification and probing of findings during the weekly briefings, presentation of preliminary findings and in all draft reports
Tight timelines	The evaluation was conducted within a very tight schedule of less than 45 days allocated for data collection, analysis and report writing.	The consulting team remained committed to meeting the timelines to deliver within the allocated period. A project extension was made to allow for report refinements and to allow payments to consultancy firm.

CHAPTER 3: FINDINGS AND RESULTS

3.1. SCORE Project: Clinical Cascade

The evaluation sought to assess whether the SCORE project was able to increase PLHIV case finding, recent infection surveillance coverage, linkages to HIV prevention and treatment, provide comprehensive HIV and TB services and provide cervical cancer screening to female ART clients. The evaluation questions are described in table 5 below.

Table 5: SCORE HTS and Linkage to Case Management evaluation objectives and questions

Evaluation Objective	A. To assess if an optimized and targeted testing approach in OPD settings, including index and recency testing, improved detection of HIV cases and linkage to treatment and prevention between 2020 and 2022 B. To assess the extent to which the LCM model improved early initiation of ART among newly HIV-diagnosed clients and retention in care and viral suppression between 2020 and 2022			
Evaluation Questions (EQ)	1) To what extent has the program implemented recency testing to identify recent HIV cases? 2) To what extent has the program utilized recency data to improve case finding among populations with the highest risk of recent infections? 3) To what extent has implementing an optimized and targeted testing approach in OPD settings contributed to case finding? 4) To what extent has the HIVST distribution contributed to case finding for HIV through index testing and facility-based distribution? 5) To what extent has the program improved linkages of men aged 20-34 and females aged 15-30 to prevention & treatment services? 6) To what extent has the SCORE program referred newly identified PLHIV for ART enrolment and retention?			
Outcome-level Performance	Indicators	Baseline at mid-term FY19	End term FY22 (Q1-Q3)	
			Target	Performance
	PLHIV who are aware of their HIV-positive status	84.7% (SHIMS, 2017)	≥ 90%	94% (SHIMS3 2021)
	% of PLHIV identified through index testing (CBHTS)	62% (mid-term review; DATIM, 2020)	50%	34.3% (FY21)
	% of PLHIV who were linked to ART	75% (mid-term review; CMIS 2020)	95%	96.8% CMIS 2022

	% of HIV negative clients identified at HTS sites who are initiated on PrEP	Not established	No target	3.8%

Evaluation Objective A: *To assess if an optimized and targeted testing approach in OPD settings, including index, and recency testing, improved detection of HIV cases and linkage to treatment and prevention between 2020 and 2022.*

Objective A discusses PSI's contribution to the first 95 of the treatment cascade to diagnose 95% of PLHIV. PSI used targeted testing approaches to improve case finding among males and females aged 25-34, and adolescent girls and young women (AGYW) 15-29 years.

HTS modalities used by PSI included:

(i) Facility HTS at OPDs in 27 (and later 25) health facilities and VCT services at New Start Clinic in Matsapha to people who walked in and requested to be tested. PSI provided qualified HTS lay-counselors to administer HTS in OPDs.

(ii) Index testing, also known as partner notification or contact tracing, which is an approach whereby the exposed contacts (sexual partners, biological children or family members, associates and/or anyone with whom a needle was shared) of a newly identified HIV-positive person (i.e., index client) are elicited and offered HIV testing services. Index testing was provided in communities. PSI provided teams comprised of a nurse, HTS counsellor and expert client (EC) to trace contacts and offer mobile HTS in their communities.

(iii) Mobile HTS offered by qualified PSI counselors and ECs through outreach in workplaces, campaigns and events to target high-risk men and AGYW.

(iv) HIV self-tests (HIVST) which were distributed in eleven pharmacies and community sites to target populations that were not comfortable testing through assisted models.

(v) HIV recency testing was conducted on newly diagnosed patients by certified testers through a rapid test for recent infection (RTRI) and virological test as part of the recent infection testing algorithm (RITA).

HIV screening and risk assessment tools were used at all PSI-supported OPD and community sites to screen out individuals who were at lower risk of infection and likely to test HIV negative, in order to offer HTS to persons who were likely to test positive. All clients who came through facility

entry points for TB, family planning, antenatal care (ANC) and child welfare including the sexual contacts of index clients were offered HIV testing without screening or risk assessment.

Evaluation question (EQ) 1: *To what extent has the program implemented recency testing to identify recent HIV cases?*

A recency test detects the avidity of HIV antibodies to determine whether an HIV infection occurred within the previous twelve months (classified as "recent") or more than 12 months (classified as "long term" infection). Recency testing algorithm incorporates HIV RNA (viral load) testing to determine recent infection using VL ≥1000 copies/mL Recency testing is conducted for the purpose of disease surveillance to guide programming and approaches towards geographic hotspots and populations at risk of infection.

PSI rolled out recency testing in Q4 of FY19 following a phased implementation schedule which begun with trainings and phased roll out from community testing points to facilities. In FY20, all newly diagnosed PLHIV older than 15 years diagnosed in community testing points, were offered to participate in recency surveillance through the opt-out approach. As shown in table 6, below, PSI diagnosed 1,885 persons who were 15 years or older as HIV positive. Specimens were collected from 40.9% (n=771) PLHIV, from which 10.2% (79/771) were identified as recent infections and the remainder (n=692) long term. Virological testing using the RITA was conducted on some of the specimens defined as recent to determine a final classification based on the maturity of infection. Thirty-two patients (40.5%) had HIV RNA ≥1000 copies/mL. The RITA recent was 4.1% in FY20.

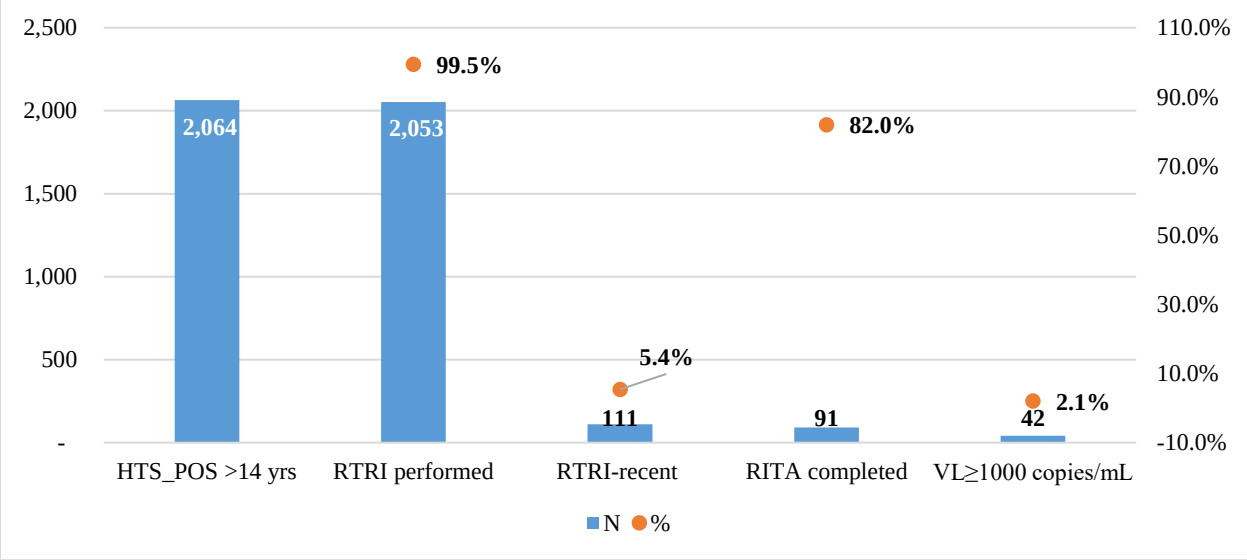
Table 6: Recency testing among HIV patients older than 14 years, FY20

	FY20	
	Number (N)	Percentage (%)
HTS_POS >14 years	1,885	
RTRI performed	771	40.9%
RTRI-recent	79	10.2%
Tested VL≥1000 copies/mL	32	40.5%
RITA - recent	32	4.1%

Source: PSI MIS, 2020

During FY21, PSI performed recency testing using the RTRI on specimens from 2,053 newly diagnosed PLHIV. It identified 5.4% (n=111) as having recent infections. Specimens from 91 out of the 111 patients that had RTRI recent infection was further tested using the RITA, which determined that 42 (46.2%) had HIV RNA ≥1000. Therefore, RITA recent was 2.1% (42/2033) in FY21. Figure 2 below describes the HIV recency cascade for FY21.

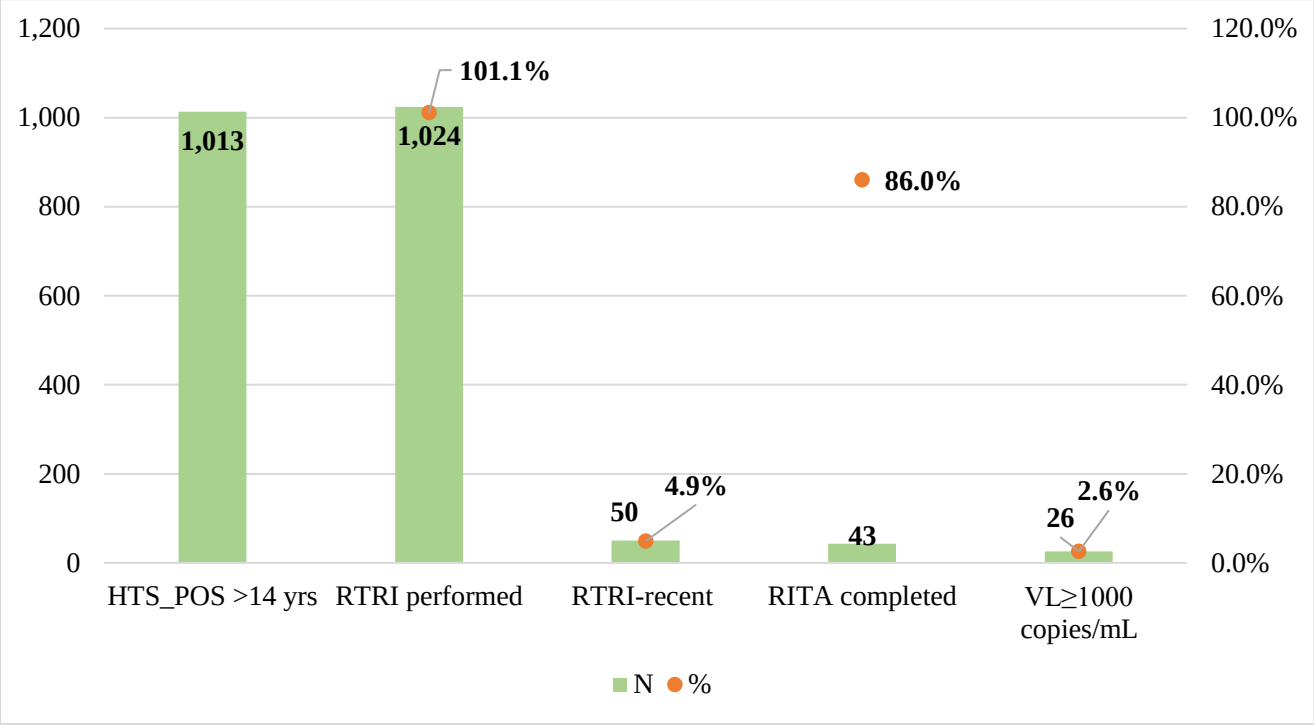
Figure 2: RTRI HIV recency cascade in FY21



Source: PSI MIS, 2021

The recency cascade for FY22 (Q1-Q3) is shown in figure 3 below. Specimens from 1,024 newly diagnosed PLHIV were tested using the RTRI and only 4.9% (n=50) were found to be recent. Specimens from 43 of patients with recent infections were further tested using the RITA which showed that 60.5% (26/43) of patients as having an HIV RNA ≥1000 copies/mL confirming recent infection. Therefore, RITA recent was 2.6% (26/1017) in FY22 (Q1-Q3).

Figure 3: RTRI HIV recency cascade in FY22 (Q1-Q3)



Source: PSI MIS, 2022

A higher number of recent infections were found those in the ages 20-29 years. In both periods, more long-term infections were found at OPD and index sites. The findings identified hot spots based on the volume of recent infections as Manzini South, Kwaluseni, Lobamba Lomdzala Tinkhundla in the Manzini region and Nkilongo, Sithobela and Siphofaneni Tinkhundla in the Lubombo region.

EQ 2: *To what extent has the program utilized recency data to improve case finding among populations with the highest risk of recent infections?*

The conceptualization of the recency testing initiative was to characterize recent infections in order to identify geographic hot spots and demographic groups that required intensified testing and HIV prevention activities. The results would also be used to monitor epidemic trends over time.

The recency data findings that over 90 percent of newly diagnosed persons had infections that were older than 12 months was not expected given that more PLHIV were aware of their HIV status as diagnosed or had detectable ARVs in their blood (i.e., ARV-adjusted diagnosed). This

was established in the SHIMS2 (2017) that 87.0% of PLHIV aged 15 years and older years knew their status, and increased to 93.7% in 2021 SHIMS3 (2021). On this, the evaluators conducted further consultations and probing of key respondents, and uncovered the potential reasons for having a lot of newly diagnosed PLHIV with long term infections as a) late diagnosis of untested PLHIV - the missing 6.3%, and/or b) PLHIV with known status that have various reasons for retesting including treatment defaulters who want to re-enroll on treatment.

PSI used the evidence of recency data to improve their use of the HIV screening tool to ensure that populations from 'hot spots' had access to HTS, reduced re-testing for clients already on ART and linked back clients who had interrupted treatment without discrimination. PSI also intensified awareness creation and HIV prevention services to targeted populations of tertiary students in Kwaluseni, Manzini region and "dagga" (marijuana) field workers in Lugongolweni, Lubombo region.

EQ 3: *To what extent has implementing an optimized and targeted testing approach in OPD settings contributed to case finding?*

As shown in table 7 below, PSI provided HTS to 11,240 individuals in FY20, which was 34.3% of the HTS_TST target. The low achievement against target was a result of PSI focus on efficient ways for case finding to meet its HTS_POS targets, through targeted testing as opposed to mass testing that characterized the earlier years of the HTS strategy, and the introduction of risk assessment and screening tools since FY20. Additionally, PSI started to report on new tests only, excluding retests. During FY20, a total of 1,900 people were diagnosed with HIV, resulting in a yield of 16.9%. Index testing offered the highest yield of 28.6%, while facility VCT and mobile testing yielded 10.2% and 10.1%, respectively. In FY20 conventional testing numbers dropped drastically due to COVID-19 movement restrictions and a mandated halt of community HTS by the MOH. Instead, PSI pivoted to distribute HIVST kits at places that were allowed to continue operating, such as pharmacies and in front of grocery stores.

In FY21 PSI introduced facility OPD testing by placing HTS lay-counsellors in 27 and later 25 facilities. Tests were conducted on 9,955 individuals, from whom 2,131 (21.4%) were diagnosed with HIV. A majority of individuals were tested in OPD sites, where 24.2% were found to have HIV. Index testing demonstrated the highest yield of 31.6%.

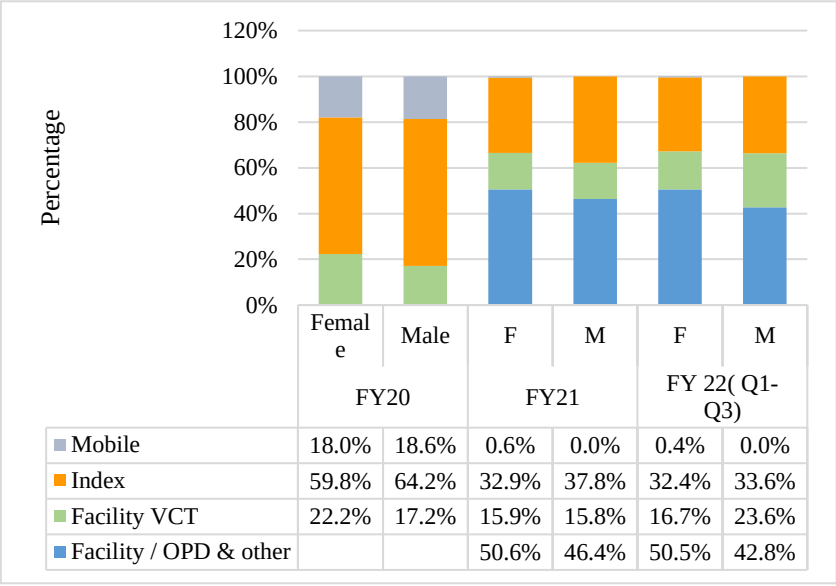
In FY22 (Q1-Q3), achievement against HTS_TST target improved to 88.4% as re-tests were included into reporting based on the advice of the donor. In FY22 (Q1-Q3), 15,992 individuals were tested including re-tests and 1,150 persons were diagnosed HIV positive, revealing a yield of 7.2%. Two thousand four hundred and eighty individuals were tested at OPDs where 22.0% (n=546) were found to have HIV. On thousand eight hundred and sixty eight persons were tested at index sites and 20.2% (n=378) were diagnosed HIV positive.

Table 7: HTS testing and positivity by HTS modality FY20-FY22 (Q1-Q3)

		Annual HTS_TST Target	**Achieved HTS_TST**	**% Achieved**	**HTS_TST_POS Target**	**HT_TST_POS**	**Yield**
FY20 (Oct 2019-Sept 2020)	**All Models**	32,792	11,240	34.3%	6,953	1,900	16.9%
	Facility -VCT				3,686	376	10.2%
	Index (excl. associates)				3,242	1,177	28.6%
	Mobile				4,312	347	10.1%
FY21 (Oct 2020-Sept 2021)	**All Models**	30,832	9,955	32.3%	9,399	2,131	21.4%
	Facility / OPD & other				4,418	1,071	24.2%
	Facility VCT				2,507	335	13.4%
	Index				2,268	717	31.6%
	Mobile				206	8	3.9%
FY22 (Oct 2021-Jun 2022)	**All Models**	18,090	15,992	88.4%	5,801	1,150	7.2 %
	Facility / OPD & other				2,480	546	22.0%
	Facility VCT				1,450	223	15.4%
	Index				1,868	378	20.2%
	Mobile				405	3	0.7%

Source: PSI MIS, 2020-2022

Figure 4: HT_TST_POS contributions by HTS modality



	Female	Male	F	M	F	M
	FY20		FY21		FY 22(Q1-Q3)	
Mobile	18.0%	18.6%	0.6%	0.0%	0.4%	0.0%
Index	59.8%	64.2%	32.9%	37.8%	32.4%	33.6%
Facility VCT	22.2%	17.2%	15.9%	15.8%	16.7%	23.6%
Facility / OPD & other			50.6%	46.4%	50.5%	42.8%

Source: PSI MIS, 2020-2022

A comparison of models based on the volume of HIV-positive individuals (HTS_TST_POS contributions) is shown in figure 4. It reveals how the change in approaches since FY21, from predominantly community focused to include OPD, resulted in more case finding in facilities than communities. Per figure 4, initially the largest proportion of positives among both males and females came through index. When the approach changed, the largest proportion of positives for both males and females came from Facility/OPD followed by index followed by facility VCT with community mobile contributing very low percentages.

The change in approaches resulted in a small increase in overall diagnoses. However, as shown in table 8 below, facility approaches appear to favor the identification of females. Proportionately, in FY20, females constituted 52% of the diagnoses. With the change to focus on facility-based approaches, the proportion of diagnoses that were female increased to 58% in FY21 and 61% in FY22.

Figure 5 and Table 8 below, which show the population of newly diagnosed individuals (HIV_POS) during FY20 to FY22 (Q1-Q3), reveal that more newly diagnosed persons were within the ages 20-39 years in FY20, 20-44 years in FY21 and 15-34 years in FY22 (Q1-Q3). On average, females constituted 56.5% (n=2,926) of newly diagnosed PLHIV. The volume of HIV positive females within the ages 15 to 19 years was almost five times higher than that of same aged males (n=319 vs n=66). Females also made up 79.4% (n=696) of positives in the ages 20-24. The trend continued until age 30 and above where males make up more positives. The shift to facility-based

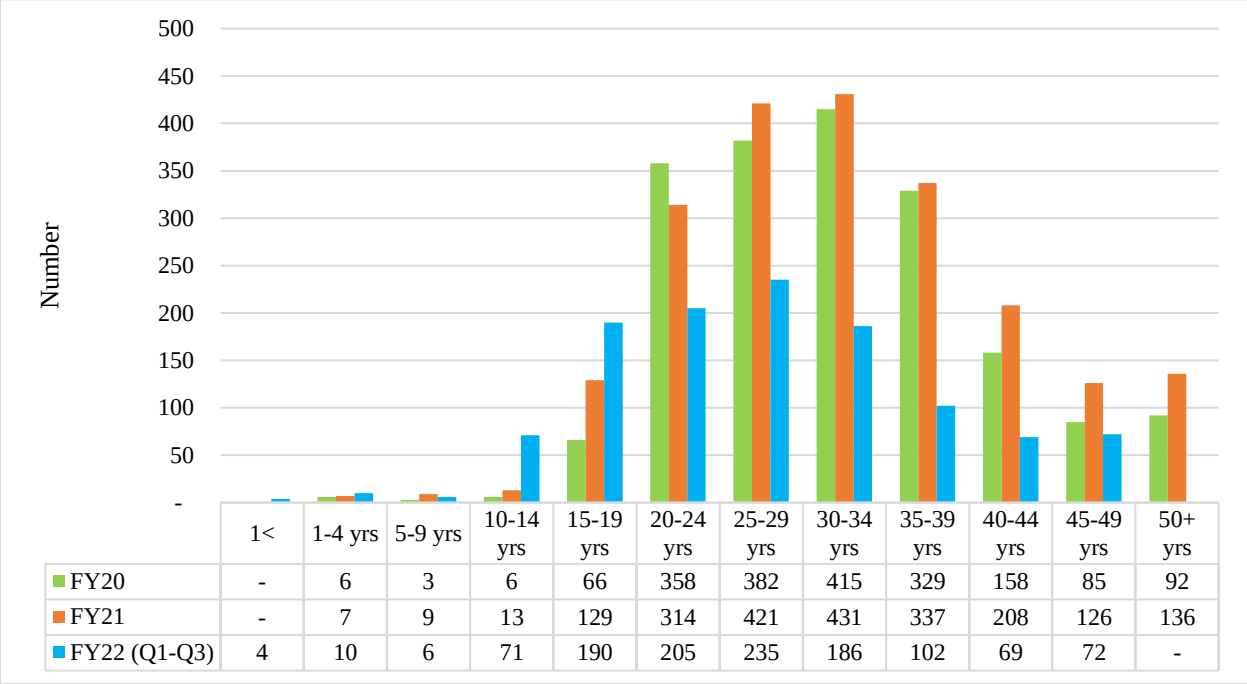
approaches appears to have significantly increased the number of 10-14 and 15-19 year olds identified among both males and females.

Table 8: Population of newly diagnosed individuals, by age and sex, FY20- FY22 (Q1-Q3)

	FY20			FY21			FY22 (Q1-Q3)		
Age in years	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**
1<	-	-	**-**	-	-	**-**	1	3	**4**
1-4	1	5	**6**	4	3	**7**	8	2	**10**
5-9	3	-	**3**	4	5	**9**	1	5	**6**
10-14	3	3	**6**	10	3	**13**	61	10	**71**
15-19	59	7	**66**	94	35	**129**	166	24	**190**
20-24	278	80	**358**	278	36	**314**	140	65	**205**
25-29	223	159	**382**	286	135	**421**	129	106	**235**
30-34	188	227	**415**	229	202	**431**	82	104	**186**
35-39	116	213	**329**	143	194	**337**	42	60	**102**
40-44	50	108	**158**	83	125	**208**	37	32	**69**
45-49	27	58	**85**	54	72	**126**	34	38	**72**
50+	32	60	**92**	60	76	**136**	-	-	**-**
TOTAL	**980**	**920**	**1,900**	**1,245**	**886**	**2,131**	**701**	**449**	**1,150**

Source: PSI MIS, 2020-2022

Figure 5: Population of newly diagnosed individuals, by age and sex, FY20- FY22 (Q1-Q3)



	1<	1-4 yrs	5-9 yrs	10-14 yrs	15-19 yrs	20-24 yrs	25-29 yrs	30-34 yrs	35-39 yrs	40-44 yrs	45-49 yrs	50+ yrs
FY20	-	6	3	6	66	358	382	415	329	158	85	92
FY21	-	7	9	13	129	314	421	431	337	208	126	136
FY22 (Q1-Q3)	4	10	6	71	190	205	235	186	102	69	72	-

Source: PSI MIS, 2020-2022

As part of index testing, PSI elicited the exposed contacts (sexual partners, biological children or family members, associates and/or anyone with whom a needle was shared) of all newly identified HIV-positive people, traced them and offered them testing in their communities. To mitigate the potential for violence, aa standard checklist that was administered to index clients (primary case) to assess intimate partner violence (IPV). Index contact tracing was not done for clients in active IPV situations. Other mitigation measures included the review of IPV reports, post contact tracing and/or refresher trainings with the HTS counselors. The evaluators conducted a direct observation of index testing and their assessment is presented in table 9 below.

Table 9: Findings from observations of index testing

General Observations	Service providers complied with HTS protocols in terms of the 5Cs of consensual, confidential, counseling, correct test results and connection to treatment or prevention services. However, the pre and post-test counseling aspect appeared to be rushed through and was not individualized. It also appeared to be information sharing as opposed to counseling.

	Female clients were reluctant to share their sexual contacts. Testing counselors had to respond to why contacts and associates were required. Some probing was observed to encourage the client to disclose sexual contacts.
Findings	Index tracing observed that one female primary client had given false information for sexual contact. Initiation of ARV and continuity was dependent on client's willingness. Those observed preferred to initiate at their nearest health facilities and not New Start Clinic.

EQ 4: *To what extent has HIVST distribution contributed to case finding for HIV through index testing and facility-based distribution?*

During FY20-FY22 (Q1-Q3), PSI provided HIV self-test (HIVST) kits under assisted and unassisted formats. Assisted formats involved testing under observation by a trained HTS counselor. This was common in index testing, where associates of PLHIV were approached with HTS and did the test in the presence of an Expert Client. Unassisted model is where the client would access the HIVST kit to use at their convenience, relying on the instructions from the insert package. Unassisted testing was common among clients who obtained HIVST kits from participating FCI pharmacies and through Community Carers who distributed HIVST kits in churches and communities.

As shown in table 10 below, PSI distributed 25,851 HIVST kits in FY20, from which 14,218 kits were collected by females and 11,633 by males. The high number of kits distributed in FY20 are due to HIVST being made widely accessible during the COVID19 national lockdown in view of movement restrictions and slowdown of persons attending health facilities. PSI had compensated by distributing HIVST kits at strategic high volume places such as malls and outside major supermarkets.

In FY21, a total of 6,004 kits were distributed, of which 3,122 were collected by females and 2,882 by males. In the same year, PSI introduced the Faith and Community Initiative (FCI) which collaborated with eleven pharmacies to distribute HIVST free of charge to target clients at high-risk of HIV acquisition. Those classified high-risk comprised of pharmacy clients that came to purchase emergency contraceptives and/or presented with STI symptoms, both being evidence of unsafe sex. However, HIVST kits were also collected by persons who came through referrals from the FCI participating churches and those who heard about the availability of HIVST kits in pharmacies from other HIVST users or via PSI's toll free information line 1212. Pharmacies did not ask clients any medical questions (such as HIV status).

By the end of June 2022, 2,908 HIVST kits were distributed. More of the kits were collected under the unassisted option and to more males (1,223) than female (1,105).

Table 10: HIVST Distribution, FY20-FY22 (Q1-Q3)

	Service provision	Clients		Total
		Female	Male	
FY 20 (Oct 2019 -Sept 2020)	Assisted	8,976	7,335	16,311
	Unassisted	5,242	4,298	9,540
	Total	**14,218**	**11,633**	**25,851**
FY21 (Oct 2020- Sept 2021)	Assisted	2,475	2,029	4,504
	Unassisted	647	853	1,500
	Total	**3,122**	**2,882**	**6,004**
FY22 (Oct 2021- June 2022)	Assisted	344	236	580
	Unassisted	1,105	1,223	2,328
	Total	**1,449**	**1,459**	**2,908**

Source: PSI MIS, 2020-2022

A majority of HIVST clients collected kits primarily for own use, but there has been a considerable increase in the collection of secondary kits for partners and families under both assisted and unassisted models. The data in table 11 reflects uptake of HIVST kits by males and females, with males constituting 45.0% (11,633 vs 14,218) in FY20 and increasing to 50.1% (1,459 vs 1,449) in FY22 (Q1-Q3). Similarly, more males collected secondary kits for their partners and families than females.

Table 11: Individuals who received HIVST by setting, October 2021 -March 2022

Setting	Female	Male	Grand Total	% of modality
Community - Index and churches	13	16	29	1.9%
Facility- OPD	103	168	271	18.2%
Pharmacy	560	629	1,189	79.9%
Total	**676**	**813**	**1,489**	**100%**

Source: PSI MIS, 2020-2022

Table 11 shows the distribution points for HIVST in FY22 (Q1-Q3) and reveals that more (79.9%) HIVST kits were collected from pharmacies under the FCI collaboration.

A total of 4,817 HIVST clients returned for follow up services in facilities in Manzini and Lubombo during FY20- FY22 (Q1-Q3). Only 37 of them were screened positive and received confirmatory testing which revealed 75.7% (n=28) as reactive to HIV. All of those who were diagnosed positive were linked to ART.

Table 12: HIV confirmatory testing among HIVST clients, April-June 2022

	HIVST Distributed	**Followed up**	**Screened positive**	**Confirmed RDT positive**	**% Reactive**	**Linked to ART**	**% Linked to ART**
FY20	25,851	519	1	1	100.0%	1	100.0%
FY21	6,004	3,257	25	25	100.0%	25	100.0%
FY22 (Q1-Q3)	2,908	1,041	11	2	18.2%	2	100.0%
Total	**34,763**	**4,817**	**37**	**28**	**75.7%**	**28**	**100.0%**

Source: PSI MIS, 2020-2022

Findings from interviews with key informants and focused group discussion revealed the information in table 13 below. Note that the words in italics are verbatim and the non-italic are general reflections as gathered by the evaluation team.

Table 13: HTS themes emanating from key informants and FGDs

Themes	Key Extracts
HIV testing Services	
Index testing	Pros: • Helped to reach more people for HIV testing • Allows targeted testing to contacts and families. • Can promote retention to treatment for couples due to known status of both partners.
	Cons " *Forces people to face their "demons" (such as partners that are no longer part of their lives)."* "*It is not correct to divulge a sexual partner to another person without their approval. What if he does not want other people (PSI staff) to know about our sexual relationship? Or that I am HIV positive."* • An on-point strategy for soliciting index sexual contacts and uncovering sexual networks. • Can create conflict between partners if not properly managed.
Access	• HIVST has contributed to reaching hard to reach populations like men and AGYW • As an entry point to HIV treatment services, HTS has performed quite well over the recent years. • Outreach approaches have helped to reach remote places and availed access to populations who cannot present themselves in the facility, like men and white-collar employees.
Preference to use PSI sites	*"PSI services are fully consumer powered."* *"PSI team speaks the same language/information across all Cadres."* • PSI empowers clients to contribute to their own health. • PSI offers comprehensive services. • PSI staff (expert clients) are able to take the time to understand/ask about the behaviors of clients through regular discussions about risk and responsibility to prevent HIV. • A holistic approach, regardless of HIV status, since negative people are referred to PrEP and VMMC. • Services are mostly youth friendly.
Successes	"*Test and start, including LCM has led to a healthier nation."*

	"The complementary approaches that have been used regarding HIV testing to close the gap have been a success." *"Index testing is 'the' strategy."* Implying that it is a game changer for case finding. • Successes in yield are attributed to the use of mixed approaches to close the gap. • The introduction of targeted approaches and index testing has contributed to success. • The introduction of HIV preventive services, e.g. PrEP. • Index testing has done really well to find undiagnosed males. • HTS has contributed to case finding of hard-to-reach populations, e.g. Men and AGYW

Evaluation Objective B: *To assess the extent to which the LCM model improved early initiation of ART among newly HIV-diagnosed clients and retention in care and viral suppression between 2020 and 2022*

Objective B discusses PSI's contribution to the second and third 95's, to enroll and retain 95% of PLHIV on ART and achieve viral suppression in 95% of patients that are on treatment. During FY20-FY22 (Q1-Q3), PSI used the lessons from the CommLink project to implement linkage case management (LCM) to enroll newly identified PLHIV to facility-based HIV care within three months of diagnosis (Mackellar et al., 2020). To expand LCM services, PSI also scaled up community ART initiations (CommART) to enroll patients in communities. PSI provided expert clients, community-based HTS counsellors (CBHTC), linkages focal points, trained health providers and team leaders to enroll newly identified PLHIV on site and/or through referral to a local facility.

Through the LCM model, a 90-day process was employed by expert clients to build rapport with newly diagnosed PLHIV to motivate them to initiate and stay on treatment. ECs offered psychosocial support using their own experiences of what it takes to live with HIV and addressed barriers to accessing treatment. Once linked to a facility, ECs and linkage coordinators assisted first-time clients to navigate the facility and familiarize them with the processes. ECs continued to support PLHIV post-enrolment on issues of status disclosure to family, HIV testing of partners

and family members, reminders for next ART refill appointment as well as to address any barriers faced by the client.

EQ 5: *To what extent has the program improved linkages of men aged 20-34 and females aged 15-30 to prevention & treatment services?*

A) Linkages to HIV prevention

PSI offered linkages to HIV prevention to all clients testing negative at HTS platforms, including DREAMS and STI services. Prevention referral services included HIV prevention sessions under FCI and DREAMS sites targeting faith-based communities and AGYW, respectively. PSI referred clients who were at substantive risk of acquiring HIV to PrEP initiations at the New Start Clinic. PrEP was also offered to all HIV negative index contacts (both male and female) and AGYW testing negative at the DREAMS mobile unit. HIV negative males from all HTS sites and programs were further referred for male circumcision at Litsemba Letfu Clinic.

A shown in table 14 below, PSI was able to initiate 1,216 people on PrEP during the period FY20-FY2022 (Q1-Q3). The data reveals that in FY20 and FY21 more males than females were initiated, until FY22 (Q1-Q3) when more females were initiated. In FY20, 134 people were initiated on PrEP and 79.1% (n=94) were male. In FY21, 153 HIV negative AGYW were part of the 469 people who were initiated on PrEP. During the same FY, PrEP was also rolled out to community HTS sites and resulted in 140 people being initiated. In FY22 (Q1-Q3), a total of 613 people were initiated on PrEP and more than half (n=340) were female.

Table 14: Clients who were initiated on PrEP (PrEP_NEW) in FY20- FY22 (Q1-Q3)

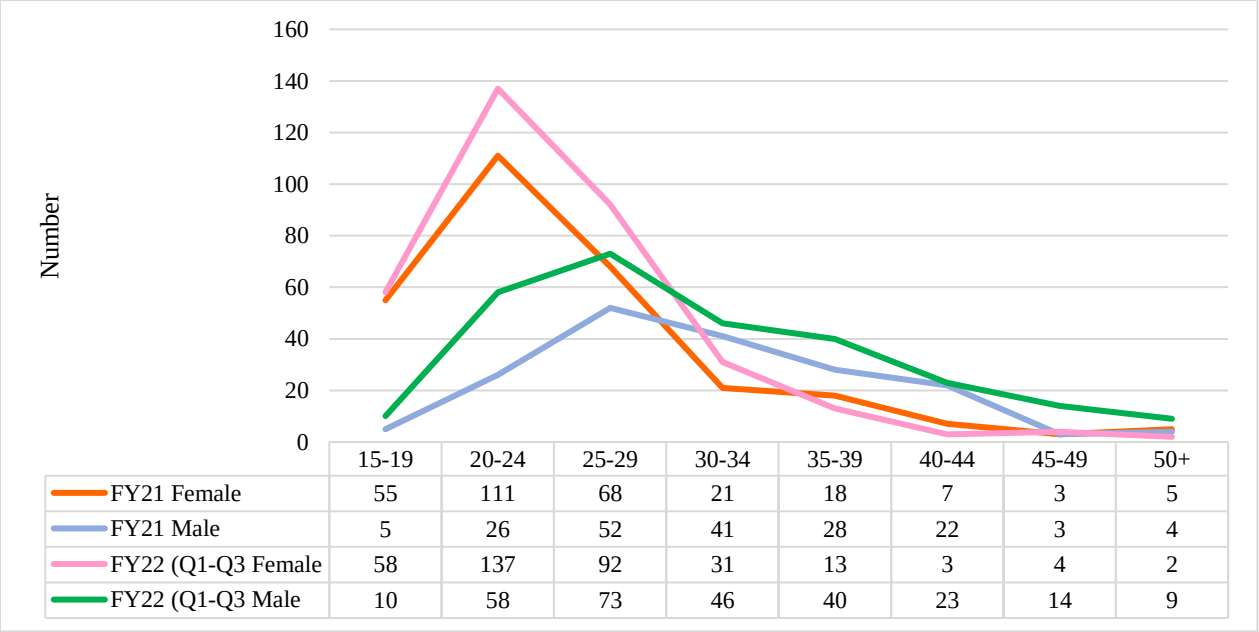
	FY20				**FY21**				**FY22 (Q1-Q3)**			
	F	**M**	**All**	**% of site**	**F**	**M**	**All**	**% of site**	**F**	**M**	**All**	**% of site**
Community HTS Sites	0	0	0	**0.0%**	65	75	140	**29.9 %**	85	126	211	**34.4 %**
DREAMS	0	0	0	**0.0%**	153	0	153	**32.6 %**	175	4	179	**29.2 %**
New Start	40	94	134	**100.0 %**	70	106	176	**37.5 %**	80	143	223	**36.4 %**

Total	**40**	**94**	**134**	**100.0 %**	**288**	**181**	**469**	**100.0 %**	**340**	**273**	**613**	**100.0 %**
% of Total PrEP Clients	**29.9 %**	**70.1 %**	**100 %**		**61.4 %**	**38.6 %**	**100 %**		**53.0 %**	**47.0 %**	**100 %**	

Source: PSI MIS, 2020-2022

Figure 6 shows the age distribution of people who received PrEP in FY21 and FY22 (Q1-Q3). More female PrEP clients were in the age group 20-24 years. Among males, more clients were in the ages 20-29 years and 35-39 years.

Figure 6: Clients who were initiated on PrEP (PrEP_NEW) in FY21 and FY22 (Q1-Q3)



	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50+
FY21 Female	55	111	68	21	18	7	3	5
FY21 Male	5	26	52	41	28	22	3	4
FY22 (Q1-Q3 Female	58	137	92	31	13	3	4	2
FY22 (Q1-Q3 Male	10	58	73	46	40	23	14	9

Source: PSI MIS, 2021

In FY22 (Q1-Q3), 284 PrEP clients returned for a follow-up or re-initiation visit and a majority of them were females aged 20-34 years and males aged 20-44 years.

B) Linkages to Treatment

Table 15 below shows linkage to treatment for 5,140 newly identified PLHIV during FY20- FY22 (Q1-Q3). On average, 90.4% (n=4,644) patients were linked to ART, with improvement of linkage from 1,640 (86.3%) PLHIV in FY20 to 1,894 (90.5%) in FY21 to 1,110 (96.8%) in FY22 (Q1-Q3). This is a great improvement from the 75.0% average linkage rate recorded during the SCORE

mid-term review in FY19. It demonstrates the impact of program improvements such CommART and same-day initiations.

In FY20, facility VCT recorded a higher linkage rate of 90.2% than community models (85.4%). This changed in FY21 with the introduction of CommART resulting in more clients being linked though community models (93.8% vs 89.0%). In FY22 (Q1-Q3), both models were able to link over 95% of newly identified PLHIV.

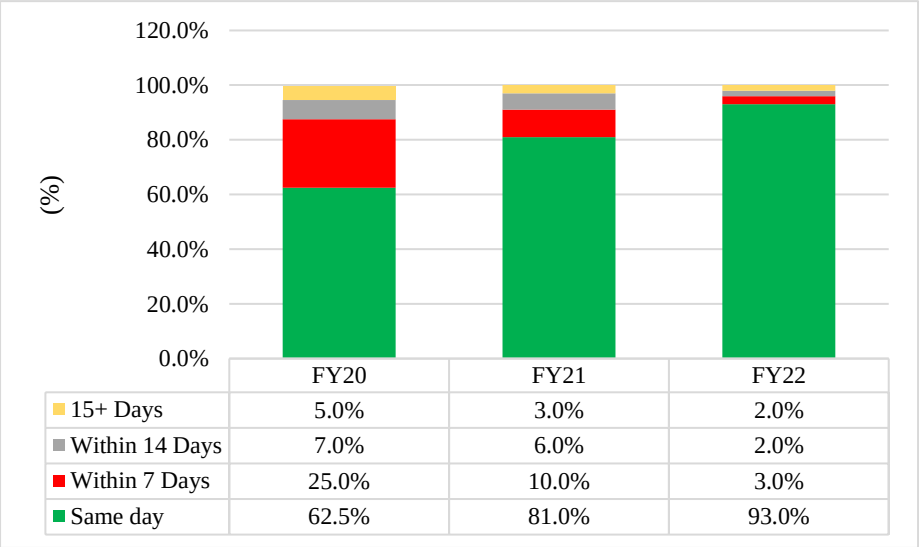
Table 15: Linkages to ART among newly tested PLHIV, FY20- (Q1-Q3)

	HT_TST_POS	LINKED TO ART	LINKAGE RATE in %
FY20 (Oct 19-Sept 20)	1,900	1,640	86.3%
Facility VCT	376	339	90.2%
Community	1,524	1,301	85.4%
FY21 (Oct 20-Sept 21)	2,093	1,894	90.5%
Facility	1,376	1,225	89.0%
Community	717	669	93.3%
FY22 (Oct 21-June 22)	1,147	1,110	96.8%
Facility	769	745	96.9%
Community	378	365	96.6%
TOTAL FY20 -FY22 (Q1-Q3)	**5,140**	**4,644**	**90.4%**
Facility	**2,521**	**2,309**	**91.6%**
Community	**2,619**	**2,335**	**89.2%**

Source: PSI MIS, 2022

As shown in figure 7 below, the time to linkage, which is a critical factor for enrollment, improved since the mid-term in FY19. On average, 95% of clients were linked within 14 days of diagnosis during FY20-FY22 (Q1-Q3). Same day initiations improved from 62.5% (N=1,640) in FY20 to 81.0% (N=1894) in FY21 and 93.0% (N=1,110) in FY22 (Q1-Q3).

Figure 7: Time to linkage for newly identified PLHIV, FY20 - FY22 (Q1-Q3)



	FY20	FY21	FY22
15+ Days	5.0%	3.0%	2.0%
Within 14 Days	7.0%	6.0%	2.0%
Within 7 Days	25.0%	10.0%	3.0%
Same day	62.5%	81.0%	93.0%

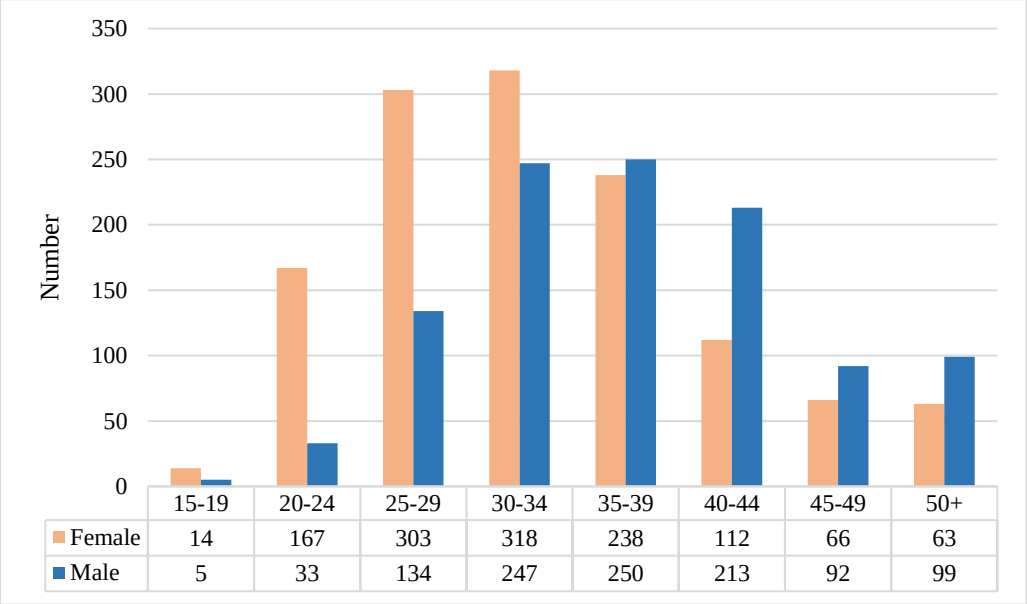
However, one of the reported challenges of the LCM same day initiations was the *"lack of time to truly absorb one's status before they are enticed to enroll in ART."* Focus Group Discussion.

Source: PSI MIS, 2020-2022

PLHIV clients on ART

Figure 8 demonstrates the ages of patients on ART (TX_CURR) in Q3 of FY22. At the end of June 2022, PSI had 2,354 active clients who were receiving ART at New Start Clinic. Fifty-four percent of clients were females (n=1,281) and 45.6% (n=1,073) male. A majority (63.6%, n=1,498) were between the ages 20 – 44 years, comprised of 788 (61.5%) females in the ages 20 - 34 years and 710 (66.2%) males in the ages 30 – 44 years.

Figure 8: PLHIV on ART (TX_CURR) by age and sex, June 2022



	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50+
Female	14	167	303	318	238	112	66	63
Male	5	33	134	247	250	213	92	99

Source: MOH Client Management Information System (CMIS), 2022

Table 16 below shows the movement of ART clients at New Start Clinic during FY20 to FY22 (Q1-Q3). It shows that 1,977 clients were on ART in FY20 including 404 new enrollments and 68 clients those who were successfully restarted after interruption in treatment (IIT). The net increase of clients on ART was 269 in FY21 and by 108 in FY22 (Q1-Q3) comprised of newly enrolled patients and those who reenrolled after treatment interruption. This increased the number of ART clients to 2,246 and 2,354 in FY20 and FY22 (Q1-Q3), respectively. Females make up 54.4% (n=1,281) of clients on ART (TX_CURR).

Over the period, the number of clients who interrupted treatment by defaulting and/or lost to follow up reduced slightly from 174 patients in FY20 to 164 in FY21 and 160 at the end of Q3 of FY22. More males interrupted treatment (IIT) than females. The common reasons for treatment interruption were '*still had tablets'* which was common among male clients and '*relocated for work or family*, by female clients. (MoH CMIS, 2020-2022).

PSI employed creative methods to reduce treatment interruptions by reminding clients of appointments through phone calls, tracing and home visits. During the period (FY20-F22), a total of 203 clients restarted treatment (TX_RTT). Sixty-four percent (n=129) of restarts were females.

(MoH CMIS, 2020-2022) Although the majority of IIT were male, the majority of clients who returned to treatment (TX_RTT) were female.

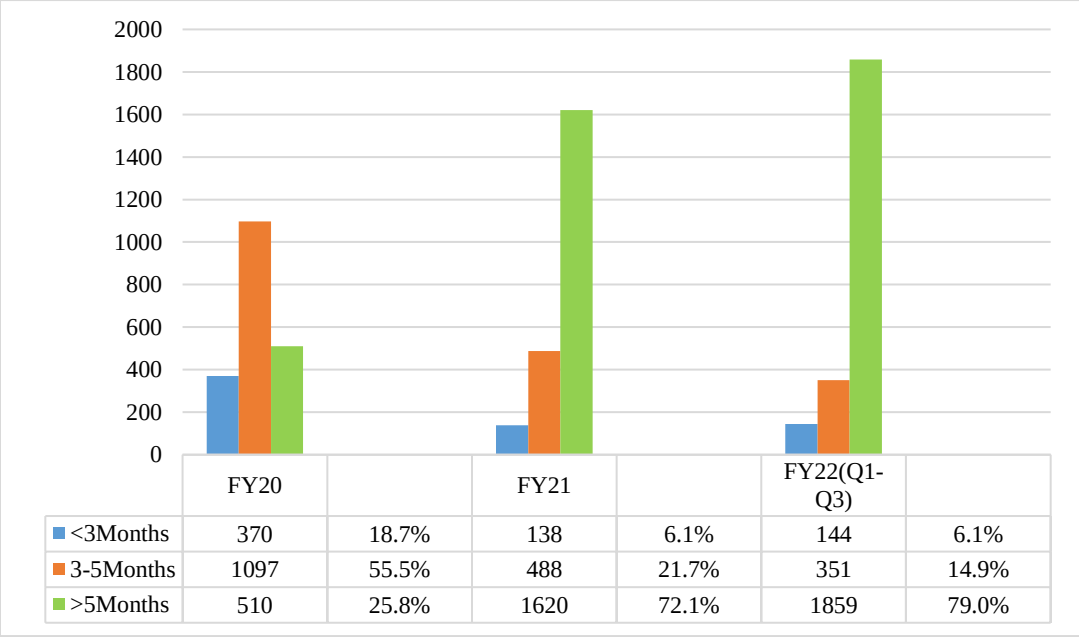
Table 16: Movement of PLHIV clients in FY20 and FY22 (Q1- Q3)

	FY20			FY21			FY22 (Q1-Q3)		
	Female	**Male**	**Total**	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**
PLHIV on ART (TX_CURR)	1,093	884	**1,977**	1,251	995	**2,246**	1,281	1,073	**2,354**
Interruption in treatment (IIT)			**174**	66	98	**164**	73	87	**160**
Clients initiated on treatment (TX_NEW)	246	158	**404**	161	124	**285**	93	95	**188**
Clients restarted on treatment (TX_RTT)	42	26	**68**	60	37	**97**	27	11	**38**
Net increase of clients on ART	203	101	**304**	158	111	**269**	30	78	**108**

Source: MOH Client Management Information System (CMIS), 2022

PSI provided **multi-month dispensing (MMD)** of ARVs to stable ART clients. As shown in figure 9 below, 1,097 (55.5%) patients were given ARVs to last 3-5 months by the end of FY20. In FY21, a majority (72.1%, n=1,620) of patients were given ARVs to last for more than 5 months, and the proportion increased to 1,859 (79.0%) at the end of June 2022. The strategy to extend the duration of prescriptions was also accelerated by the COVID19 lockdown movement restrictions and civil unrest in 2021, both of which resulted in an abrupt halt of in-person refill services.

Figure 9: Multi-month dispensing for ART clients – (TX_CURR) in FY20- FY22 (Q1-Q3)

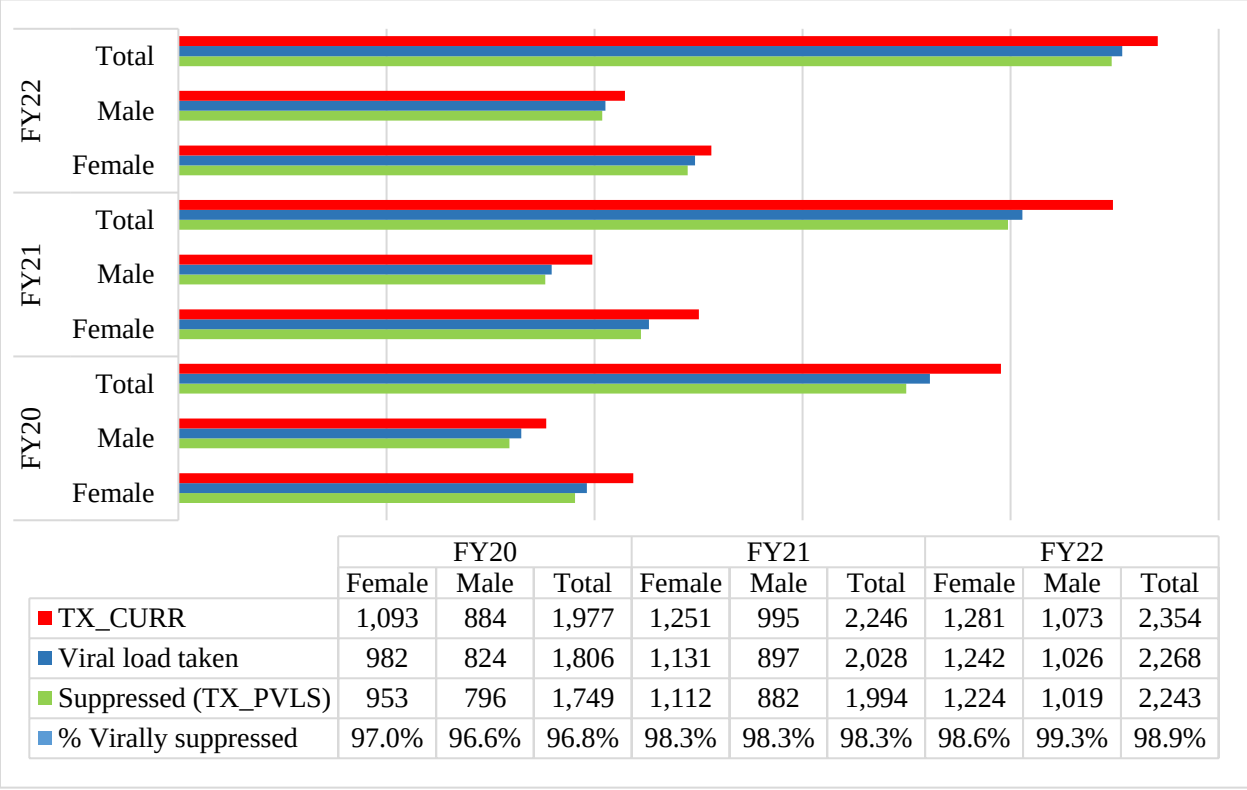


	FY20		FY21		FY22(Q1-Q3)	
<3Months	370	18.7%	138	6.1%	144	6.1%
3-5Months	1097	55.5%	488	21.7%	351	14.9%
>5Months	510	25.8%	1620	72.1%	1859	79.0%

Source: PSI MIS, 2020-2022

Figure 10 below shows trends in the third 95 to achieve **viral load suppression** in 95% of patients on ART. Between FY20 to FY22 (Q1-Q3), over 95% of patients enrolled at New Start Clinic had suppressed viral loads of HIV RNA <1000 copies/mL or a viral load test value of undetected. In FY22 (Q1-Q3), 98.9% (n=2,234) of patients were virally suppressed. The established Laboratory Information System at the New Start clinic, a dedicated phlebotomist, and improved sample transportation system contributed to quick turnaround of results and high VL testing among patients.

Figure 10: Viral load suppression among ART clients in FY20-FY22 (Q1-Q3)



	FY20			FY21			FY22		
	Female	Male	Total	Female	Male	Total	Female	Male	Total
TX_CURR	1,093	884	1,977	1,251	995	2,246	1,281	1,073	2,354
Viral load taken	982	824	1,806	1,131	897	2,028	1,242	1,026	2,268
Suppressed (TX_PVLS)	953	796	1,749	1,112	882	1,994	1,224	1,019	2,243
% Virally suppressed	97.0%	96.6%	96.8%	98.3%	98.3%	98.3%	98.6%	99.3%	98.9%

Source: MOH Client Management Information System (CMIS), 2022

PSI supported the **prevention and treatment of tuberculosis among PLHIV** by conducting regular screening for TB in all patients at least once a year. Table 17 below shows PLHIV who received TB services during FY20-FY22 (Q1-Q3). In FY20, TB screening was provided to 86.9% (n= 1,718) ART patients. TB screening improved to 88.4% (n= 1,985) and 98.7% (n= 2,324) in FY21 and FY22 (Q1-Q3), respectively.

The number of patients who had their specimens sent for bacteriologic investigation increased from 19 patients in FY20 to 109 in FY22 (Q1-Q3). In FY20, three out of the 19 samples came back reactive for TB, 9.1% (n=6) were reactive in FY21 and 5.5% (n=7) in FY22 (Q1-Q3). All TB/HIV co-infected patients were started on TB treatment.

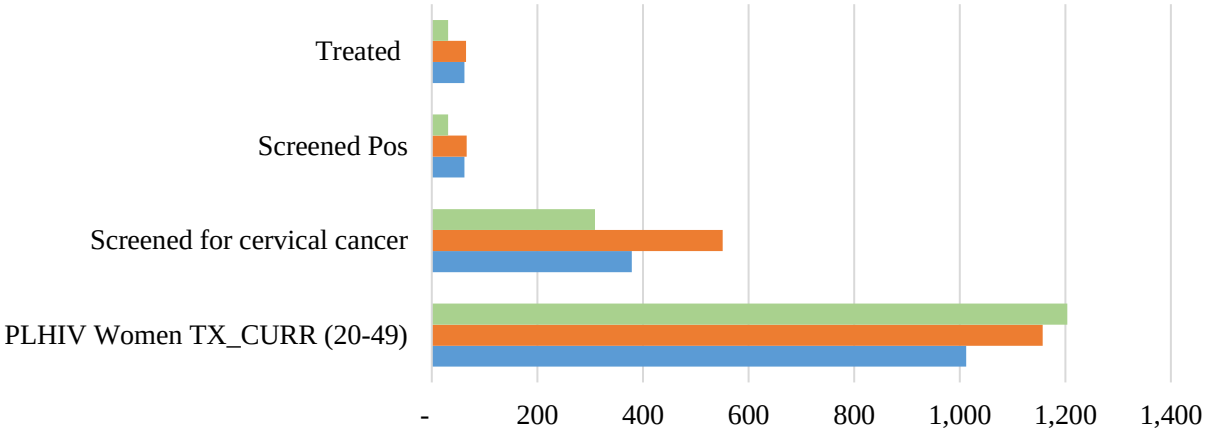
Table 17: TB/HIV Treatment cascade at New Start Clinic, FY20- FY22 (Q1-Q3)

	FY20	FY21	FY22(Q1-Q3)
Patients currently on ART (TX_CURR)	1,977	2,246	2,354
ART patients who were screened for TB at least once during the reporting period	1,718	1,985	2,324
% of patient screened for TB at least once a year	86.9%	88.4%	98.7%
ART patients who had a specimen sent for bacteriologic diagnosis of active TB disease	19	66	109
ART patients who had a positive result returned for bacteriologic diagnosis of active TB disease	3	6	6
% of patients with TB/HIV coinfection	15.8%	9.1%	5.5%
Started TB Treatment	3	6	7
% TB/HIV patients started on TB treatment	100%	100%	100%

Source: PSI MIS, 2020-2022

PSI provided regular screening for **cervical cancer** in all female PLHIV older than 14 years who were enrolled at New Start Clinic at least once in two years. As shown in figure 11 below, PSI conducted cervical cancer screening on 37.5% (n=379) PLHIV aged 20-49 in FY20. Sixty-two (16.4%) were found to have abnormal cervical lesions and all received treatment. In FY21, screening was provided to 47.6% (n=551) women of whom 12.0% (n=66) were found to be positive. All but one received treatment. In FY (Q1-Q3), 25.7% (n=309) women were screened for cervical cancer and 10.0% (n=31) were found to have abnormal lesions, all of whom received treatment.

Figure 11: Screening for cervical cancer among female clients on ART aged 20-49 years at New Start Clinic, FY20- FY22 (Q1-Q3)



	PLHIV Women TX_CURR (20-49)	Screened for cervical cancer	Screened Pos	Treated
FY22 (Q1-Q3)	1,204	309	31	31
FY21	1,157	551	66	65
FY20	1,012	379	62	62

Source: MoH paper-based cervical cancer register, 2020-2022

Findings from interviews with key informants and focused group discussion on linkages and referrals revealed the information in table 18 below. Note that the words in italics are verbatim and the non-italic are general reflections as gathered by the evaluation team.

Table 18: SCORE Themes emanating from key informants and FGDs

Themes	**Key Extracts**
Linkages to treatment	
Test and Start	*"Awareness creation of the benefits of Test and Start must be emphasized, and must be implemented without compromising the readiness of the client."* *"Starting treatment before getting sick is beneficial for the client."* "*Test and Start has removed components which are critical in terms of readiness in the life long journey with ART. This contributes to high number of defaulters after the 90 days of the LCM."*

	• Benefits of early treatment are clearly explained to PLHIV. • More time that is personal is required for newly diagnosed PLHIV to fully comprehend/accept one's HIV positive status and requirements of lifelong treatment.
Challenges	• Not enough time is given to PLHIV to accept new status but encouraged to link to treatment immediately.
Linkage to prevention	
Motivation to link to prevention services	"*I truly don't understand PrEP. So this is another ARV for negative people. I don't understand how this thing works."* *"I was so happy to be negative, but I cannot just start PrEP without thinking about it first. What will my mother say if I bring ARVs home. She will not believe that I am negative."* • People are not comfortable to take PrEP because they are unclear about it being an ARV for negative people. Advocacy is required on this area.

Analysis of the SCORE Project Clinical Cascade:

The evaluation found that PSI HTS approaches have contributed to increased case finding of undiagnosed PLHIV. PSI contributed to the national performance revealed by the SHIMS3 (2021) that 93.7% of PLHIV aged 15 years and older were aware of their HIV-positive status, comprised of 94.9% of women and 91.6% of men.

Among the HTS approaches employed by PSI, facility OPD and index testing were most effective for finding positives as reflected by their higher yields and overall contribution to case finding in terms of the volume of PLHIV. PSI was unable to meet the target of improving the contribution of CBHTS to the volume of newly detected HIV-positive cases to 95%. This was due to the shift in testing approaches from a focus on community to facility-based approaches. While this improved case finding among females, it resulted in a 10% decrease in the proportion of males identified. This is concerning in light of SHIMS3 findings which demonstrate that the vast majority of unidentified cases are men. This could indicate that strategies for finding men need to maintain a community component. SCORE also demonstrated a marked increase in the identification of adolescents, with a 10-fold increase in 10-14 year olds and a 3-fold increase in 15-19 year olds between FY20 and FY22. Further analysis is needed to determine the extent to which this was due

to the shift to the facility-based testing approaches versus the implementation of DREAMS. The higher yields and high volumes offered by the OPD model, while being the least resource intensive, make it is cost efficient for case finding. PSI investment in facilities was only for the HTS lay-counsellors, while the community approaches utilized more staff and required travel to set up sites. Key informants and HTS respondents reflected that while the index approach was ideal for finding and testing high-risk populations through sexual networks and relations, the strategy requires significant time investment to trace, negotiate for testing, and travel to test contacts.

PSI's LCM enabled more PLHIV to be initiated on ART at the quickest convenience and receive peer support for early retention to remain on treatment. This resulted to a high number of patients being enrolled to treatment within two weeks of diagnosis by the end of the project period. Against a target to improve linkage of identified PLHIV to ART facilities to 95%, PSI exceeded the target and linked 96.8% of newly diagnosed PLHIV on ART by FY22 (Q1-Q3). This performance is comparable to the SHIMS3 finding that 97.3% of adult PLHIV, comprised of 98.1% women and 95.9% who are aware of their status are on ART.

While interruption of treatment continued to exist among enrolled patients, this decreased over the period as PSI introduced innovative follow up methods of using expert clients to trace including visiting clients at their residences to remind them of their next appointment if they were not able to be reached by phone. This resulted in fewer patients being lost to follow up. This was supported by the facilitation of a welcoming environment for defaulters to rejoin treatment without judgment or excessive questioning. Although the interruption of treatment decreased for both men and women, men had more interruptions compared to women, but more women returned to treatment than men. This may indicate that additional strategies need to be explored to reengage defaulting men in treatment.

By Q3 FY22, almost all (98.9%, n=2,234) patients were virally suppressed. This is higher than the SHIMS3 population viral load suppression (VLS) rates that 88.6% of PLHIV that are 15 and older have suppressed viral loads. The high viral suppression was achieved in the context of 79% of PSIs patients being transitioned to 6-month multi-month drug dispensing (MMD). The complimentary services for TB and cervical cancer ensured that more PLHIV remained healthy as PSI was able to screen almost all (98.7%, n= 2,324) patients for TB and conformed to two yearly

screening of cervical cancer for all female patients. All patients who were co-infected with TB and/or had abnormal cervical lesions received related treatment.

PSI's referral to HIV prevention did not perform well in terms of linking to PrEP as only 3.8% (1,216) of all people found to be HIV negative at HTS sites were initiated during FY20-FY2022 (Q1-Q3). Save for VMMC referral vouchers that were given to HIV negative men to redeem at Litsemba Letfu Clinic, there was no system to follow up prevention referrals from HTS sites. PSI did not design an approach to attract 'at risk' persons to initiate to PrEP beyond the opt out criterion. This was a critical omission given that risk behaviour and exposure to HIV had been established through the HTS screening and risk tools. Future evaluations should consider an in-depth analysis of individuals testing negative over time to identify whether they continued to be at risk of acquiring HIV or had been initiated on PrEP.

3.2.Voluntary Medical Male Circumcision (VMMC) intervention

The evaluation sought to assess whether the VMMC project, which created demand for medical male circumcision and circumcised HIV negative males, was able to achieve the objectives described in Table 19 below.

Table 19: Voluntary Medical Male Circumcision (VMMC) evaluation objectives and questions

Evaluation Objective	A. To determine the extent to which the VMMC program was effective at providing VMMC services to eligible men between 2020 and 2022			
Evaluation Questions (EQ)	1) How effective has the VMMC program been in providing VMMC services to eligible men?			
Outcome-level Performance	Indicator	Baseline at mid-term FY19	End term FY22 (Q1-Q3)	
			Target	Performance
	% of HIV-negative males aged 15 or older linked to VMMC services	No baseline	≥ 80%	82.3%

PSI used VMMC as referral to HIV prevention for HIV negative men that were identified in all HTS and STI services. PSI promoted VMMC in four communities in Manzini region, at workplaces, churches and through social media. Up to FY20, PSI used a demand creation approach that targeted in-school males using VMMC mobilizers who provided educational sessions and registered those interested. All males were required to consent to VMMC and parents

and guardians of those under 18 years were required to consent for them. PSI provided transport to and from the Litsemba Letfu clinic for surgery. Out of school and older males were mobilized at sporting events, community promotions, door-to-door, churches, workplaces and social gatherings. Social media platforms such as the New Start Clinic and Litsemba Letfu Facebook pages, WhatsApp number and U-Report were also used to mobilize men. The PSI toll-free line 1212 was available for call ins. Interested individuals would receive a unique voucher which they redeemed at the clinic.

Guided by PEPFAR's corrective and acceleration plan, the demand creation approach was changed in FY21 to target men 15-29 years using Interpersonal Communication (IPC) agents and counselors who mobilized in four Tinkhundla (Lobamba Lomdzala, Manzini North, Ludzeludze and Kwaluseni). HIV negative males that were identified from HTS in OPD, index contacts, DREAMS, FCI and STI screening were given vouchers to redeem at Litsemba Letfu (LL) Clinic. VMMC was also promoted under the FCI messages of hope to overcome barriers to male circumcision due to religious beliefs. Walk-ins to the LL clinic were also received. Some in-school mobilization was implemented during the second half of FY21 to target high school boys aged 15-18 who received transport to and from the clinic. The program was reinforced by one-on-one sessions with eligible men.

Evaluation Objective A: *To determine the extent to which the VMMC program was effective at providing VMMC services to eligible men between 2020 and 2022*

EQ 1: *How effective has the VMMC program been in providing VMMC services to eligible men?*
The objective for PSI's VMMC program was to improve the linkage of HIV-negative males aged 15 or older to VMMC services to 80% by FY22 (Q1-Q3). As shown in table 20 below, 82.3% (n=2,451) males who were registered to be circumcised were circumcised at Litsemba Letfu Clinic during FY20 to FY22 (Q1-Q3). This comprised of 907 males in FY20, 805 in FY21 and 739 at the end of June 2022. The slight reduction between FY21 and FY20 is in line with re-targeting to older men under the corrective and acceleration plan. In FY20 performance was affected by the COVID19 national lockdown, which resulted in service interruption during March-May 2020 until it resumed to full scale in June 2020.

Ninety-two percent (n=2,247) of those who were circumcised came through community IPC. Only 2.8% (n=69) persons came through referral of HIV negative males from HTS, DREAMS, FCI and the STI program.

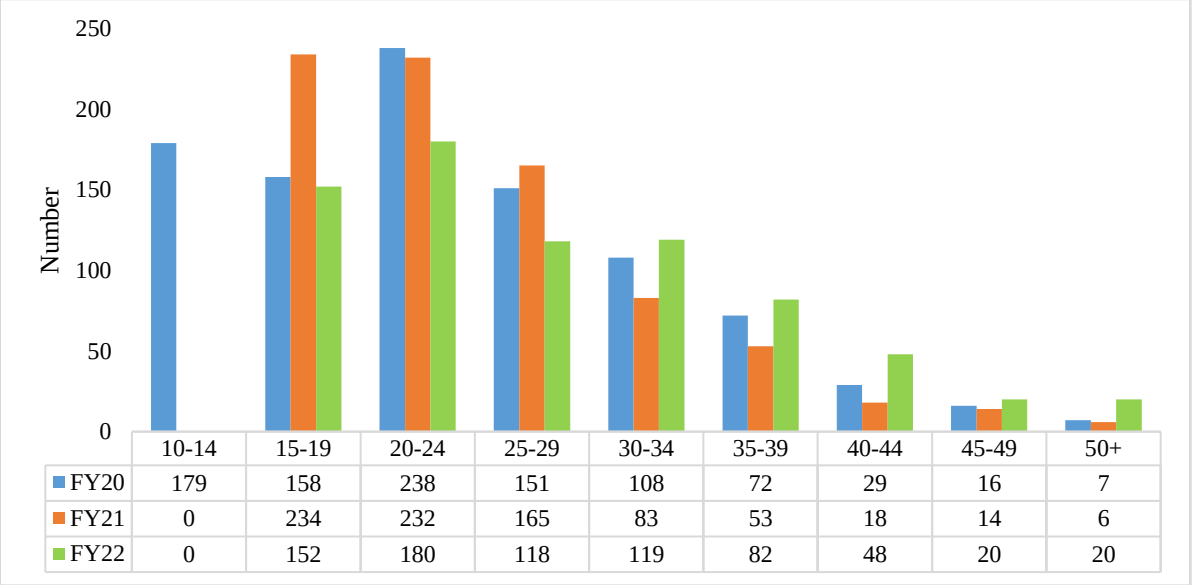
Table 20: Number and percentage of males circumcised between FY2020 to FY2022

Recruitment site	Total number of males registered for VMMC	Total Number of males circumcised VMMC_CIRC	% achievement of registered	As a % of total males circumcised
HTS sites	58	46	79.3%	1.9%
DREAMS sites	7	6	85.7%	0.2%
FCI sites	1	0	0.0%	0.0%
STI program	18	17	94.4%	0.7%
Social events	5	3	60.0%	0.1%
Social media platforms	86	84	97.7%	3.4%
Walk ins	55	48	87.3%	2.0%
Community IPC	2,747	2,247	81.8%	91.7%
TOTAL	**2,977**	**2,451**	**82.3%**	**100%**

Source: PSI MIS, 2020-2022

As shown in figure 12 below, 65.0% (n=1,594) of men who were circumcised were within the targeted ages of 15-29. No boys aged 10-14 were circumcised in FY21 and FY22 (Q1-Q3) as the approach shifted to older age groups.

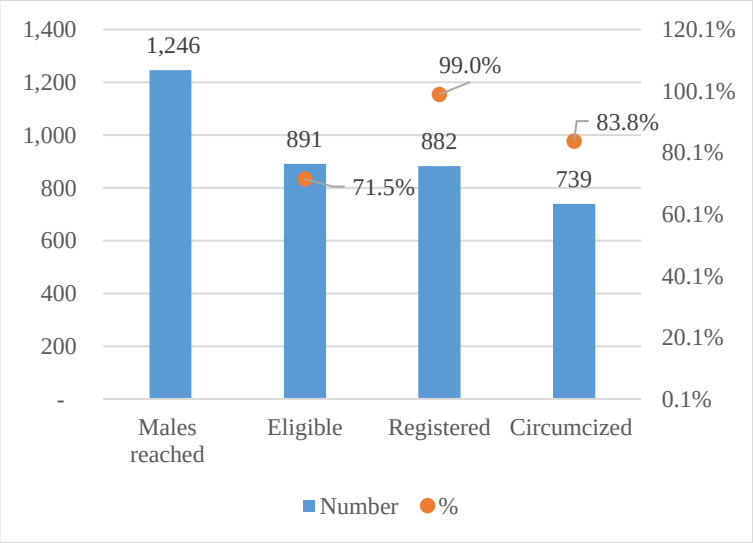
Figure 12: Male circumcision by age, FY20-FY22 (Q1-Q3)



	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50+
FY20	179	158	238	151	108	72	29	16	7
FY21	0	234	232	165	83	53	18	14	6
FY22	0	152	180	118	119	82	48	20	20

Source: PSI MIS, 2020-2022

Figure 13: VMMC cascade in FY22 (Q1-Q4)



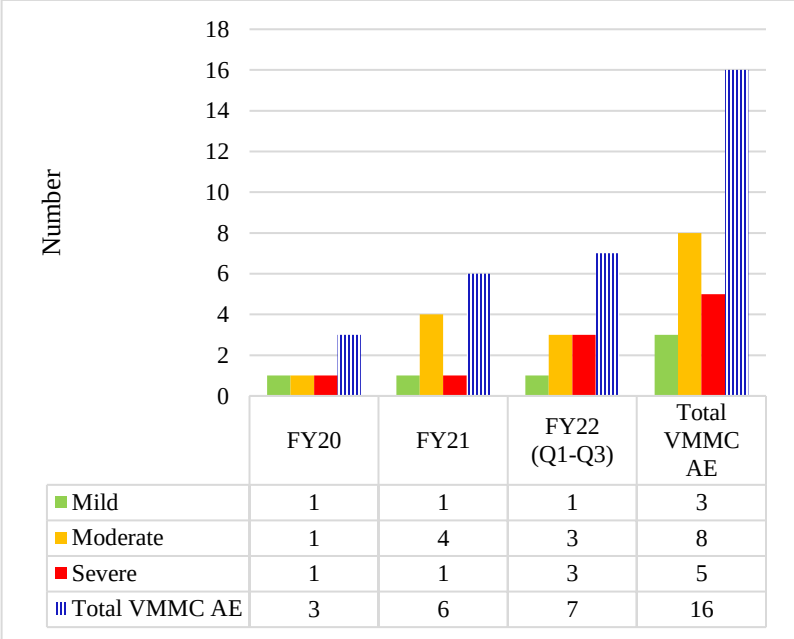
Source: PSI MIS, 2022

Figure 13 depicts the VMMC cascade for FY22 (Q1-Q3) and reveals that 71.5% (n=891) of all the men reached through demand creation were eligible for VMMC. Eligibility was determined by a) not already circumcised, b) an HIV negative status and c) being older than 15 years. Almost all (99.0%, n=882) of those that were eligible were registered and 83.8% (n=739) were circumcised.

Adverse effects among men who have undergone male circumcision at Litsemba Letfu Clinic

A critical component of an effective VMMC program is to provide the service safely and to have good procedures in place for cases where adverse events (AE) occur post circumcision. As shown in figure 14 on the right, a total of 16 (<1%) out of the 2,451 men who were circumcised at LL clinic had adverse events after undergoing the procedure during FY20-FY22 (Q1-Q3). Five of the cases were severe, eight were moderate and three mild. All of the cases were attended to, received appropriate treatment and referral to higher levels of care for the complicated cases. One notifiable AE case was reported to MoH and CDC where the client had a severe surgical site infection with significant wound disruption. Over time, the client healed with no permanent disfigurement.

Figure 14: Averse events from VMMC conducted at Litsemba Letfu Clinic, by severity, FY20- FY22 (Q1-Q3)



	FY20	FY21	FY22 (Q1-Q3)	Total VMMC AE
Mild	1	1	1	3
Moderate	1	4	3	8
Severe	1	1	3	5
Total VMMC AE	3	6	7	16

Source: PSI MIS, 2022

Table 21 below reveals a summary of findings from KIIs and men who had undergone the procedure. Note that the words in italics are verbatim and the non-italic are general reflections as gathered by the evaluation team.

Table 21: Attitudes, access, satisfaction and challenges by clients who received VMMC services at Litsemba Letfu clinic

Theme	Sub-theme	Quotes and highlights
Access	Reason to get circumcised at Litsemba Letfu	"*Well for me firstly it was privacy, I didn't want to go to (name of know health facility in Manzini) where a lot of people know me. Secondly, is that PSI specializes in VMMC so I wanted to go there because I believed it was safer and there will be no complications*"

		"I was treated very well and I will encourage others who have not yet circumcised to come to PSI" *"Friendly staff."* *"I just wanted to get circumcised here" (Litsemba Letfu)*
	Barriers to VMMC services	• Transport costs for post-surgery evaluation. • Fear of HIV testing.
	Access to other HIV services	*"HIV Testing was a fast process."* • Other HIV services are accessible and the facility staff provides information about HIV prevention services offered.
Attitudes	Unexpectedly successful experience	*"I was reluctant to circumcise because I am not a fan of scissors, injections and such, so I was scared of the pain. But, there was totally no pain involved, like it was minimal when they were injecting. I did not use even the painkillers given to me. Everything was all good"* *"I thought MC was a bad thing but when I had arrived and they told me to get in and I did everything they asked. They said I should strip naked, do this and that I did not waste time because I had told myself I am doing this for my health. I was surprised when they said they were done as I had closed my eyes and did not want to see anything [laughing]. I only felt slight pain when they injected me around my penis, soon after that I heard that they were done. It wasn't a difficult thing at all and was really quick. I am wondering what was holding me back from being circumcised."*
	Family support	"*I was surprised when, after circumcision, my partner said she was happy because that this would protect her from sexually transmitted diseases*." "*My girlfriend made sure that we did not have sex until I was fully healed. I was more worried for her, that maybe she was missing sex (laughs)."* • Female partners of clients were reported to be happy with circumcision and knew about the additional benefits of circumcision for them.
	Cultural barriers	• VMMC still considered a foreign concept.
Satisfaction	What worked well	• Clients were satisfied with quality VMMC services with no adverse effects.

Analysis of VMMC: PSI's VMMC approaches were able to exceed the target to link 80% of HIV-negative males aged 15 or older to VMMC by FY22 (Q1-Q3) as 82.3% males who were registered for circumcision were circumcised and over 90% of those circumcised were HIV-negative. In line with the re-targeting approach, PSI was successful at identifying and circumcising men within the ages 15-29 years who constituted 65.0% of all men who were circumcised. The overall adverse event rate post-circumcision was also very low over the course of PSI's VMMC implementation.

Seventy-two percent (n=891) of those that were circumcised were reached through demand creation for eligible men. However, only 2.8% (n=69) of those circumcised came through referral from HTS, DREAMS, FCI and the STI program, exposing the general weakness of the HIV prevention referral system.

Barriers to circumcision were largely around the perception that VMMC was a foreign intervention and fear of surgery. The one-on-one sessions were therefore a useful to dispel some of the misconceptions and negative influences. The evaluation also noted that family, friends, and sexual partners played an important role in a man's decision to be circumcised.

3.3. Determined Resilient, Empowered, AIDS-free, Mentored and Safe (DREAMS) intervention

The evaluation sought to test whether the DREAMS project which provided adolescent and youth friendly sexual and reproductive health (SRH) services including economic strengthening was able to target and provide services to vulnerable AGYW in order to achieve the objectives described in table 22 below.

Table 22: Determined Resilient, Empowered, AIDS-free, Mentored and Safe (DREAMS) evaluation objectives and questions

Evaluation Objective	A. To determine if DREAMS clinical services met the health needs of AGYW in the community between 2020 and 2022 B. To assess the first 18 months of implementation including successes, failures, operational lessons learned, and the strategy/approach for implementation		
Evaluation Questions (EQ)	1) How helpful were the clinical aspects of DREAMS to AGYW? 2) What are the successes, failures, operational lessons that were learnt in the first 18 months of implementation?		
Outcome-level Performance	Indicator		End term FY22 (Q1-Q3)

		Baseline at mid-term FY19	Target	Performance
	% of AGYW aged 10-29 years diagnosed with HIV	Program began in 2021	Open	10 diagnosed with HIV out of 734 tested

PSI initiated the DREAMS project in FY21 to mitigate the high levels of new HIV infections among AGYW that were established in the SHIMS1 and 2, by providing targeted services to AGYW aged 10-29 years in three Tinkhundla namely, Mafutseni and Kukhanyeni in the Manzini region and Lugongolweni in the Lubombo region. Implementation began in FY21 after targeting and enrollment of AGYW.

The DREAMS model implemented by PSI is a combination of best practices outlined in the PEPFAR DREAMS Guidance, PACTs approach being implemented in other Tinkhundla in Eswatini, PSI's extensive global experience leading successful programs for AGYW, and insights from the Georgetown University (GU)-led LISTEN project. DREAMS services included access to biomedical interventions such as HTS, PrEP, STI, SRH and other clinical services, increasing AGYW's social capital, and providing strategic economic opportunities. This was enhanced by two fully staffed DREAMS-on-Wheels mobile clinics which would rotate between the three Tinkhundla. All three Tinkhundla were visited every week at different venues in communities. This would bring health services closer to AGYW. In FY22 (Q1-Q3), a DREAMS youth friendly corner was established at New Start Clinic to provide clinical services to AGYW.

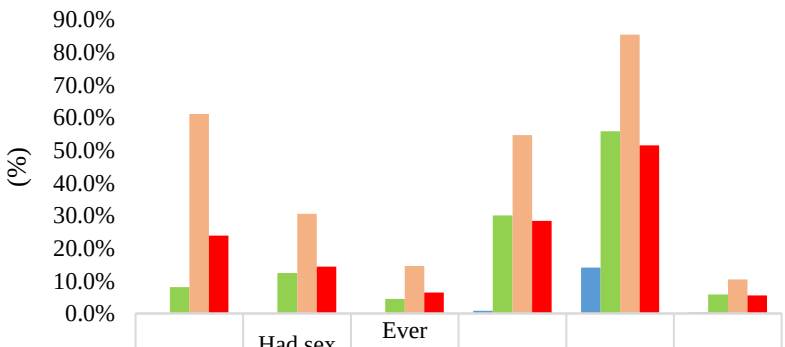
The DREAMS program provided a primary and secondary package of services. The primary package, which was intended to meet their immediate needs, comprised of social asset-building skills, school, or community-based HIV and violence prevention education, condom education, skills or commodities, HTS screening, PrEP information or enrolment, financial literacy, and contraceptive mix (counseling or commodity). The secondary package was contextual and aimed at addressing vulnerabilities related to HIV risk, included contraceptive mix, post-violence care, financial literacy, PrEP, combination socio-economic approaches, social asset building and parenting/caregiver programs.

Profiles of AGYW at enrollment into DREAMS

A total of 5,601 AGYW were enrolled in DREAMS, comprised of 35.2% (n= 1,970) aged 10-14, 29.7% (n= 1,664) aged 15-19, and 35.1% (n=1,967) aged 20-29. Nearly two-thirds (65.4%, n=3,663) AGYW were in school. Of the 34.6% (n=1,938) who were out of school, 81% (n=1582) were unemployed.

More than half (n=3,278) of those enrolled were single. Thirty-six percent (n= 2,014) reported to having one sexual partner and 5.5% (n=309) had more than one sexual partner. Those with more than one sexual partner resided in Kukhanyeni and Tinkhundla in Manzini region. Annex B shows summary profiles of AGYW that were enrolled in the program.

Figure 15: Sexual and reproductive health profiles of AGYW enrolled in DREAMS



	Has ever given birth	Had sex with benefits in last 12 months	Ever had STI or current STI symptom	Condom use in recent sex	Current contraceptive use	Has multiple sexual partners
10-14 yrs	0.1%	0.0%	0.0%	0.8%	14.1%	0.3%
15-19	8.1%	12.4%	4.5%	30.0%	55.8%	5.8%
20-29	61.1%	30.5%	14.5%	54.6%	85.4%	10.5%
Total	23.9%	14.4%	6.4%	28.4%	51.5%	5.5%

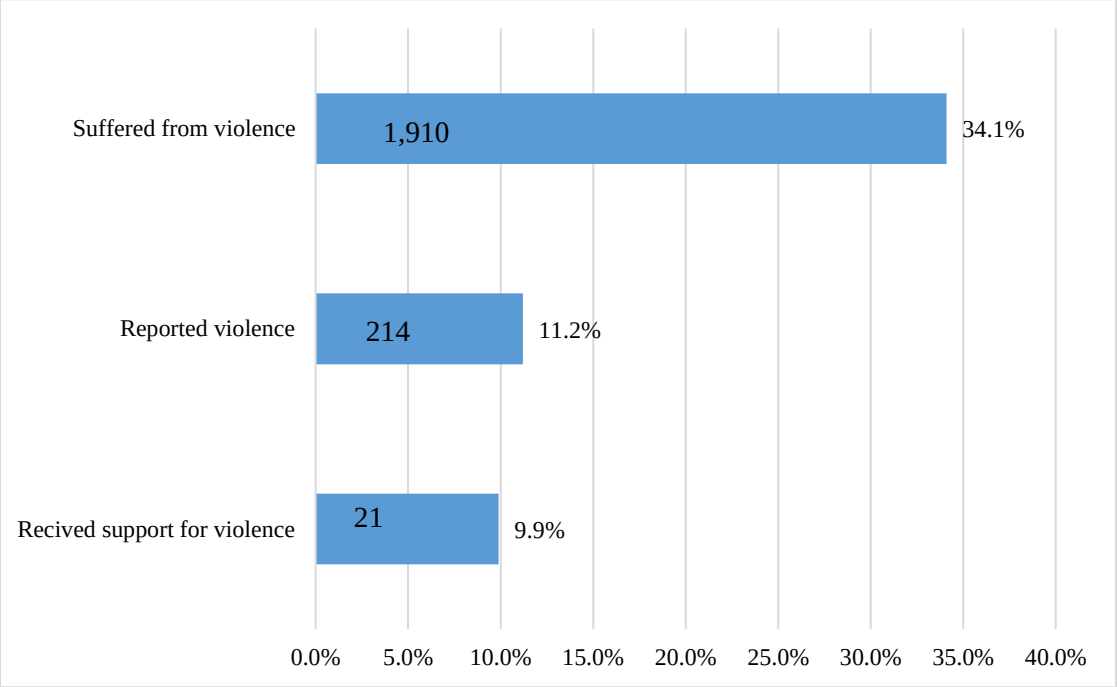
Source: PSI MIS, 2021

Figure 15 demonstrates that almost a quarter had ever given birth of whom 61% were aged 20-29 years. Thirty-one percent (n=617) of young women aged 20-29 years and 12.4% (n=206) of adolescent girls aged 15-19 years self-reported to having sex in exchange for benefits (cash, food and airtime) in the last 12 months before enrollment. Six percent (n=309) of the AGYW have multiple sexual partners, including 6 (0.3%) girls aged 10-14 years and increasing in proportion by age to 10% of women aged 20-29 years.

Fifteen percent (n=301) of young women aged 20-29 had ever had an STI or experienced STI symptoms at the time of enrollment. Condom use at recent sex was considerably lower among

those aged 15-19 years from whom 30.0% (n=167) of those who reported to being sexually active used a condom during recent sex. More than half (n=3,299) of the AGYW were using some contraceptive method at the time of enrollment, including 14.1% (n=278) of those aged 10-14 years.

Figure 16: Occurrence of GBV among AGYW enrolled in DREAMS



Source: PSI MIS, 2021

Figure 16 above shows self-reported occurrence of gender based violence (GBV) which was defined as violence experienced from a current or ex- partner in the form of physical, sexual and emotional abuse. One thousand nine hundred and ten (34.1%) AGYW reported to have ever experienced GBV. This is comparable to the evidence that one out of four females in the ages 13-24 years in Eswatini experienced violence in their lifetime. (VACS, 2022). Ninety percent of those that ever experienced GBV revealed that it had occurred more than 30 days prior to enrollment, while 9.2% (n=176) reported that it had occurred less than 5 days before enrolment. Two hundred and fourteen (11.2%) AGYW who experienced violence reported the incident to a family member or authority and only 9.9% (n=21) had received any type of support, whether medical or psychological.

Evaluation Objective A: *To determine if DREAMS clinical services met the health needs of AGYW in the community between 2020 and 2022*

Table 23 below shows that by the end of June 2022, a total of 3,756 AGYW had completed the primary package of DREAMS services. Thirty-eight percent (n=2,264) AGYW completed both primary and parts of the secondary package.

Table 23: AGYW enrolled in DREAMS who received primary and secondary packages

	AGYW	% of AGYW_PREV Total
AGYW who completed primary package only	3,756	62.4%
AGYW who completed primary package + some of secondary	2,264	37.6%
AGYW_PREV total	6,020	100%

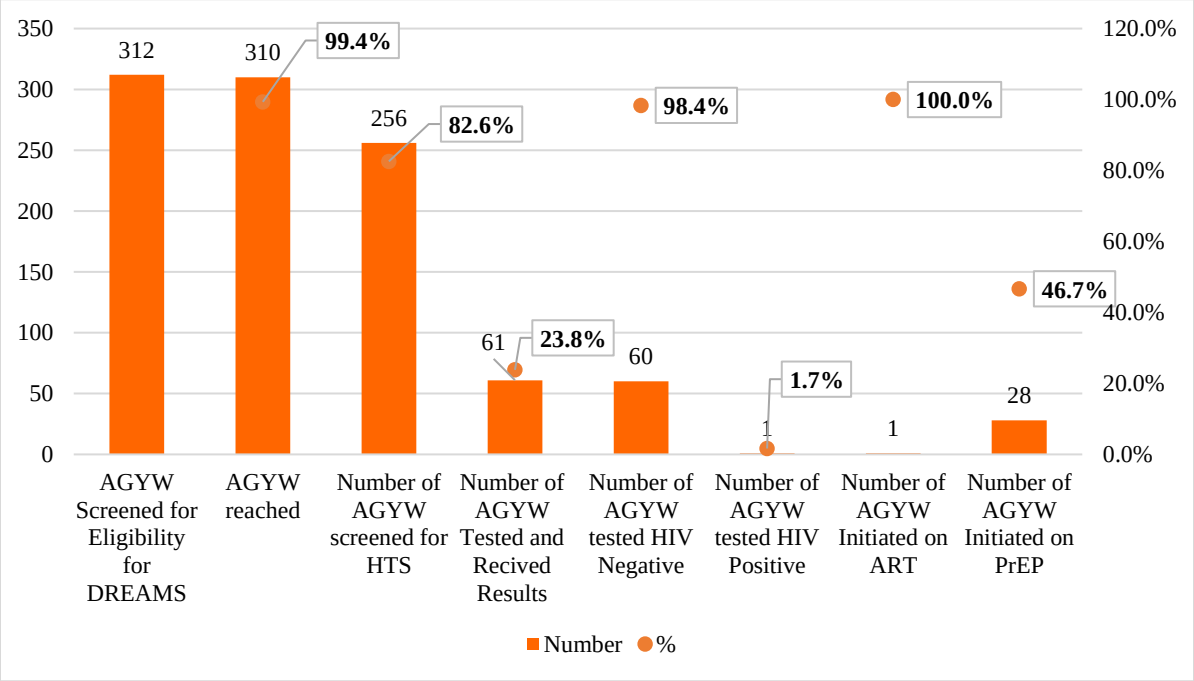
Source: PSI MIS, 2021

EQ 1: *How helpful were the clinical aspect of DREAMS to AGYW?*

A) Services received at New Start Clinic's AGYW Friendly Corner

Figure 17 below shows the uptake of DREAMS packages during FY22 (Q1-Q3). It shows that out of 312 AGYW that were screened for DREAMS eligibility at the New Start Clinic between October 2021- March 2022, 256 (82.6%) were screened for HIV risk. From those, 61 (23.8%) were found to be eligible for testing and tested. Test results diagnosed only one AGYW as HIV positive and was initiated on ART. Twenty-eight of those who tested HIV negative were initiated on PrEP, which was less than half (46.7%, n=28) of those who tested negative. More than half (53.3%, n=32) opted out of PrEP initiation. Forty-two (69%) of the at-risk AGYW were referred to Nazarene Compassionate Ministries (DREAMS partner in Kwaluseni) for enrolment in DREAMS.

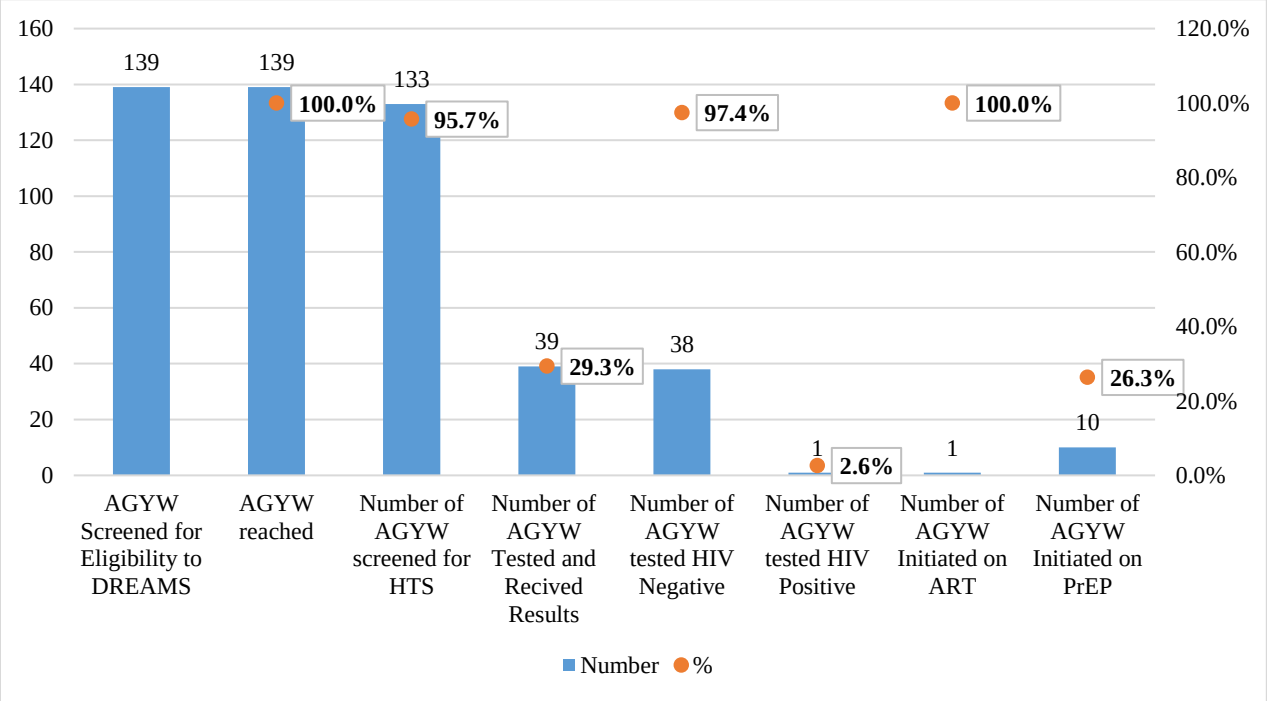
Figure 17: HIV Cascade for AGYW using New Start Clinic AGYW friendly corner in FY21



Source: PSI MIS, 2022

In quarter April-June 2022 and as reflected in figure 18 below, the screening rate for HIV increased to 95.6% (n=133) of AGYW who were reached. Twenty-nine percent (n=39) of those screened were tested for HIV and received their results. Only one person was diagnosed as HIV positive and initiated on ART. However, only ten out of 38 (26.3%) AGYW who were found to be HIV negative were initiated on PrEP, a lower proportion than the previous FY.

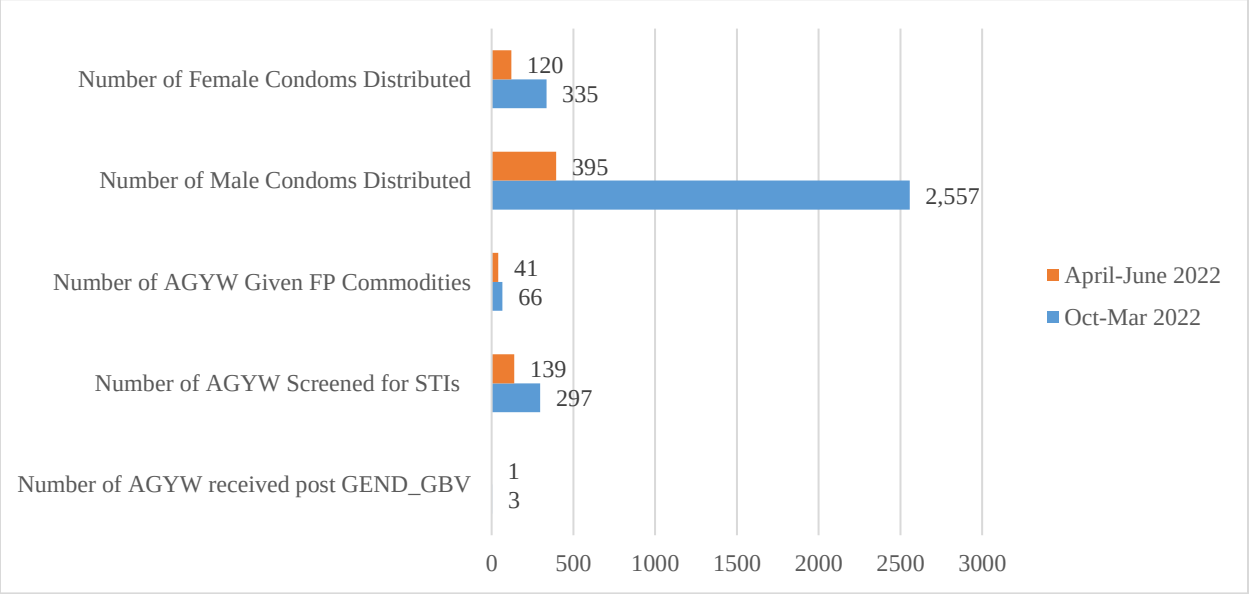
Figure 18: HIV Cascade for AGYW using New Start Clinic AGYW friendly corner, April-June 2022



Source: PSI MIS, 2022

Figure 19 below shows that 297 AGYW were screened for STI at New Start Clinic in October 2021 to March 2022. In April to June 2022, all 139 AGYW reached were screened for STI. Sixty-six (22.2%) AGYW received family planning commodities in October 2021 to March 2022 and 41 (29.5%) received family planning (FP) commodities in April to June 2022. Four AGYW received post GBV services in FY22 (Q1-Q3).

Figure 19: AGYW who received GBV, STI and FP commodities at New Start Clinic AGYW friendly corner, FY22 (Q1-Q3)



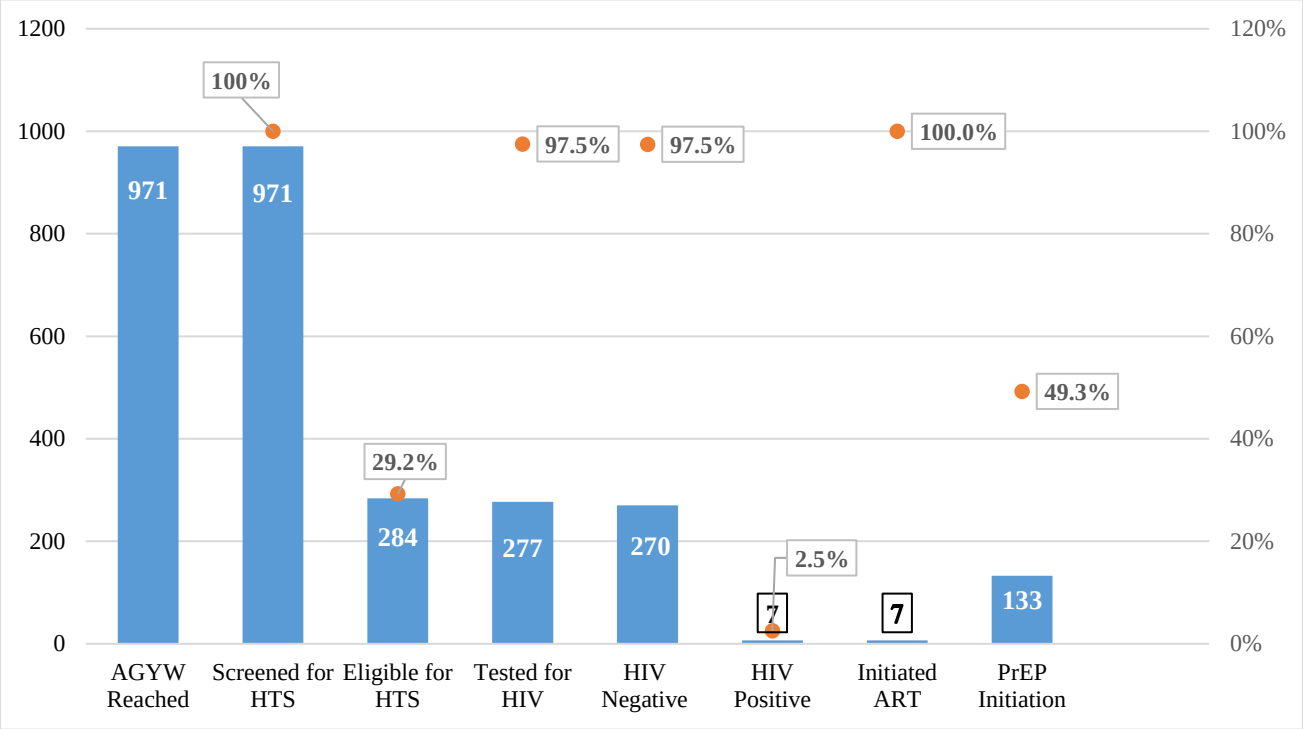
Source: PSI MIS, 2022

B) Services received in DREAMS-on-Wheels

The DREAMS- on-wheels mobile clinic attended to AGYW in communities and provided HIV prevention sessions (PP_PREV), routine HIV risk screening and testing for those screened to be at risk, routine screening of STI symptoms, routine healthcare for AGYW aged 10-17 years (OVC_SERV) and clinical services to AGYW who were referred or had health/clinical needs. Each event began with group sessions with AGYW for PP_PREV followed by clinic assessed risk exposure and finally clinical needs. The next visits of the mobile clinic were promoted during educational sessions.

During FY21 and shown in figure 20 below, the DREAMS-on-wheels reached 971 out of 1,302 AGYW who were met in communities. AGYW serviced by DREAMS-on-wheels included both DREAMS beneficiaries and walk-ins (non-DREAMS beneficiaries). All were screened for HIV risk and 284 (29.2%) were found to be eligible for testing as established by risk and exposure to HIV. Of those eligible, 277 (97.5%) were tested for HIV and a majority (97.5%) was found to be HIV negative. Only 2.5% (n=7) AGYW were diagnosed HIV positive and all were initiated on ART. All of them were enrolled in DREAMS. Less than half (49.4%) of those who were negative were initiated on PrEP in the DREAMS-on-Wheels.

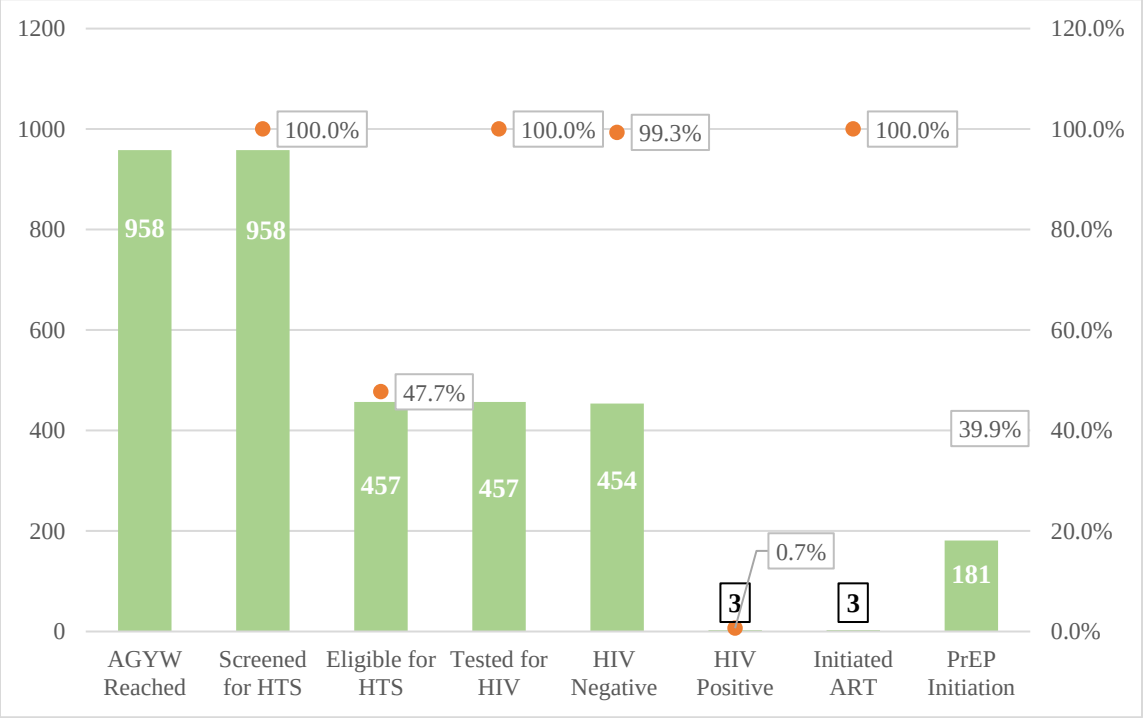
Figure 20: HIV Cascade for AGYW receiving services received on DREAMS-on-Wheels during FY21



Source: PSI MIS, 2021

In FY 2022 (Q1-Q3), 958 out of 3,399 AGYW enrolled in DREAMS were reached in communities. All of those reached were screened for HIV risk and 457 (47.7%) were found to be eligible and tested for HIV. Ninety-eight percent of those tested were found to be HIV negative and only three (0.7%) were HIV positive. All three AGYW diagnosed with HIV were initiated on ART. Only 39.9% (n= 181) of those who tested negative were initiated on PrEP.

Figure 21: HIV Cascade for AGYW receiving services received on DREAMS-on-Wheels during FY22 (Q1-Q3)



Source: PSI MIS, 2022

AGYW were asked for reasons to decline PrEP initiation after receiving a negative HIV result. In response to their decision to opt-out of PrEP, AGYW cited lack of support and/or requiring permission from a person of importance in her life, be it a boyfriend, friends and/or parents/guardians.

In terms of receiving SRH services and commodities, table 24 below shows that 98.8% (n=971) and 59.6% (n=958) AGYW were screened for STIs in FY21 and FY22 (Q1-Q3). One hundred and fifty five (16.0%) and 215 (22.4%) AGYW received FP commodities during FY21 and FY22 (Q1-Q3), respectively. Nineteen thousand four hundred and sixty-four (19,464) male condoms were distributed in FY21 and more (36,861) condoms were distributed in FY22 (Q1-Q3). The distribution of female condoms increased from 372 in FY21to 6,099 in FY22 (Q1-Q3) as a result of promotions by PSI's Social Behavior Change Department, which promoted female condoms, and as more AGYW became aware of their role in preventing HIV.

Table 24: AGYW who received GBV, STI and FP commodities during FY21 and FY22 (Q1-Q3)

	FY21					FY22 (Q1-Q3)			
	Oct-Dec 20	**Jan-Mar 21**	**Apr-Jun 21**	**Jul-Sep 21**	**TOTAL**	**Oct-Dec 21**	**Jan-Mar 22**	**Apr-Jun 22**	**TOTAL**
AGYW reached during quarter	355	336	172	120	**983**	327	861	419	**1607**
STI screening	350	330	171	120	**971**	297	434	227	**958**
% screened for STI	93.0%	98.2%	99.4%	100%	**98.8%**	90.8%	50.4%	54.2%	**59.6%**
AGYW who collected FP commodities	53	57	16	29	**155**	57	95	63	**215**
% of AGYW who collected FP commodities	15.1%	17.3%	9.4%	24,2%	**16.0%**	19.2%	21.9%	27.8%	**22.4%**
No# of male condoms distributed	9,991	3,438	3,355	2,680	**19,464**	12,163	20,750	3,948	**36,861**
No# of female condoms distributed	362	10	0	0	**372**	431	4,104	1,564	**6,099**

Source: PSI MIS, 2022

Evaluation Objective B: *To assess the first 18 months of implementation including successes, failures, operational lessons learned, and the strategy/approach for implementation.*

EQ 2: *What are the successes, failures and operational lessons that were learnt in the first 18 months of implementation?*

The successes, failures and operational lessons of the DREAMS initiative are best described through the lens of beneficiaries and community carers who were interviewed through FGDs in the three Tinkhundla, and direct observation of service delivery that was conducted by the independent evaluators.

As summarized in table 25 below, DREAMS beneficiaries reported an exciting experience in DREAMS where they discussed issues of sexuality and HIV with peers. The economic strengthening module and clinical services in DREAMS-on-Wheels were most preferred by beneficiaries. Beneficiaries' self–reported to having benefitted from the economic strengthening skills to reduce reliance on older sexual partners for money and focus on own income-generating initiatives.

Beneficiaries enjoyed the privacy and confidentiality of DREAMS-on-Wheels as well as the attitudes of the staff who were reportedly better than those at the local facility. Challenges included an unstructured schedule for the DREAMS-on-Wheels with late notification for meetings, late start and end of meeting. They reported that this created suspicion among their parents/guardians who believed that they had gone about their own business. Other challenges included the unreliable availability of FP commodities. The independent evaluators confirmed the late arrival of the DREAMs-on-Wheels during direct observation. In all three observations, the evaluation team arrived at the site before the mobile clinic and found many AGYW waiting and some were with their infants. However, service provision moved swiftly when the mobile clinic arrived. No stock-outs of FP commodities were observed during DOs.

Note that the words in italics are verbatim and the non-italic are general reflections as gathered by the evaluation team.

Table 25: Successes, failures and operational lessons learned, or implementation through the lens of DREAMS beneficiaries

Theme	Sub-theme	Quotes and highlights
Attitudes	Exciting experience	*''Being a participant in DREAMS made me so excited because that's where I met my peers and we were able to talk about socials issues including sex related topics and ways of making a living. Most of us have just finished school, so it is a very exciting experience.''*
	Gains	*"I gained that, like for instance, if I am not working how I can survive without relying on my boyfriend or sugar daddy/blesser to get money. Here in our community, we have managed to start an association and that helped us so much that we no longer go for alcohol but we concentrate on our association as young girls."*
	Challenges	• Expectation of incentives like food, sanitary packs or airtime • Some young girls pulled out because they were not getting anything as an incentive • Lack of support in terms of inputs into their business initiatives (chicken raising, Spaza shops) that were introduced by PSI
	Family support	• Family members were happy that their daughters were participating in DREAMS with regards to business initiatives and HIV preventive services
Access	Easy Accessibility	"*It is good to be attended by somebody that you do not know and who is not from the community. I told her more than I have ever told anyone in my life*." • DREAMS-on-Wheels is accessible and confidential (as compared to local clinics). • Some mobile clinic staff are in the same age range as the AGYW and that is an advantage. • Free clinic services.
	Meeting clients' needs	• Client needs were not entirely met. Some FP commodities were reportedly continuously unavailable in the mobile clinic. • Some services are not offered at the mobile clinic e.g. cervical cancer screening
	Challenges	*"The late notification, late start and finish gets us in trouble with our families as it is suspected that we are not where we say we were."* *"We like the mobile clinic but we do not know the days it comes and it always arrives late."* *"We wait for long hours and get hungry. Sometimes I am not able to concentrate because I am hungry and want to go home to eat."*
Satisfaction	What worked well	• Business initiatives (agriculture, savings, etc.) • Getting more knowledge about HIV and preventive services

Analysis of DREAMS: The target for DREAMS was to reduce HIV infection among AGYW aged 10-29 years by providing targeted services to prevent HIV, test those who are exposed and link them to treatment as well as link those found negative to HIV prevention.

PSI enrolled a total of 6,020 AGYW and was able to provide the primary package to 3,756 (62.4%) AGYW and 37.6% (n=2,264) received with the primary package and some components of the secondary package. The risk-factor profiles of DREAMS beneficiaries include 69.9% (n=3,915) who reside in homes with only one parent. About 2.9% (n=145) resided in child headed households. Their HIV risk profiles at enrollment included 14.4% (n=807) who reported having sex with benefits, 5.5% (n=309) with multiple sexual partners, and 6.4% (n=358) had current symptoms of STI's. Further evaluation is needed to determine if the AGYW who were enrolled in DREAMS are indeed the most at risk, or if revisions are needed to better identify, screen, and enroll those most at risk.

DREAMS services met the needs of DREAMS beneficiaries. DREAMS beneficiaries reported an exciting experience in the program and listed the economic strengthening module to have influenced their decision to reduce reliance on transactional sex. This was followed by the clinical services offered in the DREAMS-on-Wheels. The high uptake of female condoms between the two years is testament to the impact of the HIV prevention and empowerment sessions.

All AGYW that were reached received routine screening for STI and HIV. All of those who were found to have STI symptoms received treatment and those screened as being at risk of HIV acquisition received an HIV test. Those needing clinical services received a referral from their DREAMS mentors to the Dreams-on-Wheels clinical unit. An analysis of clinical service provision reveals that those aged 20-29 were the major beneficiaries of DREAMS clinical services and given their risk profiles, this demonstrates effective prioritization. More girls aged 10-14 received educational sessions and fewer clinical services.

Among those that were eligible to HTS, less than 3 percent of eligible AGYW were diagnosed with HIV and were initiated on ART. While PSI was able to screen, test and swiftly enroll all those diagnosed HIV positive on treatment, the program performed poorly in the referral of 'at risk' HIV

negative to HIV prevention, in particular PrEP, as less than half of negative AGYW were initiated on PrEP during both years. Further probing of service providers revealed that PSI did not design an approach to attract 'at risk' AGYW to initiate to PrEP beyond the opt out criterion.

3.4.Faith and Community Initiative (FCI) intervention

The evaluation sought to test whether the FCI project was able to contribute to HIV case finding as described in table 21 below.

Table 26: Faith and Community Initiative (FCI) evaluation objectives and questions

Evaluation Objective	A. To determine if the uptake of HIV self-test kits (HIVST) contributed to HIV case findings between 2020 and 2021. B. To assess the change in the reporting of GBV cases following the implementation of the project between 2020 and 2021.			
Evaluation Questions (EQ)	1) To what extent has HIVST distribution under the FCI project improved access to and uptake of HIV testing as well as case identification for targeted populations? 2) How successful were faith-based and community structures in distributing HIVST kits? What contributed to success (or lack thereof)? 3) What was the experience of PSI in implementing the evidence-based interventions in the various church denominations? 4) How effective were the structured trainings in building the capacity of faith leaders on effective messaging around HIV knowledge?			
Outcome-level Performance	Indicators	Baseline at mid-term FY19	End term FY22 (Q1-Q3)	
			Target	Performance
	Proportion of those who received an HIVST kit and tested positive	Program began in 2021	Open target	2.1%
	Proportion of those who tested positive by unassisted HIVST who sought confirmatory testing			2%
	% of GBV cases and disclosures among children 09-14 years			No data

The Faith and Community Initiative (FCI) is a PEPFAR initiative that partners with faith communities to reach men, women, and children living with HIV with HIV prevention, testing,

and treatment services. The objectives were to; (1) to find undiagnosed men, youth and children living with HIV and support them with prompt linkage to treatment and continuity of care; and (2) to prevent sexual violence among children and accelerate justice for children who are victims of violence. Through the FCI project, PSI educated faith leaders with up-to-date scientific information about HIV prevention, care, and treatment as well as Messages of Hope for PLHIV and those close to them. This was done to empower faith leaders to replace messages of fear and guilt with those of hope thereby improving access and uptake of HIV prevention, care, and treatment services and to prevent sexual violence against children.

PSI also distributed HIVST kits via two channels: pharmacies and community carers. PSI collaborated with eleven pharmacies (seven in Manzini and four in Lubombo) to distribute HIVST kits free-of-charge to clients who came to purchase condoms, emergency contraceptives and/or presented with STI symptoms. HIVST kits were also collected by persons who came through referrals from FCI participating churches who presented vouchers to redeem for an HIVST kit and those who had heard about the availability of HIVST kits in the pharmacies from other HIVST users, or via PSI's toll free information line 1212. There was flexible distribution in that if a client asked for the HIVST kit, they were given one. HIVST kit recipients were requested to fill in basic information about themselves as well as contact numbers. Pharmacies and community carers did not provide and pre and post-test counselling. They also did not ask any medical questions to clients (such as current knowledge of HIV status).

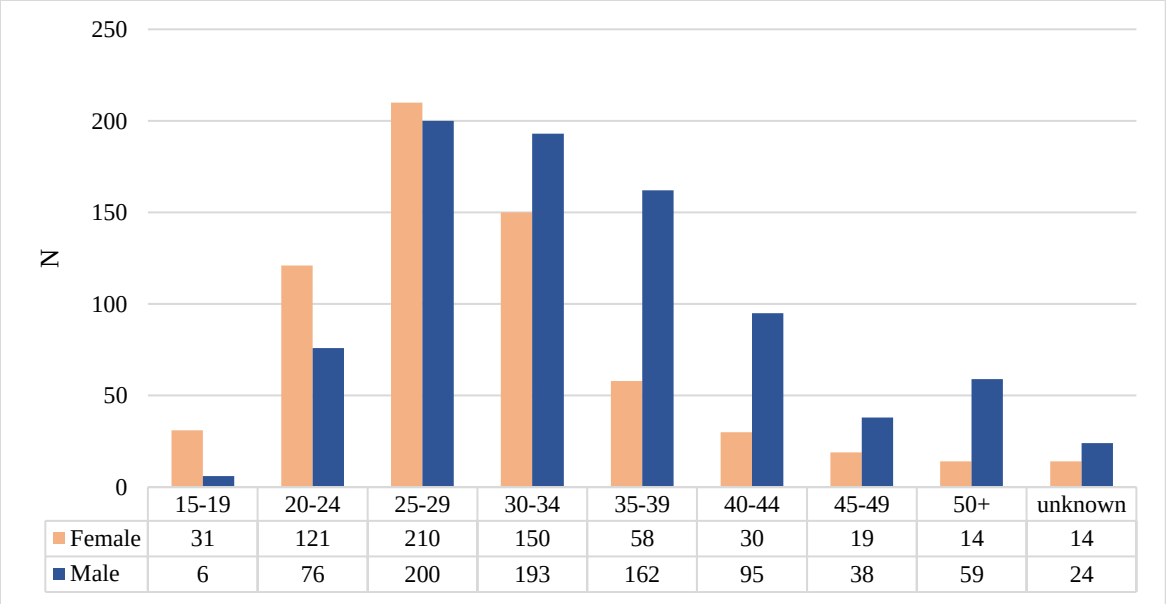
Evaluation Objective A: *To determine if the uptake of HIV self-test kits (HIVST) contributed to HIV case findings between 2020 and 2021.*

EQ 1: *To what extent has HIVST distribution under the FCI project improved access to and uptake of HIV testing as well as case identification for targeted populations?*

A total of 2,154 HIVST kits were distributed in pharmacies to 1,500 primary recipients (647 females and 853 males in FY21. Figure 22 below shows the ages of primary recipients of HIVST kits. More of those who were in the ages 25-39 years, with the largest number of females within the ages 25-29 years and males within the ages 25-39 years. Sixteen percent (n=237) of those who

collected kits in FY21 had last tested over a year ago, 42.8% (312 females and 330 males) more than three months ago and 2.1% (12 females and 19 males) had never tested.

Figure 22: Number of individual primary recipients who collected HIVST in pharmacies, FY21



	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50+	unknown
Female	31	121	210	150	58	30	19	14	14
Male	6	76	200	193	162	95	38	59	24

Source: PSI MIS, 2021

Ninety-four percent (n=1,409) of primary recipients did not test on site. Fourteen (15%) of the 91 individuals who were assisted to test were found to have HIV and referred for confirmatory testing at the nearest health facility. Primary recipients of HIVST were offered the option to take secondary kits for their partners and families, which were collected by 724 primary recipients (317 females and 407 males). There could have been repeats as there were no unique identifiers of clients.

Table 27 below shows that, during FY22 (Q1-Q3), 2,142 clients collected HIVST kits from pharmacies. Fifty clients (2.3%) who collected kits self-reported a positive HIVST result and 34 (69.0%) were referred for confirmatory testing. Confirmatory testing diagnosed 27 (80%) as positive of whom 25 (93%) were linked to ART.

Table 27: HIV treatment cascade for HIVST follow up clients in FY22 (Q1-Q3)

	No# of clients who used primary test kit	No# of clients who clients with unassisted HIV_POS status	No# of clients who received confirmatory test	Client Confirmatory HIV_ POS status	Linkage to ART
Female	1,104	26 (2.4%)	19 (74%)	15 (80%)	**14 (94%)**
Male	1,038	24 (2.3%)	15 (63%)	12 (80%)	**11 (92%)**
15-24	552	8 (1.4%)	5 (63%)	3 (60%)	**2 (67%)**
25-39	1,135	22 (1.9%)	16 (73%)	12 (75%)	**11 (92%)**
40-49	263	11 (4.2%)	5 (45%)	4 (80%)	**4 (100%)**
50+	170	8 (4.7%)	7 (88%)	7 (100%)	**7 (100%)**
Undefined	22	2 (9.1%)	2 (100%)	2 (100%)	**12 (100%)**
Total	**2,142**	**50 (2.3%)**	**34 (69%)**	**27 (80%)**	**25 (93%)**

Source: PSI MIS 2021

Focus group discussions with pharmacies revealed that they found the approach as useful for offering HTS to populations who exhibited high-risk behaviour, particularly clients that had come for emergency contraceptives and STI treatment. "*I often decried the many numbers of young women who came to purchase morning after pills during the festive season and worried about their HIV status*." Many pharmacies expressed enthusiasm at the potential of rolling out distribution, but lamented the lack of monetization. They said, "*We sell other prevention products, such as condoms. So why should self-testing kits be free?"* Pharmacies also complained that they were not trained to do pre and post HIV counselling, which was required for cases where a client asked to be assisted. They were also were unfamiliar or the referral system for those who test positive (or negative).

Pharmacies reflected that even though additional time was required to explain the testing procedures, especially to clients who were not literate, it was necessary to deliver the service per their need. They concluded that this approach should have been rolled out a long time ago. Their

general feeling was that HIVST kits should always be available in pharmacies since there are people who are reluctant to go to health facilities and because in some cases facilities are far from the community.

EQ 2: *How successful were faith-based and community structures in distributing HIVST kits? What contributed to the success (or lack thereof)?*

To access the HIVST kits, church members were given vouchers which they presented to any participating pharmacy and were able to redeem the voucher for an HIVST kit. Community carers also distributed vouchers in a discreet place inside the church (e.g., bathroom, corridor, classroom, etc.). Carers also provided posters with instructions for how to retrieve the vouchers.

As shown in table 28 below, community carers distributed 1,053 HIVST (983 kits to primary beneficiaries and 70 kits to secondary beneficiaries) in communities. Thirty-four beneficiaries who self-reported to having a positive diagnosis were referred for confirmatory testing in the nearest health facility. Only six of those referred were diagnosed as HIV positive and only three were initiated on ART. Carers cited the reasons for the low linkage as inaccessibility of health workers or PSI staff when needed by community carers or failure to confirm linkage to health facilities,

Table 28: Distribution of HIVST, testing and referral in communities

	Female	**Male**	**TOTAL**
Number of individuals who were met by community carer	1,570	987	2,557
Total HIVST distributed	653	400	1,053
primary recipient	605	378	983
secondary recipient	48	22	70
Number of individuals who collected HIVST primary kits	554	363	917
HIVST recipients followed up	342	236	578
HIVST recipients receiving confirmatory testing	22	12	34
Number diagnosed HIV+	5	1	6

Initiated on ART	2	1	3
Linkage to ART rate	**40.0%**	**100%**	**50.0%**

Source: PSI MIS 2021

Table 29 below summarizes the experience in distributing HIVST kits from the views of community carers. Note that the words in italics are verbatim and the non-italic are general reflections as gathered by the evaluation team.

Table 29: Views on distribution of HIVST kits by community carers

Themes	**Key Extracts**
Accessibility and acceptability	• Most recipients of HIVST were women, followed by youth and adult males. • Community members are happy with the confidential unassisted service. • Peer community carers were preferred, especially for younger populations.
Stigma	• Misunderstanding by the community regarding the HIV status of carers. Communities assumed that carers were living with HIV and expert clients. • Community members expressed their preferred to interact with somebody that they do not know from their community (a fear of status reveal). • Difficult to distribute HIVST in churches. Congregants were reluctant and felt that carers wanted to invade their privacy.
Sensitization	"*Distributing these testing kits required me to first gain the trust of the community as it was not truly understood what my true intentions were."* • Information and advocacy is key before implementation.
Linkage to ART	• Traumatic experience for those who were unassisted and tested positive. They did not have immediate support from PSI, community carers or health workers. • Absence of counseling for unassisted clients.
Successes	• Community carers sensitized within their communities and close friends and relatives • Hard to reach men were reached through the distribution of HIVST kits.
Challenges	*"Men were not easily convinced to use the HIVST."* *"Difficult to work in community where you are known"*

	• Cannot confirm linkage to health facilities, as health workers or PSI staff were not available when needed by community carers. • There was no referral tool for those who requested to be assisted within the pharmacy (those who are reactive). • Pharmacists were not trained to do pre and post HIV counselling in cases where a client asked to be assisted with the testing. • PSI never followed up on community members who had undergone unassisted self-testing as promised.
Sustainability	• Need to strengthen collaboration with other implementing partners. • Collaboration with health workers on the ground is key, especially for confirmatory testing and linkage to ART for those testing positive.

EQ 3: *What was the experience of PSI in implementing the evidence-based interventions in the various church denominations?*

The experience of the FCI was extracted through focus group discussions with congregants and some church members. Table 30 below summarizes the discussions along common themes. Note that the words in italics are verbatim and the non-italic are general reflections as gathered by the evaluation team.

Table 30: Experiences of faith based communities of the FCI program

Themes	Key Extracts
Acceptability	"*For the first time in my church, we were able to discuss HIV which was a taboo topic."* • Faith leaders were able to address the sensitive issues of sexuality and HIV with congregants. • Church was compelled to accept that it was not perfect, congregants could contract HIV and/or experience incidents of GBV.
Sensitization	• Collaboration with PSI was considered successful. • Information and advocacy are key before implementation.
Successes	• Congregants living with HIV shared their experiences and promoted linkage to HIV treatment.
Attitudes towards offering HTS in faith constituency	• Difficult to distribute HIVST in churches. Congregants were reluctant, felt that carers wanted to invade their privacy.

	• People were reluctant to take the HIVST kits in the church setting. • Prefer to interact with somebody they do not know in the community
Successes	• Young Christians were able to receive a lot of information on HIV. • Encouragement to use HIV prevention and treatment services. • Visits to churches by PSI justified program importance.
Challenges	*"Some victims of abuse in the church do not want to involve the police."* • HIV positive and GBV cases were not followed up (issues with linkage) • Lack of Counseling for unassisted self-testing which led to non-linkage.

EQ 4: *How effective were the structured trainings in building the capacity of faith leaders on effective messaging around HIV knowledge?*

PSI provided training to 120 faith leaders from 23 churches and 77 community carers to disseminate messages of hope to congregants. Seventeen church leaders were made champions for delivering messages of hope to encourage men, women and young people to adopt safer behaviours and access health services sooner.

Among all churches, congregants that received of messages of hope consisted of 236 individual youth members, 67 couples, 80 women's groups and 70 men's groups. Topics covered included 'how men feel', 'men's preference to care,' 'how mothers can help men feel,' 'how children and youth leaders can help,' and 'GBV and access to services.'

Analysis of FCI: Through the FCI, PSI was able to achieve their objective to increase access to HIV prevention services among men and women. Congregants received prevention and treatment information as well as messages of hope. The church-based messages of hope were identified as useful to the faith constituency and most sustainable beyond the PSI project. All participating churches had reportedly mainstreamed them as part of their information. The findings reveal that men were most commonly reached by through men's groups and youth groups and men, particularly those 25-39 had high uptake of HIVST through pharmacies. The community carer strategy was more successful among women than men.

Even though a trend analysis could not be established given the short implementation period, the findings indicate that offering HIVST in pharmacies has improved access to HIV testing services for previously untested populations as demonstrated by the 2.1% and 3.4% of females and males who tested for the first time in their lives. Most recipients for HIVST at pharmacies had their last test more than three months prior. The consideration to offer kits to clients who revealed risky behaviour (emergency contraceptive and STI symptoms) is an ingenious contribution to case finding. The finding that men aged 25-39 had high uptake of HIVST through pharmacies, reveals a promising strategy to close the gap in case identification among 25-34 year olds demonstrated by the SHIMS3. Additionally, targeting men is useful in order to make gains given that Eswatini is a patriarchal society, which regards men as heads of homes and decision makers for the family, including, in some cases, sexual and reproductive health needs. (MICS, 2014).

However, the lack of a mechanism to provide counseling for both assisted and unassisted HIVST clients and poor comprehension of the linkage model (by providers) are of the major challenges for HIVST. Similarly, pharmacies reported a lack of referral system for those who were reactive. PSI explained that the kit contained details for referral to confirmatory testing at the nearest health facility. However this may have been a barrier to linkage for clients who were not literate.

Given the high uptake of HIVST at pharmacies, particularly among populations in which a large proportion of PLHIV remain undiagnosed, the pharmacy distribution model appears to be a promising approach to close remaining case finding gaps, particularly for people who are reluctant to go to health facilities and/or prefer to test in private (unassisted). Overall, pharmacies were also appreciative of the opportunity to offer this service, although some concerns were raised regarding the lack of monetary compensation. Important findings for strengthening implementation include a need for additional counseling education for pharmacy providers and stronger linkage and referral protocols.

The messages of hope intervention was well received and provided a structure to discuss otherwise “taboo” topics as well as provided the opportunity for members living with HIV to share experiences with other congregants. While the messages of hope covered topics on GBV and

access to services, there was no data available on GBV cases and/or how those were managed. Therefore, the evaluation was unable to determine whether the objective to reduce violence against children aged 9-14 years was achieved.

CHAPTER 4: SUMMARY OF PERFORMANCE FOR SCORE PROJECT AND COMPLEMENTARY PROGRAMS

Table 31 below shows the aggregate performance of SCORE project including complementary programs. It summarizes that PSI interventions were able to achieve many targets at end term.

Table 31: Summary of program performance for SCORE projects

SCOPE INTERVENTION	OUTPUT LEVEL INDICATORS		OUTCOME LEVEL INDICATORS			
	INDICATOR	VALUE FY22 (Q1-Q3)	BASELINE FY17	MID-TERM FY19	END OF TERM FY22 (Q1-Q3)	
					TARGET	PERFORMANCE
HIV Testing Services (HTS)	No#/% of persons tested using index testing services	378 (32.3%)	84.7% PLHIV who are aware of their HIV-positive status (SHIMS2, 2017)	No data	≥ 90%	94% (SHIMS3 2021/22)
	No# of people who received HIVST through community-based distribution and linked to prevention services	29	3.1% of PLHIV identified through index testing (CBHTS)	62%	50%	34.3% (FY21)
	No# of men aged 20-29 who received HIV testing services and received their results	309/800	% of HIV negative clients identified at HTS sites who are initiated on PrEP	Not established	No target	3.8%
	No#/ of women aged 15-29 who received HIV testing services and received their results	717/1059				
	No# of contacts elicited in facilities and communities	1,234				
	No#/% of people aged 15+ who tested HIV positive and received recency testing	1,024				

	No# of HTS self-testing kits distributed 2,908					
Linkage to care and treatment (LCM)	No# of adults and children newly enrolled on ART % of newly diagnosed PLHIV who were successfully linked to ART 4,644	188 (FY22 (Q1-Q3))	% of newly diagnosed PLHIV who were successfully linked to ART (SHIMS, 2017- 74.1% of all PLHIV)	70% (3172/4501) DATIM, 2020)	95%	96.8% CMIS 2022
	No# of adults and children currently receiving ART	1,281 (F) 1,073 (M)	% of PLHIV who are initiated on ART within 1 month of diagnosis	83% (MoH, 2020)	95%	98%
	No# of ART clients lost to follow-up, by age and sex	164 (FY21)	% of ART patients who received viral load testing	92%	95%	99%
	No# of active ART patients eligible for VL testing	2268/ 2354	% of PLHIV on ART who were retained on treatment 12 mths after initiation	77% DATIM, 2020)	95%	98%
			93% of ART clients virally suppressed (MoH, 2018)	79% DATIM, 2020)	95%	99%
			73.1% of stable PLHIV clients on Multi-month dispensing (MMD) beyond 3 months (SHIMS, 2017)	11%	85%	93.9%

VMMC	No # males circumcised by Litsemba Letfu Clinic No # of HIV neg. males accessing MC through referral from OPD, Index, DREAMS, STI and FCI	907 (FY20) 805 (FY21) 739 (FY22 (Q1-Q3)) 69	% of HIV-negative males aged 15 or older linked to VMMC services	No baseline	≥ 80%	82.3%
DREAMS	No# AGYW who received clinical services % of AGYW who were newly diagnosed with HIV and successfully linked to ART No# of AGYW who received post-GBV services No# of AGYW who received services on the DREAMS-on-Wheels	PrEP-= 1 STI= 139 FP=41 Post-violence care= 1 12 (100%) 2 (FY22 (Q1-Q3)) 971 (FY21) 958 (FY22 (Q1-Q3))	% of AGYW aged 10-29 years diagnosed with HIV	Program began in 2021	Open target	10/734 (1.4%)
FCI	No# of HTS self-testing kits distributed through pharmacies	3,154	Proportion of those who received an HIV S-T kit and tested positive	Program began in 2021	Open target	2.1%

	No# of HTS self-testing distributed by community carers No# of individuals who received counseling and referral services for GBV No# of faith leaders who received trainings on effective messaging around HIV knowledge No# of new congregations reached with all new messages of hope	1,053 No data 120 526	Proportion of those who tested positive by unassisted HIVST who sought confirmatory testing. % of GBV cases and disclosures among children 09-14 years.			2% No data

CHAPTER 5: DISCUSSION OF SUCCESSES, LESSONS AND CHALLENGES FROM IMPLEMENTATION

The following chapter discusses the relevance, effectiveness, efficiency and sustainability of the SCORE Project and supporting initiatives.

1) Relevance of SCORE interventions, including VMMC, DREAMS, and FCI:

The findings revealed that the HTS approaches that were used by PSI to identify new cases of HIV were very relevant and designed to contribute to successful HIV case finding as guided by SHIMS2 and program data. Their design was aligned with key national priorities in the Eswatini National Multisectoral HIV and AIDS Strategic Framework (NSF) 2018 – 2023 and PEPFAR COP guidelines. The annual COP planning sessions and quarterly program review platforms including technical working groups enabled PSI to evolve community testing approaches based on new approaches. This resulted in the inclusion of index contact tracing, recency testing, routine implementation of LCM, VMMC and justified the modifications to include complementary initiatives of DREAMS and FCI. Additionally, the allocation of regions among PEPFAR-supported IPs enabled PSI to intensify their efforts in the two regions.

Recency testing has come at an opportune time for Eswatini who is nearing epidemic control. The recorded data of more long-term infections suggests the need to modify HTS approaches in order to find new infections earlier and/or research to interrogate the reasons for many long-term infections and respond. The LCM model coupled with CommART has been successful in linking newly diagnosed patients to ART, where a majority were linked within the same day of diagnosis. The patient-centered approaches that were used to follow up clients for new appointments, through phone calls, tracing and home visits were person-centered and innovative. This likely contributed to the reduction in patients being lost to follow up, from 174 in FY20 to 164 in FY21 and 160 in FY22 (Q1-Q3), while 203 clients restarted treatment over the three years. However, the pressure some clients felt to rapidly initiate ART under LCM requires urgent attention so that clients are fully involved in the decision to enroll for treatment.

Given that the median age of sexual debut is 18 years for males (SDHS,2006/7), the VMMC programs' retargeting of 15-29 populations offered an opportunity for immediate gains in HIV

prevention as some in this population are already sexually active. The introduction of the DREAMS initiative was an innovative model for catchment of AGYW and their partners, including to respond to their needs. DREAMS seems to be targeting some higher-risk AGYW as the profiles of those enrolled in DREAMS include 5.5% (n=309) self-reported to having multiple sexual partners, 14.4% (n=807) having sex with benefits, and 6.4% (n=358) with current symptoms of STIs. DREAMS beneficiaries reflected on the opportunity to discuss issues of sexuality that they could not have otherwise discussed. For AGYW, DREAMS-on-Wheels was their most preferred clinical service provider as it offered confidentially and friendly staff. The package of clinical services in the mobile clinic was also reportedly responsive to their needs, which were mostly for FP commodities, STI screening, HTS screening and testing.

The FCI approach came at a critical time in the last mile as existing approaches become saturated. FCI enabled access to a 'secured' population, which is perceived to have lower HIV risk. The FCI initiative was a smart contribution to the HIV response for both prevention and case finding as well as sensitizing congregants on violence. The consideration to offer test kits to clients who revealed risky behaviour (emergency contraceptive and STI symptoms) is a creative contribution to case finding.. By end of project, FCI implementing churches had reportedly mainstreamed messages of hope. Similarly, participating pharmacies supported the initiative to place HIVST kits in pharmacies and expressed a willingness to continue providing service.

2) Effectiveness of SCORE interventions including VMMC, DREAMS, and FCI:

PSI's HTS approaches have contributed to the identification of PLHIV. Facility OPD and index testing were most effective for finding positives as reflected by their higher yields and overall contribution to case finding in terms of the volume of PLHIV. However, the shift in testing approaches from community to facility-based approaches resulted in PSI being unable to meet the target of improving the volume of newly detected HIV-positive cases from CBHTS to 95%. SCORE also demonstrated a marked increase in the identification of adolescents, with a 10-fold increase in 10-14 year olds and a 3-fold increase in 15-19 year olds between FY20 and FY22

Facility based testing (OPD) approach was able to diagnose over 60% PLHIV since FY21. Facility-based testing using lay-cadres in OPDs was marginally more effective for finding more

PLHIV overall, however favored case finding for females as the proportion of women identified increased from 52% to 61% while the proportion of men dropped from 48% to 39% of the positives identified. Within index testing, more male clients than females revealed their contacts and a majority of contacts consented to testing.

While HIVST did not contribute a lot to case finding, it availed HTS to populations who had never tested and improved access to testing for individuals with high-risk behaviors who presented to pharmacies rather than health facilities. This approach can be used for general regular knowledge of one's status and to target sub-populations with a large proportion of PLHIV who remain unaware of their status (males 25-34 year old and AGYW aged 15-29) (SHIMS3, 2021), who should be encouraged to test regularly.

PSI used the evidence of recency data to improve HTS and HIV prevention programming by intensifying HTS in 'hot spots', reducing re-testing among clients already on ART, and welcoming back clients who had interrupted treatment without discrimination. PSI also intensified awareness creation and HIV prevention services in hot spots.

PSI's linkage to HIV prevention through PrEP initiation and referral to VMMC for clients who were tested negative in all HTS sites resulted in 1,216 people being initiated on PrEP and 69 males to undergo VMMC at Litsemba Letfu Clinics. However, this was gross underperformance against the 32,006 persons who tested negative at HTS sites. PSI did not design an approach to attract 'at risk' persons to initiate to PrEP beyond the opt out criterion. This was a critical omission given that risk behaviour and exposure to HIV had been established through the HTS screening and risk tools. Due to time constraints, the evaluators were not able to establish testing trends (through their unique ID's) of persons who had previously tested negative over the quarters and cross-tabulate them with PrEP initiation. This more in-depth analysis could inform improved targeting of those at continued risk of acquiring HIV and track the rate of referral to HIV prevention interventions.

The LCM model of using expert clients is a best practice for enrolling PLHIV on treatment. From a 75.0% average linkage rate recorded during the SCORE mid-term review in FY19, PSI was able to link 96.8% of newly diagnosed PLHIV on ART by FY22 (Q1-Q3), surpassing the target to link

95% PLHIV to ART facilities. Over 95% of ART patients at New Start clinic had suppressed viral loads, indicating an achievement of the third 95.

PSI was able to provide regular screening for TB and cervical cancer in over 90% PLHIV and all TB/HIV co-infected patients and those with cancerous lesions were started on related treatment.

PSI was able to achieve the VMMC target to link and circumcise HIV negative men, as 82.3% of eligible males were linked and circumcised at LL clinic. Ninety percent of the clients presenting for VMMC were HIV negative. Effective targeting resulted in 65.0% circumcisions being performed on men aged 15-29 years. Peer counselling and one-on-one motivation the most successful demand creation approaches because myths and misconceptions were discussed during sessions. Acceptability of VMMC remains a challenge as culture and misconceptions continued to act as barrier to service uptake.

By the end of June 2022, a total of 6,020 AGYW had been enrolled in DREAMS. Of those 3,756 (62.4%) AGYW had completed the primary package of DREAMS services. Thirty-eight percent (n=2,264) AGYW completed both primary and parts of the secondary package. Almost all 98.2% of AGYW were screened for HIV and those screened positive were offered an HIV test, which diagnosed less that 3 percent as positive. All of those found positive were initiated on ART. The clinical services offered in DREAMS-on-Wheels were both convenient and beneficial to AGYW who mostly required FP commodities that were brought closer to them and provided in private. However, the program performed poorly in the referral to PrEP for 'at risk' HIV negative AGYW as less than half were initiated on PrEP during both years. There was no linkages or referral approach beyond the opt out criterion, even though the reasons for non-initiation were provided by AGYW as lack of support and/or requiring permission.

Through the FCI messages of hope trainings, churches were able to introduce topics of health, HIV and GBV into their sermons and community programming. The adaptability of messages and complimentary with Christian morals were cited as some of the reasons for project success and reasons to sustain beyond PSI support. The community carer strategy was more successful at offering HIVST kits for women (n=1,570) than men (n=987).

The evaluation found a generally weak emphasis on HIV prevention that is reflected by the low uptake of PrEP by referred clients. Save for the VMMC intervention, linkages to prevention were not clearly defined and there was poor effort in prevention planning as was done for treatment. Key informants said, "*it is as though PSI waits for people to get infected and then they begin their (good) work to link clients to treatment.*"

3) Efficiency of SCORE interventions including VMMC, DREAMS, and FCI:

The discussion on efficiency was not a primary question asked in the evaluation and as a result, evaluators did not perform any cost or budget assessment to fully respond. While respondents recognized that SCORE interventions were impactful, they also agreed that these involved huge investments for staff (expert clients, HTS lay counselors, linkage cadres in facilities and demand creation agents), physical assets such as the clinics in Matsapha, and setting up testing sites in communities. Justifying the investment, key informants conceded that "*it was always expected that finding the last of the untested PLHIV would be more expensive*" and concluded that "*the gains in community footprint far outweighs the cost of delivering the service*". Informants suggested that the investments made should be measured against the opportunity cost of not intervening.

The partnerships and collaborations that PSI made with other entities are some of the reasons for program success. These include the a) the use of CMIS and APMR national databases, b) participation in regional teams, and c) collaborations with ICAP and PACT for recency and DREAMS, respectively. Additionally, the evaluation found an overall high level of quality assurance and compliance to monitoring standards. Planning was guided by data which was available in quarterly and annual reports. Regular reporting on activities was enabled by the use of information technologies. However, the evaluation uncovered sub-optimal synergies between the PSI MIS and CMIS at MoH. In some cases, patient data from the two systems was conflicting and a time-intensive process was employed to align the data.

Duplication of services by partners was identified as a common weakness, including poor partner mapping by the donor. Duplications were more common in demand creation for VMMC and evident in the parallel implementation with Regional Health Management Team (RHMT). This

together, with the drive for testing yield could have created competition rather than synergies among partners.

4) Sustainability of SCORE interventions, including VMMC, DREAMS and FCI:

Informants agreed that the SCORE project had been instrumental in pioneering programs such as CommART and LCM. These projects enabled the development of SOPs such as the LCM manual, community testing SOPs and more recently, the index testing SOPs. While government's commitment to SCORE interventions may sustain the momentum, the reality is that sustainability of the current approaches would require a greater government investment to 1) absorb the staff and 2) sustain the community approaches. Government's dire fiscal position and freeze policy on hiring threatens government's capacity to absorb project implementation approaches. Even though discussions are ongoing with Government to absorb the Litsemba Letfu clinic, the associated costs of providing VMMC may hinder its sustainability beyond PEPFAR support.

The evaluation found weaknesses in strengthening community systems and PLHIV networks. This was demonstrated by the superficial engagements with existing staff in facilities' and PLHIV networks, since the project relied heavily on PSI supported cadres. This implies that a lot of work will have to be done to sustain the approaches beyond this project, especially for LCM community initiations, retention in care, and HTS index testing.

Another factor that was cited as counterproductive was the low appetite to invest in human resources by the donor, to which PSI responded by issuing short-term contracts. The issuance of short-term contracts was largely necessitated by changes in annual work plans that would require new skillsets. However, this demotivated staff and led to high attrition, which resulted in program disruptions.

Table 32 below summarizes the best practices and lessons learnt from implementing the SCORE and complimentary interventions.

Table 32: Best Practice and Lessons learnt from implementing SCORE and complimentary initiatives

BEST PRACTICES AND LESSONS LEARNT
1. Index and facility OPD that were able to produce higher yields and contributed to case finding for 75.1% (n=3,889) of all newly diagnosed PLHIV during FY20-FY22 (Q1-Q3).
2. The potential use of recency data in program planning to identify retesters and improve strategies for earlier identification of HIV infections.
3. Index testing for identifying and testing the contacts of newly diagnosed PHIV and linking them to care.
4. Distribution of HIVST kits in pharmacies to target risk populations who may not present through other entry points, as demonstrated by the 2.1% and 3.4% of females and males who tested for the first time in their lives. Also, the high uptake among women 15-29 and men 25-34, both of whom are target populations for case finding based on SHIMS3 data.
5. LCM using expert clients to motivate newly diagnosed PLHIV to enrol and be retained on treatment.
6. Targeting of males between ages 15-29 years for VMMC offers potential for immediate gains in HIV prevention.
7. Litemba Letfu's VMMC approach including service quality can be incorporated into the national program to enable other sites to adopt and improve the quality of services or attractiveness of VMMC.
8. Captive audience of AGYW under DREAMS and the successes of the DREAMS-on-Wheels as a preferred clinic.
WEAKNESSES
1. Poor planning for HIV prevention. No approach to attract 'at risk' persons to initiate to PrEP beyond the opt out criterion. A streamlined referral system was only defined for VMMC through the redeemable vouchers. No targets were allocated for prevention.

2. No investment in strengthening community and health systems to sustain the gains. i.e. no collaboration between expert clients vs PLHIV support groups and lay counsellors at OPD and OPD nurses.

CHAPTER 6: RECOMMENDATIONS

The following recommendations are suggested to respond to the evidence and discussions that have been presented in the Chapters 3 and 5. The recommendations are designed to reinforce the successes and addresses shortcomings.

Recommendations for HTS and linkages

1) HTS approach
    a. HTS strategies must reconsider the prioritization of targeted testing approaches at the expense of 'knowing of one's status' models. This is pertinent for Eswatini where 25% of PLHIV men aged 25-34 years are not aware of their status and therefore not enrolled in care (SHIMS3, 2021). Moreover, new infections and sero-conversion continues to be high among AGYW 15-34 (SHIMS3, 2021). These and other sub-populations that are at higher risk of exposure must be encouraged to test regularly.
    b. HTS approaches must continue to maintain a community component in order to diagnose more males, given that the shift in focus from community to facility approaches reduced the number and proportion of men diagnosed annually.
    c. Further analysis of index testing data should be conducted to provide knowledge about sexual networks, which will enable the roll out targeted HIV prevention and treatment services.
2) Recency testing
    a. Recency analysis must be continued as it indeed offers potential for identification of hot spots and sub-populations at risk of infection.
    b. Undertake research to identify the reasons for high number of long-term infections and develop strategies to resolve emanating systemic and structural bottlenecks.
    c. Patients identified with long-term infections must be classified as ever enrolled in ART or never enrolled. This will enable the ART program to strengthen their strategies to reduce retesting and/or address underlying retention issues.
3) HIVST
    a. Expedite the immediate rollout of HIVST distribution in pharmacies as a targeted approach for case finding in populations with risk factors that are not likely to present to health facilities.

b. HIVST models need to be enhanced with a clear linkages and referral model, including access to counselling for HIV positive cases. The toll free number can be used by unassisted clients.
c. Explore the reasons for the difference in diagnosis between self-testing and confirmatory testing. Higher HIV positive diagnosis was identified during self-testing, but lower positive diagnosis after confirmatory testing.

4) LCM
    a. There is a need to leverage on the acceptance of PSI approaches by communities, i.e., index, HIVST and LCM to build strong community systems and activate the role PLHIV networks as a cost effective method for activating their role in providing peer support.
    b. Build the capacity for pre-and prost HTS counselling, including LCM referral among pharmacies and community carers.
5) Linkage to Prevention
    a. There is need to design a referral and linkages model (beyond the "opt-out" approach) for at-risk HIV-negative persons from HTS to PrEP and VMMC services, including setting performance targets for accountability.
    b. Conduct in-depth analysis of individuals testing negative over time to identify whether they continued to be at risk of acquiring HIV or had been initiated on PrEP and VMMC.

Recommendations for VMMC:

1) Mitigate the barriers to circumcision by providing population level awareness and demand creation about the benefits of circumcision, as the decision to circumcise is often influenced by people other than those targeted during one-on-one demand creation activities.
2) Demand creation initiatives must also target the partners of men who can become advocates for VMMC, and promote the health benefits for women.
3) Incorporate PSI's Litemba Letfu's VMMC approach including service quality into the national VMMC program to enable other sites to adopt and improve the quality of services or attractiveness of VMMC.

Recommendations for DREAMS:

1) Improve parent and partner confidence in and understanding of the DREAMS program to strengthen support for enrolment and completion. Expand the program to interface with the families and partners of AGYW beyond HTS and STI services.
2) Improve the planning and schedules for DREAMS sessions and DREAMS-on-Wheels mobile clinic. Also, create a system to notify parents/guardians of AGYW attendance.
3) Conduct more advocacy about the benefits of PrEP in all SBC educational sessions and include partners and parents/guardians of AGYW.
4) Capitalize on the business initiatives of AGYW with options to access credit for business startup. This is critical, since AGYW considered the economic empowerment module as most responsive to their current needs and enabled them to reduce reliance on transactional sex.
5) Ensure that DREAMS-on-Wheels is fully stocked with sufficient FP commodities.

Recommendations for FCI:

The following are recommendations for the FCI program:

1) Expand the partnership with pharmacies to distribute HIVST to sub-populations that do not routinely attend facilities and clients who exhibit risky-behaviours.
2) Roll out FCI trainings to include more churches in more faiths as this is self-sustaining and can reach wider captive audiences.
3) Strengthen the faith based GBV program for GBV case management and referral mechanisms.
4) Utilize youth carers for HIVST distribution in order to offer HTS to peers.
5) Capacitate community carers and pharmacies to provide HTS counseling and referral.

Recommendations for Planning, Programming and M&E:

1) Give equal priority to preventing new infections among clients who exhibit risky-behaviours that tested negative during targeted HTS approaches.
2) Provide empowerment programs for the greater involvement of PLHIV in communities and identify community partnerships to sustain LCM.
3) Reduce service duplication through effective partner mapping.

4) Improve data quality management by conducting regular data quality assessments to enhance synergies between the PSI MIS, DATIM and CMIS.
5) Create synergies among partners implementing the COP in order to foster collaborations rather than competition. The specialization of partners must be considered when awarding implementers for COPs.
6) There is need to resuscitate or reengage facilities to conduct outreach services using their regular staff as a measure to sustain the community footprint.

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ANNEX 1: KII CONSENT FORM – STAKEHOLDERS

Hi, my name is _____. I am work with PSI Eswatini as a consultant. We are collecting information for the United States Centers for Disease Control and Prevention (CDC)-funded project on community testing and linkages to HIV treatment. You have been chosen to represent stakeholders that work with PSI Eswatini. You have been invited to participate in an interview to provide input about the project. Your participation is entirely voluntary. The information you provide will inform future HIV programming in the country. The interview may take between 30-60 minutes. You are free to stop at any time and may refuse to answer any questions you are uncomfortable with. With your consent, we will be audio recording the interview. You will not be given anything to participate in the evaluation. There are no consequences for refusing to participate. There are no direct benefits for participating in this study., however, your participation in will contribute to improving HIV programming. All information will be treated with confidentiality.Your name will not be used in any report or on the findings. Only an approved person from the evaluation team will have access to the data collected. If at any time you feel uncomfortable, please let the interviewer know and the interview will be stopped.

To consent, please sign at the end.

Consent Form

I voluntarily agree to take part in this interview.

……. ……./……./…….

……..……

Name of participant Date Signature

(In cases the participant cannot read, a person should be identified to read the consent form for the participant and duly register their name below:

I am unable to read it, but this consent document has been read and explained to me by _____ (name of reader). I volunteer to participate in this interview.

Should you have questions or feel that you have been harmed by taking part in the study, please contact:

Endale Tilahun: PSI Country Rep : +268 7802 6122 email: etilahun@psi.org

Makhosazana Dlamini: PSI Deputy Country Rep: mobile: +268 7606 5728; email: khosi@psi.sz
Taurai Kambeu: Senior Monitoring Advisor: +268 2404-9817; email: tkambeu@psi.org
Sindi Matse: EHHRRB: Mobile:76289474: email: matsesindy@gmail.com

ANNEX 2: KII CONSENT FORM – BENEFICIARIES

Hi, my name is _____. I work with PSI Eswatini as a consultant. We are collecting information for the United States Centers for Disease Control and Prevention (CDC)-funded project on community testing and linkages to HIV treatment. You have been selected to participate in an interview about the project.

The interview will take between 30-60 minutes. You are free to stop the interview at any time. You may refuse to answer any question that makes you uncomfortable. With your permission, we will audio record our conversation. The recording will not be shared with anyone.

Are there costs to participate?

There is no cost to participate. There are no direct benefits to participation in this study. Your participation will help improve HIV programming in the country.

Why is the evaluation done?

We are interested in your thoughts and experiences about the services you received as a participant. Your information will help inform future HIV prevention, testing, and treatment programs in the country.

Disclosure of Potential Conflict of Interest

The people doing conducting this evaluation are paid.

Will anyone know I am in the evaluation?

Any information you provide is private. To protect the privacy of your information, you will only be identified using a unique number. The organization responsible for the evaluation will keep all records locked in a secure location. All files containing identifiable information will be password protected\ This information will only be accessible to specific staff through a password. Audio recordings will be kept for twelve months then all files will be destroyed. Information from the interview will be presented in as a summary, and you will not be identified in any publications or presentations.

You may refuse to answer any question. t. Your participation is entirely voluntary. If you refuse to participate, it will not impact your ability to get medical care or to participate in future programs. All information will be private. Your name will not be used in any report. To consent, please sign at the end.

Consent Form

I voluntarily agree to take part in this interview.

…… ……/……./…….
……..……

Name of participant Date Signature

In cases where the participant cannot read, a person should be identified to read the consent form for the participant and duly register their name below:

I am unable to read but this consent document has been read and explained to me by _____ (name of reader). I volunteer to participate in this interview.

Should you have questions or feel that you have been harmed by taking part in the study, please contact:

Endale Tilahun: PSI Es Country Rep: +268 7802 6122 email: etilahun@psi.org
Makhosazana Dlamini: PSI Es Deputy Country Rep: mobile: +268 7606 5728; email: khosi@psi.sz
Taurai Kambeu: Senior Monitoring Advisor: +268 2404-9817; email: tkambeu@psi.org
Sindi Matse: Mobile: EHHRRB: 76289474: email: matsesindy@gmail.com

ANNEX 2: FGDs CONSENT FORM - BENEFICIARIES

Hi, my name is _____. I work with PSI Eswatini as a consultant. We are collecting information about the United States Centers for Disease Control and Prevention (CDC)-funded project on community testing and linkages to HIV treatment. You have been invited to participate in a discussion about the project. We will ask questions about delivery of HIV services in the community. You may answer honestly.

Your participation is completely voluntary. You do not have to participate. Nothing will happen if you do not participate. You will still have access to health services whether you participate or not. If you decide to participate, you may leave the discussion at any point if you feel uncomfortable. You also do not have to answer any questions that make you uncomfortable.

You will join a group of 8-10 people for the discussion who have received the same services as you. There will be someone to guide the discussion. The discussion will last between 60-90 minutes. The discussion will be audio recorded if all participants agree. You will not be given anything to participate.

There is a small risk that other people in the discussion will know who you are or tell others that you were in the discussion. We are asking all participants to not share any information that was said during the discussion. The information from the discussion will be included in a report, but your name will not be shared. Audio recordings will be stored in a locked, secure location for twelve months, and then they will be destroyed. Only the evaluation team will have access to the recordings.

If you understand the above information and decide to take part, please sign below.

Signature of Participant	Date
Evaluation Moderator Signature	Date

In cases the participant cannot read, a person should be identified to read the consent form for the participant and duly register their name below:

I am unable to read but this consent document has been read and explained to me by _____ (name of reader). I volunteer to participate in this interview.

If you have questions or feel that you have been harmed by taking part in the study, please contact:

Endale Tilahun: PSI Country Rep : mobile: +268 7802 6122 email: etilahun@psi.org

Makhosazana Dlamini: PSI deputy country Rep: mobile: +268 7606 5728; email: khosi@psi.sz

Taurai Kambeu: PSI Senior monitoring Advisor: tel: +268 2404-9817; email: tkambeu@psi.org

Sindi Matse: EHHRRB: mobile : 7628 9474 : email : matsesindy@gmail.com

ANNEX 2A: FGD CONSENT FORM -BENEFICIARIES, SISWATI

Sawubona, libito lami ngingu_____. Ngisebenta nenhlangano yaka PSI njenge mncwanini. Inhlangano yaka PSI Eswatini icela lusito lwakho kunalu lucwaningo loluchazwa langetansi. Njengemuntfu losebentise tinsita tetemphilo kulelilanga lanamuhla ubonakele kutsi bowungaba yincenye yalolucwaningo. Unelilungelo yekuvuma nome kwala kuba yincenye yalolucwaningo. Ukhululekile kuma noma kuyekela noma kunini ngekusatisa. Shayela lenombolo lengentasi noma usibhalele kulelikheli lelibhaliwe nangabe ufuna kwati kancono ngalolucwaningo.

Awukaphoceleleki kutsi uvume kuba yincenye yaletingcogco kepha kuba yincenye kwakho kutatisita kakhulu tinhlelo tenhlangano yaka PSI Eswatini kutfolisisa tindlela letincono tekuletsa tinsita letiphatselele nekuhlola ligciwane lembulalave kanye nekucala emaphilisi emiphakatsini. Kutawuphindze kusite kutfolisisa imphumelelo netingcinamba tetinhlelo letikhona. Kute tincabekelwano tsite lotobanato nangabe ungakhoni kuba yincenye yaletincociswano.

Sicela ube yincenye yalabanye bantfu labasiphohlongo kuya kulabalishumi labatawucocisana. Kutawuba nemholi walengcoco, letawutsatsa sikhatsi lesingangelihora. Ukhululekile kuyekela kubayincenye yalengcoco uma uva sidzingo. Kute lotawunikwa kona ngekuba yincenye yalengoco. Utawuchubeka utfole letinsita lowutitele kulendzawo noma ngabe awusiyo incenye yalengcoco

Uyacelwa kutsi konkhe lokutawukhulunywa kulengcoco kunye nemagama ebantfu ungakucoceli umuntfu wangephandle noma longasiyo incenye yalengcoco. Loku sikwentela kuvikela labo labatawuba yincenye yalengcoco nekuciniseka kutsi konkhe labatokusho akuphumeli ngephandle. Timphendvulo takho titawuba yincenye yembiko walolucwaningo Sikunika siciniseko sekutsi lokushoko kutawubonwa ngulabahola lolucwaningo kuphela. Emagama enu nako konkhe lokuphatselene nawe lokutawushiwo kulengcoco ngeke kusetjentiswe kulombiko walolucwaningo. Konkhe lokucoshiwe kutawucishwa emvakwetinyanga letilishumi nakubili.

Nangabe uyakuvisisa lolokungetulu futsi uyavuma kuba yincenye yalolucwaningo, sicela usayine langentansi

Lilunga lengcogco- Sayina	Lusuku
Umholi ngcogco Sayina	Lusuku

Nangabe lobutwako angakhoni kufundza, kutawucelwa lomunye umuntfu amufundzele bese uyasayina

Angikwati kufundza lesicephu, kepha _____ ungifundzele waphindze wangichazela kabanti ngalesicephu.

Uma unemibuto noma ufise kubika kuhlukubeteka kwakho nawuseseyincenye yalengcoco, sicela ushayele noma ubhalele lalabalandzelako

Endale Tilahun: PSI Country Rep; Lucingo: +268 7802 6122; email: etilahun@psi.org

Makhosazana Dlamini: PSI Deputy Country Rep; lucingo: +268 7606 5728; email: khosi@psi.sz

Taurai Kambeu: PSI Senior monitoring Advisor lucingo: +268 2404-9817; email: tkambeu@psi.org

Sindi Matse; EHHRRB lucingo: 76289474: email matsesindy@gmail.com

ANNEX 3: EVALUATION STAFF CONFIDENTIALITY AGREEMENT

Study Title: End-Term Evaluation of the Strategic Scale Up of Community-Based HIV Testing and Counseling (CBHTC) and Linkage to Treatment to Optimize Response for Epidemic Control (SCORE Project) in Eswatini under the President's Emergency Plan for AIDS Relief (PEPFAR) Project

With regards to the above study, I Nokwazi Mhlanga- Mathabela _ hereby declare that:

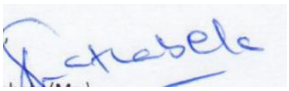
[**X**] I understand that all the material I will be asked to record and/or transcribe is confidential

[**X**] I understand that the contents of the data forms, consent forms, interview tapes, sound files or interview notes can only be discussed with the researchers.

[**X**] I understand that the identity of clients enrolled in the study is confidential and cannot be discussed with third parties

[**X**] I will not keep any copies of the information nor allow third parties to access them.

[**X**] I will delete all interview and other relevant files from my computer after transcription.

Signature: 

Evaluation Team Member

Date: __**15 August 2022**_____

Signature: _____**Principal Investigator**

ANNEX 4: FGDs ASSENT FORM - BENEFICIARIES (AGYW)

Study group: Adolescent girls and young women 15-17 years of age and older

Who are we and why are we meeting you?

Hi, my name is _____. I am work with PSI Eswatini as a consultant. We are collecting information for the United States Centers for Disease Control and Prevention (CDC)-funded project on community testing and linkages to HIV treatment, including the DREAMS program.

We want to invite you to participate in this evaluation because you participated in the DREAMS intervention. We are interested in learning about your thoughts and experience in the DREAMS program. a

This form will give you the information you will need to understand why this evaluation is being done and why you are being invited to participate. It will describe what you will need to do to participate, and any known risks, inconveniences or discomforts that you may have while participating. We encourage you to ask questions now and at any time. If you decide to participate, you will be asked to sign this consent form. If you would like a copy of this form, one will be provided to you.

Why is this evaluation being done?

We are conducting this evaluation to learn more about your experience in DREAMS. We are interested in your perceptions of the activities and clinical services related to HIV prevention. Findings from the evaluation will inform future HIV prevention, testing, and treatment programs for adolescent girls and young women in this community.

What will happen to me in this evaluation?

If you agree to take part in this evaluation, you will participate in a group discussion with 8-10 other DREAMS participants. The discussion will last between 60-90 minutes. The interviewer will ask the group questions about the DREAMS program during the discussion. Also, parental consent for you to participate in the evaluation will be requested.

Can anything bad happen to me?

There are minimal risks to participate in the discussion. It is possible that other participants will recognize you and tell others in the community that you were in the discussion. To avoid this happening, we will ask all participants to not discuss anything mentioned during the discussion with others and that all information is to be kept confidential. Also, participants will be asked not to use their names, but assigned unique numbers to identify them.

Can anything good happen to me?

The information you share with us may help make better programs to support sexual health and HIV services in your community. There are no direct benefits to you.

Are there costs to participate?

There are no costs to you to participate.

Will I receive payment if I participate?

No.

Disclosure of Potential Conflict of Interest

The evaluators are getting paid to conduct this evaluation.

Will anyone know I am in the evaluation?

Any information you provide during the discussion is private. To protect the privacy of your information you will only be identified using a unique number. The organization responsible for the evaluation will keep all records locked in a secure location. All electronic files containing identifiable information will be password protected. Any computer storing such information will only be accessible to specific staff through a password. Information from the discussion may be presented in a summary format and you will not be identified in any publications or presentations. With consent from the participants, the discussion will be audio recorded. Only the evaluation team will have access to the recordings and the recordings will be destroyed 12 months after the evaluation.

What if I do not want to do this?

You do not have to participate if you do not want to. If you agree to participate, but later change your mind, you may stop t at any time. There are no consequences if you do not participate. Your participation will not impact your participation in participate DREAMS intervention or other medical services. y. You may refuse to answer any question that you want. **MANDATORY REPORTING**

We will not tell anyone what you tell us without your permission unless there is something that could be dangerous to you or someone else. If you tell us that someone is or has been hurting you, we may have to tell that to people who are responsible for protecting children so that they can make sure you are safe.

Who can I talk to about this evaluation?

Take as much time as you like before you make a decision to participate. We will be happy to answer any question you have. If you have further questions, want to voice concerns or complaints, you may contact:

Endale Tilahun: +268 7802 6122 email: etilahun@psi.org or

Makhosazana Dlamini: mobile: +268 7606 5728; email: khosi@psi.sz

Taurai Kambeu: tel: +268 2404-9817; email: tkambeu@psi.org

If you would like to discuss your rights as a participant, discuss problems, concerns, and questions; obtain information; or offer input with an informed individual who is unaffiliated with the evaluation, please contact:

Sindi Matse : mobile : 7628 9474 : email : matsesindy@gmail.com

Signature:

If you understand this study and you are willing to participate, please sign below:

_____

Subject Name

_____ _____

Subject Signature Date

I am unable to read but this consent document has been read and explained to me by _____ (name of reader). I volunteer to participate in this interview.

_____ _____

Subject Date

_____ _____

Witness Date

Signature of Investigators or Responsible Individual:

"To the best of my ability, I have explained and discussed the full contents of the evaluation including all of the information contained in this consent form. All questions of the evaluation subjects and those of his/her parent(s) or legal guardian have been accurately answered."

_____

Investigator/Person Obtaining Consent Name

_____ _____

Signature Date

ANNEX 5: PARENTAL CONSENT FORM—FGD AGYW 15-17 YEARS OF AGE

Study group: Adolescent girls and young women 15-18 years of age, parental consent

Introduction

Hi, my name is _____I am working with PSI Eswatini as a consultant. We are collecting information for the United States Centers for Disease Control and Prevention (CDC)-funded project on community testing and linkages to HIV treatment, including the DREAMS program. Your daughter has been invited to participate in a discussion about the DREAMS program to discuss her experience and thoughts of the program.

No discussion or activity will be conducted with your daughter until you have had an opportunity to review this consent form, ask any questions you may have, and provide consent.

This consent form will give you the information to understand why we are evaluating DREAMS and why your daughter is invited to participate. It will describe what she will need to do to participate and any known risks, inconveniences, or discomforts she may have while participating. We encourage you to ask questions now and at any time. If you decide that you want your daughter to participate, you will be asked to sign this consent form and have your daughter return it to the evaluation team. If you would like a copy of this form, one will be provided to you.

Why is this evaluation being done?

We are conducting an evaluation of the DREAM program to learn more about your daughter's experience as a participant in the program. Specifically, we are interested in how your daughter perceived the activities and clinical services related to HIV prevention. Findings will inform future HIV prevention, testing and treatment programs for adolescent girls and young women this community.

What are the procedures? What will she be asked to do?

If your daughter agrees to take part in this evaluation, she will be asked to participate in a discussion with 8-10 other adolescent girls and young women who also participated in the

DREAMS program. There will be someone to guide the discussion. The discussion will last between 60-90 minutes.

What are the risks if she participates in the evaluation?

There are a few small risks in participating. The other people in the discussion may recognize her and tell others that she was in the discussion. To reduce this risk, we are asking all participants to not share any information that was said during the discussion. Also, participants will be asked not to use their names but will be assigned unique numbers for identification purposes.

What are the benefits of the evaluation?

By participating in the evaluation, she will help the people who design and implement health programs in the country to understand how to better promote sexual health and HIV services in your community. There are no direct benefits to her.

Are there costs to participate?

There are no costs to participate.

Will my daughter be paid to participate?

No. There is not compensation for participating.

Disclosure of Potential Conflict of Interest

The consultants conducting this evaluation are paid to do the evaluation.

How will my daughter's personal information be protected?

Any information discussed in the discussion is private. To protect the privacy of your daughter's information she will only be identified using a unique number. The team leading this evaluation

will keep all records locked in a secure location. All electronic files containing identifiable information will be password protected. Any computer storing such information will only be accessible to the organization responsible for the evaluation through a password. Information from this evaluation may be presented to a larger audience, but your daughter's identity will not be disclosed. With consent from the participants, the discussion may be audio recorded. Only the evaluation team will have access to the recordings and the recordings will be destroyed 12 months after the evaluation ends.

Can your daughter stop being in the evaluation and what are her rights?

Your daughter does not have to participate if she does not want to or if you do not want her to. If you agree for her to participate, but later change your mind, she may drop out at any time. There are no consequences if she does not participate. Her participation will not affect her participation in the DREAMS intervention in any way. Also, she does not have to answer any question that she does not want to answer.

MANDATORY REPORTING

We need to make you aware of one exception to confidentiality. In certain research studies and evaluations, it is our ethical and legal responsibility to report situations of child abuse, child neglect, or any life-threatening situation to appropriate authorities. However, we are not seeking this type of information in this evaluation, nor will you be asked questions about these issues.

WHO DO I CONTACT IF I HAVE QUESTIONS ABOUT THE EVALUATION?

Take as much time as you like before you make a decision about your daughter's participation. We will be happy to answer any question you have. If you have further questions, want to voice concerns or complaints, you may contact one of the following people by email or telephone:

Makhosazana Dlamini: mobile: +268 7606 5728; email: khosi@psi.sz
Taurai Kambeu: tel: +268 2404-9817; email: tkambeu@psi.org

If you would like to discuss your daughter's rights as a participant, discuss problems, concerns, and questions; obtain information; or offer input with an informed individual who is unaffiliated with the specific research, you may contact:

Sindi Matse : mobile : 7628 9474 : email : matsesindy@gmail.com

Documentation of Consent:

I have read and understand this form and have decided that I will allow my daughter to participate in the evaluation described above. I have been given enough time and opportunities to ask about the details evaluation and to decide whether or not I want my daughter to participate. The purpose of the evaluation, what she is asked to do, and the risks and benefits have been explained to my satisfaction. I understand that she can withdraw at any time without giving any reason without her medical care or legal rights being affected. My signature also indicates that I have received a copy of this consent form if I would like one.

_____ _____

Subject Date

_____ _____

Parent/Legally Authorized Representative Date

_____ _____

Person Obtaining Consent Date

I am unable to read but this consent document has been read and explained to me by

_____ (name of reader).

_____ _____

Parent/Legally Authorized Representative Date

_____ _____

Witness Date

ANNEX 6: REQUEST FOR WAIVER OF INFORMED CONSENT FOR THE COLLECTION OF THE INDIVIDUAL LINE-LISTED DATA

Nsindiso Dlamini – Strategic Information Director
Address: 173 Tsekwane St, Mbabane, Eswatini
Email: nsindiso.dlamini@psi.sz

May 2022

RE: Study Title: End-Term Evaluation of the Strategic Scale-Up of Community-Based HIV Testing and Counseling (CBHTC) and Linkage to Treatment to Optimize Response for Epidemic Control (SCORE Project) in Eswatini under the President's Emergency Plan for AIDS Relief (PEPFAR) Project

Subject: Request for waiver of informed consent for the collection of the individual line-listed data

The end-term evaluation will use a mix of both qualitative and quantitative methods. Program data including patient level data that are routinely documented as part of standard medical or program services will be used with no direct interaction with the patients. No additional patient information will be collected outside of what is routinely recorded in patient records during standard medical care of patients. A waiver of informed consent is being requested for the following reasons according to the U.S. Code of Federal Regulations (CFR 46.116(d)):

1. The evaluation presents no more than minimal risk of harm to subjects,
2. The waiver will not adversely affect the rights and welfare of the subjects; and
3. The evaluation could not practicably be carried out without the waiver".

All program routine data will be de-identified before analysis for this evaluation.

If further enquiry is required, please do not hesitate to get in touch.

Yours Sincerely,

Nsindiso Dlamini

ANNEX 9: KEY INFORMANT INTERVIEW GUIDE- SCORE STAKEHOLDERS

Date of interview:

Location of interview:

Name of interviewer:

Name of interviewee:

Title of interviewee:

Organization of interviewee:

Language of interview:

Interview start time:

Interview end time:

INTRODUCTION: PSI Eswatini is conducting an end-term evaluation of its current health programs (specifically, the SCORE project) funded by the United States government under the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the Centers for Disease Control and Prevention (CDC). We would like to get your views on the extent to which these health programs have been a success. We want to know your involvement in the programs, your perceived successes of and barriers from a technical and logistical perspective. The interview will last between 30-60 minutes.

A. Relevancy:

1. To what extent did the interventions (ART, HTS, VMMC) implemented by PSI-Eswatini funded under the SCORE project address the needs of the target population (Men, Women, AGYW?

2.How did the interventions (ART, HTS, VMMC) respond to challenges in access to HIV testing services and linkages to treatment and prevention affecting the target populations (Men, Women, AGYW)?

3. What were the key elements of the approaches used to implement interventions (ART, HTS, VMMC) relevant to the objectives of the project?

B. Effectiveness:

4. What results under the SCORE project were achieved against planned targets?

5. To what extent were the project objectives achieved?

6. What factors contributed to the achievement or non-achievement of the results?

7. What changes were experienced as a result of the intervention?

8. What unintended results were achieved and why?

C. Efficiency:

1. What resources were used in implementing the project?

2. What were the resources for the project? Please describe how the resources were accurately projected and effectively tracked?

3. How did the results (outputs/outcomes) of the SCORE project justify the cost incurred?

4. How did project activities overlap and duplicate other similar interventions (funded nationally and /or by other donors? How? Please describe any alternative ways and means of delivering the same or better results (outputs and outcomes) at the same cost.

5. Please describe the appropriateness of the management and accountability structures of the project.

6. To what extent do the total project costs compare to the project outcomes/benefits?

7. What are the strengths, weaknesses, opportunities, and threats of the project implementation process?

D. Sustainability:

8. To what extent are the benefits for beneficiaries likely to be sustained after the project completion?

9. What measures (resources and capacities) did implementing project partners put in place to sustain the interventions funded by this grant?

10. What measures can be taken to improve prospects of sustainability of project outcomes and the potential for replication of the approach?

THANK YOU.

ANNEX 8: SECONDARY DATA EXTRACTION TOOL

Participant unique #_____

HTS Intake variables

Community: _____	Modality: _____
Inkhundla: _____	Strategy: _____
Region: _____	Ever tested: _____Previous HIV result: _____
Age: _____Gender: _____	Client type: _____Final HIV result: _____
	Date final HIV result: ___/____/_____

ART Linkage variables

New HIV diagnosed: _____	ART initiated: _____Date ART started: __/____/____
Verified Not on ART: _____	Received escort services: _____
Eligible for ARROWS: _____	Received counseling sessions: _____
ARROWS start date: _____	Returned for 1st refill visit: _____
Linkage status:	

HTS Indexing variables

Offered index testing: _____	# Contacts followed: _____
Accepted index testing: _____	# Contacts tested for HIV: _____

Gave list of contacts: _____ #Sexual Partners: _____ #Associates: _____ #Biological Children: _____	Contacts final results: #HIV-_____ #HIV+_____ #HIV-_____ #HIV+_____ #HIV-_____ #HIV+_____
# of contacts listed: _____	# HIV+ contacts linked to treatment: _____ # HIV- contacts linked to VMMC/PrEP:_____

ART adherence and Viral Suppression variables

Active status: _____	ART initiated: _____Date ART started: __/____/____
ART #/*CMIS#: _____	Eligible for VL: _____Done VL: _____
VL test results: _____	Client age: _____Client gender: _____

***CMIS – Client information management System

ANNEX 10: DIRECT OBSERVATION SERVICE DELIVERY ASSESSMENT CHECKLIST

Date of assessment: _____

Region: _____

Name of Community: _____

Name of Facility: _____

	HTS & LINKAGES SERVICES					
		Completely/ Always (100%)	**Mostly (60%-99%)**	**Partly (<60%)**	**Not at All (0%)**	**Comments**
1.	Tested clients received prior screening for HTS using standard questionnaire					
2.	Clients eligible for testing are provided the rapid tests according to national algorithm					
3.	Known HIV positives not on treatment and newly diagnosed HIV positives are given ART adherence counseling services and referred for linkage to treatment at a health Clinic					
4.	Clients testing in outreach sites receive services of a counselor and expert client (if HIV+) as well as a nurse as per the linkage case management (LCM) program package					
5.	Index testing is consistently offered to 100% of clients newly diagnosed for HIV at outreach and New Start Clinic					
6.	All listed contacts of index clients are followed up for testing as per the index testing SOPs					
7.	All HIV+ clients identified are assessed for eligibility for LCM					
8.	All HIV+ clients eligible are enrolled in ARROWS					
9.	All clients enrolled on LCM are provided the package of services as defined in the LCM SOP					

10.	Linked clients are followed up to ensure they return to the facility for 1st refill visit					

ANNEX 11: FGD GUIDE- BENEFICIARIES HTS

Date: **Location:** **Name of Facilitator:**

Name of Notetaker: **Number of participants:**

Start time: **End time:**

INTRODUCTION: [*moderator reads through the FGD information scripts.*]

INSTRUCTION: Moderator should ensure that each audio file records discussions pertaining to only one FGD. A new audio file must be recorded for the next FGD.

A. Access to HIV testing services:

1. Could you describe your experience regarding access to HIV testing services in the community where you live?

    1.a What has changed since the establishment of the outreach testing site?

2. Please tell us about your deciding factors to seek HIV testing services at the PSI site instead of the nearby Clinic? What motivated you to utilize the PSI outreach site?

3. What recommendations do you have for PSI in order to improve access to HIV services in your community?

4. In general, how do you feel about the services you received at the PSI testing site? Would you recommend others to seek health care at this site? Why?

B. Linkages to treatment

5. Please tell us about your experiences around test and start for People Living with HIV (PLHIV). *For interviewer: define test-and-start to interviewee.* [Probe: if negative or

positive experience, probe to understand why they perceived their experience as ‘good’ or ‘bad’].

5a. What are your views on starting treatment early?

5b. Why do you think some people may delay starting treatment?

6. PSI Eswatini has a special approach to linking people to treatment for HIV called Linkage Case Management (LCM) where clients are escorted to a treatment facility to start ART and provided ongoing support by an Expert Client for 30 days after initiation, tell us your views about this approach?

7. Tell us, from your view, in what ways has the PSI staff at this site promoted the benefits of early ART initiation among PLHIV?

7a. What else can be done to ensure more PLHIVSTart treatment and remain on treatment?

8. Please describe what are some of the barriers to starting ART for different groups (e.g., women, AGYW, men, key pops, etc.) in your communities? How would you suggest PSI assist in addressing these barriers in the future?

C. Index Testing

9. Please tell us about your views on index testing (or partner notification services) as an approach to reach contacts with testing services?

9a. What has been your experiences using this strategy?

9b. What can be done to improve the implementation of this strategy?

Probes:

- **Staff:** Elicitation strategies, locating contacts, Testing contacts
    - Or
- **Clients**: Providing clients, Disclosing, Assistance with notification

10. Do you think people experience any retaliation from people who were reached with partner notification services after they listed as their contacts? How would you say this relates to the way the strategy is being implemented?

11. How difficult or easy is it to discuss and relay information about sexual partners with the PSI staff at the site? Would you recommend anything to change from the way they interact with you or others like you?

D. Linkages to Prevention

12. What HIV prevention services other than HIV testing are offered at this site?

13. What would you say are the benefits of preventive services in curbing HIV? In your view, in what ways has the PSI staff at this site promoted these benefits to clients?

14. Please briefly describe your experiences relating to the services you received.

E. Overall Effectiveness

15.? Please share your views on whether PSI services offered at this site have met or not meet your needs.?

16. What is one thing about the services that you would improve?

ANNEX 12. FGD GUIDE-AGYW (DREAMS)

Date: **Location:** **Name of Facilitator:**

Name of Notetaker: **Number of participants:**

Start time: **End time:**

INTRODUCTION: [moderator reads through the FGD information scripts.]

INSTRUCTION: Moderator should ensure that each audio file records discussions pertaining to only one FGD. A new audio file must be recorded for the next FGD.

Attitudes of being part of DREAMS:

1. What was your experience as a DREAMS participant?

2. In your opinion, what did you gain from participating in DREAMS?

3. What were the challenges to participating in DREAMS? Did you have to make any sacrifices to participate in the program?

4. How did your family feel about your participation in the program?)

Clinical Services:

Now I would like to ask you about experiences receiving clinical services from the DREAMS program. Did you attend a facility? Did you attend a mobile van (DREAMS-on-Wheels)?

5. In general, how was the experience of accessing clinical services for DREAMS participants?
    a. How accessible were the services? If not accessible, what were the challenges to accessing services?
6. How were you or DREAMS participants received by the provider?
7. Were you able to get all your health needs addressed through DREAMS? What other clinical services did you need?
8. What would make DREAMS clinical services better?

a. How could the services be improved to be more friendly to AGYW?

b. Did you feel comfortable accessing clinical services through this project? (How would you propose to make it more youth-friendly)

9. For those of you who accessed services through a mobile van or know of others who accessed services through a mobile van (DREAMS-on-WHEELS), what was your experience?
    a. What were the benefits of the DREAMS mobile services?
    b. What would you have liked that was not accessible through the mobile services?

10. How did you know the schedule for the DREAMS-on-Wheels and was it accessible when you needed it?

Satisfaction:

12. What worked well for you as a participant of the DREAMS project?

13. If you were asked to design a DREAMS-like program to prevent HIV, what would you include in the program?

What would be different from the current program?

14. What other services would have been helpful for you or your partner(s)? Your parents/caregivers? Your community? To make sure they can also get HIV services.

ANNEX 13. FGD GUIDE- COMMUNITY CARERS (FCI)

Date: **Location:** **Name of Facilitator:**

Name of Notetaker: **Number of participants:**

Start time: **End time:**

INTRODUCTION: [moderator reads through the FGD information scripts.]

INSTRUCTION: Moderator should ensure that each audio file records discussions pertaining to only one question. A new audio file must be recorded for the next question.

1. Can you tell us about your experiences working as a community carer under the FCI Project?

2. What were the challenges to distributing HIVST in the community?

    a. How did you address those challenges?

    b. Was there a strategy that you used to help you distribute the kits?

3. How was the uptake of HIVST kits in the churches and communities?

    a. What was the response of church members and community members to the HIVST kit distribution?

4. What worked well in the implementation of the project in your community? What did not work well?

5. According to your experience, how would you describe faith-based and community structures in distributing HIVST kits?

6. What contributed to success or lack thereof?

7. Describe any improvements in the distribution of HIVST kits during the implementation of the project?

8. Which populations were you able to distribute the HIVST kits to?

   [probe on the specific groups if they were not mentioned in the response]. Probes: Describe how easy or difficult it was to reach men? Reach adolescents?

9. Part of your role as a community carer was to link community members to HIV prevention and treatment services. Please discuss your experience acting as a navigator/linking people to services. [ALLOW PARTICIPANT TO RESPOND BEFORE ASKING THE NEXT QUESTION]
   a. What were the challenges?
   b. What were the successes?
   c. What recommendations do you have to improve the process?

10. What could be improved to ensure the sustainability of the project and its replication in other communities and denominations?

11. What recommendations would you offer PSI to improve access to HIV services in your community?

ANNEX 14. FGD GUIDE- AGYW CLINICAL TEAM

Date: **Location:** **Name of Facilitator:**

Name of Notetaker: **Number of participants:**

Start time: **End time:**

INTRODUCTION: [moderator reads through the FGD information scripts.]

INSTRUCTION: Moderator should ensure that each audio file records discussions pertaining to only one question. A new audio file must be recorded for the next question.

1. What is your understanding of the DREAMS project?

2. Did you receive the training you needed to be able to provide adolescent friendly services to AGYW? Was the training helpful? If not what, training would have been helpful?

3. What are your thoughts/experiences as a service provider for clinical services for the DREAMS project?

4. Do you feel the services provided for the AGYW were/are sufficient to their needs? If not, what was lacking?

   Did you provide a **comprehensive** clinical service that catered for their needs?

5. What have the girls in DREAMS shared with you about how DREAMS has helped them?

6. What are the lessons learned from offering the mobile clinical services though the DREAMS-on-Wheels?

7. As part of DREAMS, we want AGYW to be able to access all the services they need, including contraceptives, HIV testing, STI treatment, post-violence care and PEP, PrEP and other reproductive health services, were you able to provide access to these services?

8. Could you please describe the implementation process for the DREAMS clinical services and discuss any challenges with process?

9. What is your advice for us to improve the DREAMS program?

ANNEX 15. DREAMS: KII WITH PARTNERS IMPLEMENTING DREAMS COLLABORATING WITH PSI

Date of interview: _____ *Name of interviewee:* _____

Designation of interviewee: _____ *Organisation:* _____

1. Please explain how your organisation is involved in the DREAMS project.

2. As related to DREAMS: Briefly describe:
    a. your organizations focus areas,
    b. its strategy,
    c. relevance to the needs of the targeted population,
    d. relevance to government priorities

3. How does your DREAMS program work? How does it complement other donor programmes aimed at improving the livelihoods of AGYW? If yes, which ones?

4. How do you think the program contributes to improvements in retention, enrolment and drop-out rates for targeted AGYW?

5. What factors have influenced achievement (or not) of the intended outcomes of the program?

6. How could DREAMS be more efficient? (i) timeliness of activities, (ii) quality of services provided and (iii) implementation approach?

7. What have been some of the positive and/or negative effects that you have observed as a result of the programme activities on AGYW?

8. Can you explain the referral process between your organization and PSI? Can you share any challenges with this process? Any successes?

9. How has the programme promoted community ownership?

10. What are the key factors that drive community ownership of the program?

11. From your viewpoint, what are the key considerations that must be considered for the DREAMS program to be a success? (Recommendation)

12. How did you work with partners implementing DREAMS? Can you share the process for coordination and collaboration with relevant stakeholders?

ANY OTHER INFORMATION:

ANNEX 16. FCI: KEY INFORMANT INTERVIEWS FOR STAKEHOLDERS - PHARMACIES

Date of interview: _____ Name of interviewee:

_____

Location of pharmacy (region, town): _____ Pharmacy name:

_____

1. Please explain your understanding of the HIVST kits distribution for the Faith and Community Initiative (FCI) project through pharmacies.

2. What role did/does your pharmacy play in the distribution of HIVST kits?

3. How did you work with PSI in the distribution of HIVST kits?

4. What capacity building was conducted with pharmacies in relation to HIVST kit distribution? How would you describe the capacity building you received?

5. How does the HIVST kits distribution through the pharmacies, as currently designed and implemented, complemented other HIV prevention services in Eswatini?

6. How were you able to provide targeted distribution of the HIVST kits to the congregants?

7. How did the distribution of HIVST kits through the pharmacies improve the uptake of HIV testing according to your opinion?

8. Briefly describe the most significant achievements/results of the HIVST kits distribution through pharmacies?

9. What are the best practices and key lessons emerging from the HIVST kit distribution program through pharmacies?

10. What are the key questions you are left with - in relation to what did or did not happen?

11. What were the main challenges? [Management, Programming/Operational, Staffing, Partnership, Funding.

12. Should HIVST kit distribution continue through community pharmacies? What should be done differently? What adjustments are required to the design and implementation of the approach to make it effective to ensure a high uptake of HIV testing?

ANY OTHER INFORMATION:

ANNEX 17. FCI: KEY INFORMANT INTERVIEWS FOR STAKEHOLDERS – FAITH COMMUNITY LEADERS

Date of interview: _____ *Name of interviewee:* _____

Denomination: _____

1. Please explain your understanding of the FCI project?

2. What role did you play in the implementation of the FCI project?

3. How did you work with PSI and other institutions in the implementation of the FCI project?

4. What capacity building (e.g., training) was provided to faith leaders through the FCI project in relation to:

    a. effective messaging on HIV knowledge?

    b. supporting and referring GBV disclosures?

    c. How would you describe the trainings you received?

    d. What other training would have been helpful?

5. Following the structured training offered to you, how did you feel with handling cases of GBV amongst congregants? How were you able to offer, advise and post GBV care and refer congregants?

6. In your opinion, how effective were the were the messages of hope in improving HIV knowledge amongst congregants?

    Why were the messages effective (or not)?

What are other messages that may be effective?

7. What were the main challenges for implementing the FCI project? [Management, Programming/Operational, Partnership, Funding]

8. Briefly describe what you consider having been the most significant achievements/results of implementing the FCI project in churches? (Probe for responses on messages of hope, GBV referrals, HIVST distribution?)

9. What are the best practices and key lessons for PSI emerging from implementing the FCI project?

10. What are the things you have benefited from having FCI activities at your church?

11. What are the key questions you are left with - in relation to what did or did not happen - and where is PSI looking to go next regarding partnerships with faith-based organisations?

12. Should there be future FCI projects that seeks collaboration with the church faith/religious sector, what should be done differently? What adjustments are required to the design and implementation of the project to make it effective to ensure a high uptake of HIV testing?

ANY OTHER INFORMATION:

ANNEX 20: END-TERM EVALUATION OF SCORE ESWATINI- KII AND FGD TRANSCRIPTION GUIDELINES

Transcription instructions:

1. When transcribing please refer to the respondent **R** and the interviewer as **I**
2. If there are sections of the audio that are not comprehensible or you cannot hear please denote this with _____
3. If the interviewer and respondent are speaking at the same time or one interrupts the other please denote this with: *
4. If slang or local jargin is used please write the words or text in cursive
5. Please denote any acctions such as couging, laughing, crying, etc. as follows: [laughing]
6. If there are interruptions during the interview or the respondent seems distracted, nervious, etc. please make a note and put the text in red.

_____

Date of interview:
Duration of audio recording:
Respondent type:
Language of interview:
Thinkhundla:

Interviewer:
Transcriber:

I:

R:

I

ANNEX 26: FGDS CONSENT FORM – COMMUNITY CARERS

Hi, my name is _____. I am working with PSI Eswatini as a consultant. We are collecting data on the evaluation of the United States Centers for Disease Control and Prevention (CDC)-funded project on community testing and linkages to HIV treatment. You have been invited to participate in a discussion about the project, providing your perception as a beneficiary of the HIV clinical services. We will be asking questions about the delivery of services in the community. You may answer honestly.

Your participation is entirely voluntary, and there will be no consequence if you do not want to participate. You will still have access to health services whether you participate or not. If you decide to participate, you may leave the discussion at any point if you feel uncomfortable. You also do not have to answer any questions you are uncomfortable with them.

You will join a group of 8-10 community carers for the discussion who have all received the same services as you and were required to provide a service to their communities. There will be someone to guide the discussion. The discussion will last between 60-90 minutes. Again, you are free to stop and leave the discussion at any point. The discussion will be audio recorded if all participants agree. You will not be given anything to participate in the discussion. With your permission, we will record the discussion.

There is a risk that other people in the discussion will know who you are or tell others that you were in the discussion. To reduce this risk, we ask all participants not to share any information said during the discussion. The information from the discussion will be included in a report, but your name will not be shared. The audio recordings from this interview will be stored in a locked, secure location for twelve months after the end of this evaluation, after which all files will be destroyed as per the PSI policy. Only the evaluation team will have access to the audio recordings.

If you understand the above information and decide to take part, please sign below.

Signature of Participant *Date*

Evaluation Moderator Signature *Date*

In cases the participant cannot read, a person should be identified to read the consent form for the participant and duly register their name below:

I am unable to read but this consent document has been read and explained to me by _____ (name of reader). I volunteer to participate in this interview.

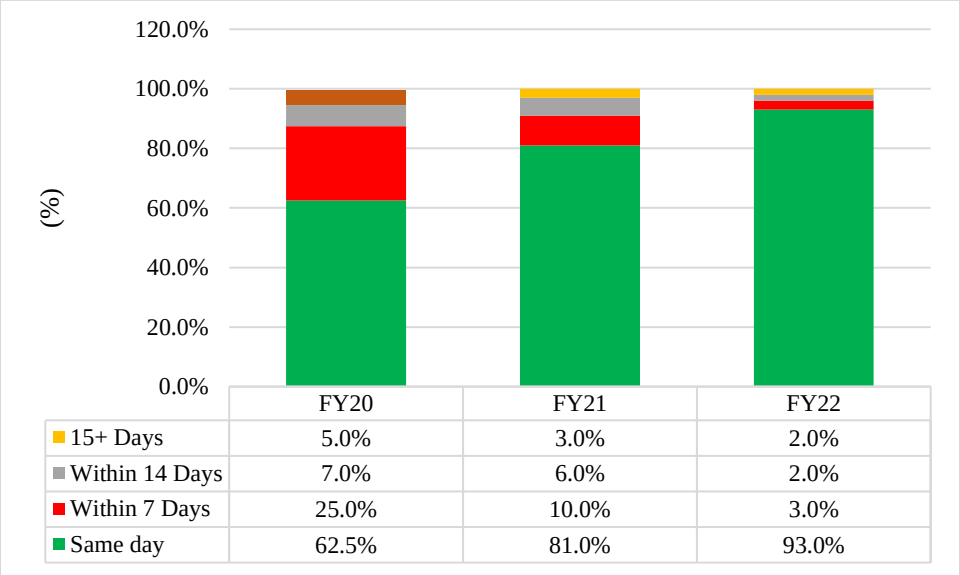
If you have questions or feel that you have been harmed by taking part in the study, please contact:

Endale Tilahun: PSI Country Rep : mobile: +268 7802 6122 email: etilahun@psi.org

Makhosazana Dlamini: PSI deputy country Rep: mobile: +268 7606 5728; email: khosi@psi.sz

Taurai Kambeu: PSI Senior monitoring Advisor: tel: +268 2404-9817; email: tkambeu@psi.org

Sindi Matse: EHHRRB: mobile : 7628 9474 : email : matsesindy@gmail.com



	FY20	FY21	FY22
15+ Days	5.0%	3.0%	2.0%
Within 14 Days	7.0%	6.0%	2.0%
Within 7 Days	25.0%	10.0%	3.0%
Same day	62.5%	81.0%	93.0%

ANNEX A: COMPOSITION OF INDEPENDENT EVALUATION TEAM

Table 33: Composition of Independent evaluation team

Name	Relevant Expertise	Designation for this Assignment	Assigned Tasks
Ms. Nokwazi Mhlanga-Mathabela	Monitoring and Evaluation Specialist Public Policy and Planning Economist	Lead Consultant	Report writing- Technical proposal, Inception report, Evaluation report Interviews with key stakeholders, implementing partners, program staff, and clinical service providers. Data analysis and report writing Presentation of findings.
Mr. Henry Ginindza	Statistician	Associate Consultant	Design of survey instruments protocols and SOPs Training field team Project and field team management Data cleaning Analysis of qualitative data
Four (4) Research Assistants Ms. Nozipho Motsa-Nzuza Mr. Nqobizwe Ndlovu Ms. Sihle Thwala Mr. Sihle Lukhele	Social Sciences SRH/Gender specialist Data collection Data Collection Data collection	Data collector	Data collection Interviews of beneficiaries Transcriptions of audio recordings of meetings

ANNEX B: PROFILES OF ADOLESCENT GIRLS AND YOUNG WOMEN WHO WEREE ENROLLED IN THE DREAMS INITIATIVE

Table 34: Profiles of Adolescent and young girls who were enrolled in DREAMS initiative

	Total		Region					Inkhundla					
			Manzini		Lubombo			Kukhanyeni		Lugongolweni		Mafutseni	
	Number (N)	%	Number (N)	%	Number (N)	%		Number (N)	%	Number (N)	%	Number (N)	%
Number of Participants	5,601	100.0	3,890	69.5	1,711	30.5		2,102	37.5	1,711	30.5	1,788	31.9
Age group													
10-14	1,970	35.2	1,334	34.3	636	37.2		757	36.0	636	37.2	577	32.3
15-19	1,664	29.7	1,135	29.2	529	30.9		549	26.1	529	30.9	586	32.8
20-29	1,967	35.1	1,421	36.5	546	31.9		796	37.9	546	31.9	625	35.0
Living arrangements													
Both parents	1,652	29	1,149	29.5	503	29.4		657	31.3	503	29.4	492	27.5
Child headed household	145	3	94	2.4	51	3.0		47	2.2	51	3.0	47	2.6
Other Head of Household	680	12	380	9.8	300	17.5		237	11.3	300	17.5	143	8.0
One parent	2392	43	1,717	44.1	675	39.5		929	44.2	675	39.5	788	44.1
Other adult	728	13	547	14.1	181	10.6		232	11.	181	10.6	315	17.6
Education status													
In school	3,662	65.4	2,530	65.0	1,132	66.2		1,359	64.7	1,132	66.2	1,171	65.5
Out of school	1,939	34.6	1,360	33.8	579	35		743	35.3	579	33.8	617	34.5
Employment status among out-of- school													
Employed	190	9.8	152	11.2	38	6.6		95	12.8	38	6.6	57	9.2
Seasonal Labour	167	10.6	119	8.8	48	8.3		72	9.7	48	8.3	47	7.6
Unemployed	1,582	81.6	1,089	80.1	493	85.1		576	77.5	493	85.1	513	83.1

Number of sexual partners													
Single	3,278	58.5	2,309	59.4	969	56.6		1,235	58.8	969	56.6	1,074	60.1
One partner not living together	1,713	30.6	1,095	28.1	618	36.1		622	29.6	618	36.1	473	26.5
One partner, living together	301	5.4	217	5.6	84	4.9		113	5.4	84	4.9	104	5.8
Multiple partners	309	5.5	269	6.9	40	2.3		132	6.3	40	2.3	137	7.7