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EVALUATION

Performance Evaluation of USAID Testing and Counseling Projects in Tanzania

February 14, 2014

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by Rachel Jean Baptiste, Charles Llewellyn, Gary Leinen, Masejo Songo, and Neema Matee of **International Business & Technical Consultants, Inc.** and Goodchance Mariki and Bahati Paul of **S.T. Associates**.

Cover photograph by Charles Llewellyn. A Community Outreach event conducted by Alpha Dance Group, a Non-Governmental Organization supported by UHAI-CT in the weekly market of Nzihi Village outside Iringa, Tanzania. During this one-day event 199 individuals were tested and 30 positive HIV cases were found and referred to Care and Treatment Centers. Group Counseling was held in the covered open area, and post-test counseling in the room with the door covered with a sheet. (Appropriate signage and branding was posted on an adjacent building.)

PERFORMANCE EVALUATION OF USAID TESTING AND COUNSELING PROJECTS IN TANZANIA:

FINAL PERFORMANCE EVALUATION OF ANGAZA ZAIDI AND UNIVERSAL HIV AND AIDS INTERVENTION FOR COUNSELING AND TESTING

February 14, 2014

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TABLE OF CONTENTS

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical and Research Foundation
ASO	Area Support Office
BCC	Behavior Change Communication
CSO	Civil Society Organization
CTC	Care and Treatment Clinic
DACC	District AIDS Control Coordinator
DMO	District Medical Officer
DQA	Data Quality Assessment
FBO	Faith-Based Organization
FSW	Female Sex Workers
FGD	Focus Group Discussion
HTC	HIV Testing and Counseling
HIV	Human Immunodeficiency Virus
IBTCI	International Business & Technical Consultants, Inc.
Jhpiego	A non-profit affiliate of the Johns Hopkins University
MoHSW	Ministry of Health and Social Welfare
M&E	Monitoring and Evaluation
MSH	Management Sciences for Health
MSM	Men Who Have Sex with Men
MSW	Male Sex Workers
NACP	National AIDS Control Program
NGO	Non-governmental Organization
PEPFAR	United States President's Emergency Plan for AIDS Relief
PITC	Provider Initiated Testing and Counseling
PMP	Performance Management Plan
PMTCT	Prevention of Mother to Child Transmission
PTC	Post Test Club
PWID	People Who Inject Drugs

RACC	Regional AIDS Control Coordinator
SPSS	Statistical Product and Service Solutions
TACAIDS	Tanzania Commission for AIDS
T-MARC	Tanzania Marketing and Communications Company
THMIS	Tanzania HIV/AIDS and Malaria Indicator Survey
UHAI-CT	Universal HIV and AIDS Intervention for Counseling and Testing
USAID	United States Agency for International Development
URT	United Republic of Tanzania
USG	United States Government
VCT	Voluntary Counseling and Testing

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EXECUTIVE SUMMARY

BACKGROUND AND METHODOLOGY

International Business and Technical Consultants, Inc. (IBTCI) conducted a performance evaluation of two USAID-funded Human Immunodeficiency Virus (HIV) Testing and Counseling (HTC) projects in Tanzania. The first, a project titled "Rapid Scale up of Innovative HIV Counseling and Testing Approaches on Tanzania Mainland," is known locally as Angaza Zaidi, and was implemented by African Medical and Research Foundation (AMREF) and partners starting in 2008 with a budget of $16.3 million over five years. The main goal of Angaza Zaidi is to increase the number of Tanzanians who know their HIV status and link those who test positive to care and treatment services. A non-profit affiliate of the Johns Hopkins University, Jhpiego, and partners received $16.5 million USD also in 2008 to lead the other project, Universal HIV/AIDS Intervention for Counseling and Testing (UHAI-CT) over five years. UHAI-CT's main goal was to increase testing and counseling particularly among high-risk populations. Angaza Zaidi implemented HTC through Stand-Alone Voluntary Counseling and Testing (VCT), Integrated VCT and Community Outreach, while UHAI-CT implemented HTC through provider-initiated testing and counseling (PITC) and Community Outreach. The team used a cross-sectional design to evaluate the two projects and collected data using a mix of qualitative and quantitative methods in six regions: Iringa, Tabora, Njombe, Tanga, Kilimanjaro, and Dar es Salaam. Six questions guided this evaluation and highlights of findings are presented below.

FINDINGS

Question 1: Has Each Project Achieved its Stated Goals and Objectives?
The evaluation team found that ***both Angaza Zaidi and UHAI-CT projects successfully achieved many of their respective objectives and targets***. Both projects intensively focused on HTC, and by working with Civil Society Organizations (CSOs) and Faith-Based Organizations (FBOs), exceeded their targets. This resulted in more than 4 million clients tested for HIV. However, PITC did not reach its potential; of the 2,532 facilities supported by the project, 872,000 clients were offered PITC throughout the 5 year implementation period. This averages to 5 clients per facility per month. Nevertheless, among all models reviewed, PITC had one of the highest yields, thus demonstrating one of the highest potentials for identifying HIV-positive clients in Tanzania. UHAI-CT tested very few individuals at risk during years 1 to 3 (226 actual vs. 6000 target), it did not establish any Post-Test Clubs, though 30 were targeted, and its quality improvement plan was not implemented with the rigor envisioned. Neither project developed an effective, robust system to link HIV-positive clients to the continuum of treatment, care and support.

Question 2: What are each project's strengths, weaknesses, and gaps in planning, management, routine data use, and service delivery?
Although the evaluation documents several weaknesses***, both projects had more strengths than weaknesses.*** Angaza Zaidi implemented a strong program, earned the trust of the public, and had great working relationships with the Government of Tanzania at all geographic levels. UHAI-CT participated in the development of learning materials for lower-cadre health staff, and provided technical assistance to the revision and translation of PITC Monitoring and Evaluation (M&E) tools and standard operating procedures (SOPs). The National Acquired Immunodeficiency syndrome (AIDS) Control Program (NACP) commended their efforts particularly during the country's transition from SD Bio Line. However, neither project created or fostered a culture of data use.

Question 3: How did each project strategically use different HTC modalities to achieve its goals and objectives?
All of the HTC modalities play a significant role in increasing HTC and reached different populations**.**

VCT, through Integrated VCT centers in health care facilities and Stand-Alone VCT centers, were effective in reaching populations concerned about their HIV status and willing to get tested. Community Outreach took counseling and testing services to the people and was effective at testing large groups of people. However, HIV prevalence data obtained suggests that ***the Community Outreach modality was not used strategically to target and test populations at high risk for HIV.*** Both projects have greatly contributed to the reduction of stigma associated with HIV, and the social and physical barriers to receiving testing and counseling.

Question 4: What are the lessons learned from successful interventions that merit continuation or replication, better practices, significant products and tools for possible dissemination and replication?

Key lessons learned by both projects include the necessity for a decentralized approach to project management, as it allows for more regular communication with key stakeholders and regular monitoring of project implementation. With UHAI-CT, the value of start-up support was highlighted as an additional key lesson learned. With Angaza Zaidi, creating linkages with other projects to provide more services to CT clients, or with other important organizations, such as churches, to create a friendly atmosphere for couples for HTC, were key to project success.

Question 5: Was each project able to successfully refer newly identified HIV-positive clients to HIV care and treatment facilities? What systems were used for these referrals?

While both projects referred HIV positive clients to care and treatment, neither project created a robust, traceable linkage system to ensure HIV+ clients are linked to care and treatment. This resulted in a misalignment of HTC along the continuum of prevention, care and treatment, with a number of missed opportunities for linking clients who test positive for HIV to treatment and care.

Question 6: How has each project built capacity and/or institutionalized its practices to heighten opportunities for sustainability? Were these efforts successful?

Both projects made measurable progress towards building capacity of local institutions and institutionalizing practices. Of all modalities implemented by Angaza Zaidi, Integrated VCT modality, which make up 85% of all of its facilities, seem to be the most sustainable, as facilities are owned by the government or private organizations and staffed by health facility personnel. UHAI-CT has solidified the necessary infrastructure, including training and M&E, for PITC, and 12 districts from 6 regions have included PITC in their budget since 2011.

CONCLUSIONS

The evaluation team concludes that both projects met many, but not all, of their objectives and targets. Although the evaluation documents several weaknesses, both projects had more strengths than weaknesses. While all of the HTC modalities played a significant role in increasing HTC and reaching different populations, they were not used strategically to reach populations at high risk. Among a number of key lessons learned by both projects is the necessity for a decentralized approach to project management in Tanzania to facilitate project monitoring, communication, and stakeholder engagement. Neither project created a robust, traceable linkage system to ensure HIV-positive clients are linked to care and treatment. However, both projects made measurable progress towards building the capacity of local institutions and institutionalizing practices for HTC.

RECOMMENDATIONS

At the programmatic level, we recommend that future projects in HTC:

- Strategically increase opportunities for counselling and testing, particularly among key populations, by using all modalities and with continuous monitoring of data;

- Strengthen capacity of the Ministry of Health and Social Welfare (MoHSW) for maximal implementation of PITC within the current system;
- Develop smooth and functional HTC- Care and Treatment Clinic (CTC) linkage system with active feedback loop;
- Adopt a proactive, innovative and flexible approach to project implementation that considers the changing landscape of HTC globally and nationally.

At the Policy level, we recommend strategic diplomatic negotiations between USAID and NACP to:

- Create change in existing policy to allow non-health counsellors to perform testing and counselling;
- Ensure stronger engagement throughout the continuum of project implementation;
- Facilitate rapid scale-up of successful interventions by enabling continuous sharing of innovations and lessons between United States Government (USG) projects and by promoting product security

INTRODUCTION

PURPOSE

IBTCI conducted an evidence-based performance evaluation of two USAID-funded HIV Testing and Counseling (HTC) projects: "Rapid Scale-up of Innovative HIV Counseling and Testing Approaches on Tanzania Mainland," known locally as Angaza Zaidi (EN: "to shed more light"), implemented by AMREF and its partner and Management Science for Health (MSH); and Universal HIV/AIDS Intervention for Counseling and Testing (UHAI-CT), implemented by Jhpiego and its partners Africare and the Tanzania Marketing and Communications Company (TMARC).

AUDIENCE

The aim of this performance evaluation was to provide USAID/Tanzania, The Government of Tanzania, and other in-country stakeholders with an objective, independent assessment of the efficiency and quality of the performance of these two projects at the national, regional, facility and community-based service levels. It identifies achievements, implementation gaps and challenges; documents lessons learned and best practices; and provides key recommendations for future programming.

EVALUATION QUESTIONS

Main questions for this program evaluation were the following:

1. Has each project achieved its stated goals and objectives?
2. What are each project's strengths, weaknesses, and gaps in planning, management, routine data use, and service delivery?
3. How did each project strategically use different HTC modalities to achieve its goals and objects? Were these modalities effective in reaching the target populations? What are the lessons learned from successful interventions that merit continuation or replication, better practices, significant products and tools for possible dissemination and replication?
4. Was each project able to successfully refer newly-identified HIV-positive clients to HIV care and treatment facilities? What systems were used during these referrals?
5. How has each project built capacity and/or institutionalized its practices to heighten opportunities for sustainability? Were these efforts successful?

In order to answer these evaluation questions and to provide the appropriate recommendations at the conclusion of the evaluation, USAID/Tanzania provided a prioritized list of questions under four major themes for the evaluation team to consider: Program Management, Program Accomplishments and Results, Monitoring and Evaluation, and Lessons Learned. More details can be found in the Evaluation Statement of Work in Annex I.

BACKGROUND

The Inception Report, included as Annex II, provides a detailed background on the status of the HIV epidemic in Tanzania, HIV counseling and testing, as well as a full description of the two projects being evaluated. A summary of key points follow:

Similar to other countries in the region, the HIV epidemic in Tanzania is mature and generalized, with an estimated 1.4 million Tanzanians living with HIV and 86,000 deaths yearly. Data indicate a statistically significant decline in HIV prevalence in recent years for all ages 15 to 49 (from 5.7% in 2007-08 to 5.1% in the 2011-12 Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS)). Notably, prevalence is nearly twice as high among women as men (6.2% vs 3.8%), and in Zanzibar, prevalence is nearly three times as high among key populations, specifically people who inject drugs (PWID), female sex workers (FSWs), and male sex workers (MSWs) who have sex with men (MSM) — 16.0%, 10.8%, and 12.3% respectively (THMIS 2011/2012). Progress in preventing new HIV infections is mixed. Knowledge about HIV and how it is spread has greatly increased over time, though in-depth understanding remains low. Testing rates have dramatically increased, from 37% of women in 2007 (THMIS 2007/2008) to nearly two-thirds, or 62.5% in 2012 knowing their HIV status, and nearly half of all men, or 44%, knowing their status, compared to 27% just a few years earlier (THMIS 2011-2012). However, this does not seem to have an impact on incidence of new HIV cases, as estimated prevalence among those ages 15 to 19, often used as a proxy measure for incidence rate in the general population, remains steady at 1% in both THMIS 2007/2008 and 2011/2012.

USAID remains a key partner to the Government of the United Republic of Tanzania in its fight to control the spread and reverse the course of the HIV epidemic in the country. As one of the original 14 countries targeted in President Bush's Emergency Plan for AIDS Relief (PEPFAR), the US Government's support to Tanzania has enabled a dramatic increase in the number of adults and children accessing Anti-Retroviral Treatment (ART), with approximately 364,000 individuals receiving treatment as of 2012. Also by 2012, a total of 3.37 million individuals sought HIV testing and counseling and received their results. As many as 1.1 million pregnant Tanzanian women have been counseled and tested to prevent mother-to-child transmission of HIV (PMTCT), and 526,000 orphans and vulnerable children (OVC) received support.

USAID's strategic objective for HIV/AIDS for the periods 2005 to 2014 is "to reduce transmission and impact of HIV/AIDS in Tanzania", with four specific intermediate results (IR). The first IR is improved HIV/AIDS preventive behaviors and social norms; IR2 is increased use of HIV/AIDS prevention to care services and products; IR3 is improved enabling environment for HIV/AIDS responses from community to national levels, and IR4 is enhanced multisectoral response to HIV/AIDS. In 2008, USAID procured two HTC projects, Angaza Zaidi and UHAI-CT, both with indicators and targets aimed at contributing to IR2. With a total five-year budget of $32.8 million USD, these two projects account for more than one third of PEPFAR funding in support of HTC in Tanzania.

AMREF – ANGAZA ZAIDI

AMREF was awarded a national five-year (July 2008-July 2013; extended through May 2014), $16.3 million USD project, under Cooperative Agreement Number 621-A-00-08-00018-00 with its partner Management Sciences for Health (MSH) titled "Rapid Scale-Up of Innovative HIV Counseling and Testing Approaches in Tanzania Mainland", also known as Angaza Zaidi, a Swahili phrase that means "shed more light." The primary goal of this project is to improve the health of Tanzanians by ensuring that they know their HIV status, take steps to protect themselves, and have better quality of life if infected. The Angaza Zaidi technical approach uses three modalities: integrated voluntary HTC, stand-alone HTC, and community-based HTC. Implementation is guided by strategies of targeting;

decentralization and community engagement; branding; partnerships and sub-granting; advocacy; and counseling and testing systems strengthening.

The major goal of the project is to reach 2.3 million Tanzanians with quality HTC services and inform them of their sero-status. The project focus is on the general population and hard-to-reach populations in the community setting. Currently, Angaza Zaidi operates in 42 sites, including 36 Integrated VCT and 6 Stand-Alone VCT sites in 18 regions in Tanzania mainland. Regions are subdivided into intensive and basic support sites. Intensive sites receive substantial financial and technical support compared to basic support partners/regions. There are 12 intensive support regions (Dar es Salaam, Mwanza, Mara, Kilimanjaro, Arusha, Iringa, Njombe, Mbeya, Rukwa, Ruvuma, Mtwara, Lindi), and six basic support regions (Morogoro, Tabora, Manyara, Dodoma, Kigoma, and Singida).

JHPIEGO – UHAI-CT

Jhpiego was awarded a national five-year (July 2008-July 2013; extended through May 2014), $16.5 million USD project titled the Universal HIV and AIDS Intervention (UHAI, which means "life" in Swahili) for Counselling and Testing "UHAI-CT", under Cooperative Agreement Number 621-A-00-08-00019-00 with its partners Africare and the Tanzania Marketing and Communications Company (T-MARC). The primary goal of this project is to increase access to testing and counselling services to Tanzanian families, couples, and individuals, particularly those at high risk, and to link those found to be HIV-positive to relevant HIV care, treatment, and prevention services. The UHAI-CT technical approach is guided by the principles of innovation, rapid expansion, diversity of strategies, quality, sustainability, strong links to HIV care and treatment and cost effectiveness. UHAI-CT activities are implemented using two modalities: PITC, and Community Outreach.

The major goal of UHAI-CT was for 1.2 million Tanzanian clients, including adults and children, to be counseled, tested, and given their results. The project focus is on the general population at health facilities and key populations at hot spots in four regions: Iringa, Njombe, Tabora, and Dodoma. The Evaluation Team visited three of these regions: Iringa, Njombe, and Tabora.

METHODOLOGY

METHODS

A team of four consultants, including two international and two Tanzanian professionals, conducted the HTC performance evaluation: Mr. Charles Llewellyn, Team Leader, Mr. Gary Leinen, an international Technical Advisor, and two local Technical Advisors, Mr. Masejo Songo and Ms. Neema Matee. Responsibilities of each of these individuals are outlined in the Inception Report (Annex II). The main data collection took place between late October and early December 2013. At IBTCI headquarters, Dr. Rachel Jean-Baptiste provided oversight to the evaluation process and took over leadership in drafting the report and disseminating results to stakeholders in January 2014.

A summary of evaluation methods is provided here (full details provided in Annex III). The team used a cross-sectional design to evaluate the two projects and collected data using a mix of qualitative and quantitative methods. These included a review of project and country documents as well as published, peer reviewed journal articles on HCT modalities; key informant interviews with stakeholders including representatives from each of the projects, USAID (in Tanzania and in Washington), regional and district health officials, community leaders, and select providers of HCT services from the full range of HCT modalities; interviews with HIV counselors; focus group discussions (FGDs) convened within the communities targeted by the two projects; and facility audits to document availability of services, materials and privacy in select HCT facilities, as well as to

gain a deeper understanding of referral mechanisms, if any, that are consistently used (Data Collection Tools can be found in Annex IV).

The team conducted exit interviews with clients of both projects who had just used services in order to assess their actual counseling experiences. All modalities were represented. This questionnaire included 32 questions, of which 4 described the client's experience before getting tested, 3 were open-ended follow up questions, and the remaining 25 focused on the counseling experience, privacy, trust and rapport with the counselor; confidentiality and disclosure; and advice and information provided. The majority (18) of the 25 questions on the counseling experience were yes/no, while the others provided three choices. Each response was weighted with a numerical value (see Annex V), and a Client Quality Score was developed by totaling the questions. Reliability Alpha was calculated and, after further adjustment, 21 questions remained in the Client Quality Score with an Alpha reliability of 0.78. The team summarized scores for each HIV testing modality and used bivariate analyses to test for statistically significant differences. All data were collected in six regions: Iringa, Njombe, Tabora, Tanga, Kilimanjaro, and Dar es Salaam. These regions were selected after discussions with USAID, United Republic of Tanzania (URT), and implementing partners. Both projects overlapped in 4 of these 6 regions.

Sites within each region were randomly assigned. Site visits were conducted in both urban and rural locations. In each of these, a mix of service delivery modalities were visited. During site visits, evaluators gathered information on current practices and standards and data from staff, clients and other stakeholders.

The team analyzed qualitative data by key themes and used quotes from key informants to illustrate different opinions or underscore points of view across the populations being served. The team used descriptive statistics to describe the populations from whom data was collected, and cross tabulations to evaluate differences by type of facility, gender, age, and other important variables. Any statistical significance was determined using t-tests for continuous variables, and chi square for binomial or categorical variables.

LIMITATIONS

Several limitations were noted in the Inception Report, and below we re-emphasize two:

1. The performance of the two projects evaluated cannot, in any strict sense, be compared. Angaza Zaidi provides HTC services directly, has a focus on the general population and uses different modalities for HTC. UHAI-CT provides services through a model that engages health care providers to strengthen systems, focuses on populations with high prevalence, and uses different modalities than Angaza Zaidi. Given these differences, this evaluation did not attempt to reliably compare the projects' quality or efficiency. This report notes the role played by each project relative to the range of service providers and models in Tanzania and presents findings that may stimulate a national dialogue on the comparative advantages of the various modalities for HTC services in Tanzania.
2. Both projects are in the close-out phase, which means that some of their personnel have left to work on other projects. Where possible and when necessary, the former employees were located and contacted for interviews or to obtain information, but this was not always feasible.

FINDINGS, CONCLUSIONS, & RECOMMENDATIONS

FINDINGS

The team conducted 44 key informant interviews (KII), including project staff, heads of counseling services at facilities, District AIDS Control Coordinators (DACCs), District Medical Officers (DMOs), Regional AIDS Control Coordinators (RACCs), Regional Medical Officers (RMOs), and community leaders. Also interviewed were 27 counselors from a wide range of facilities and 108 clients using different testing modalities were given exit interviews to assess the quality of HTC from the user perspective. After data cleaning, data from 104 client interviews were included in the analyses. Additionally, the research team conducted 14 facility audits, 7 focus group discussions, including 2 with Council Health Management Teams (CHMT), 4 with Post Test Clubs (PTCs), and 1 with representatives from key populations. Table 1 below summarizes their demographic profiles.

Table 1: Description of Evaluation Participants

	Key Informant Interview (n = 44)	HTC Counselors* (n=27)	Client Exit Interviews (n=104)	Facility Audits (n=16)	Focus Group Discussions (7 discussions, 39 participants)
Age	N/A	N/A	32.4+/-11.5 (range: 19-67)	N/A	49.1+/- 5.6 (range: 38-58)&
Sex %(n)				N/A	
Male	52.3% (23)	14.8% (4)	54.8% (57)~		38.5% (15)
Female	47.7% (21)	70.4% (19)	41.3% (43)~		61.5%(24)
Level			N/A		N/A
Project	3				
NACP	2				
Region	7				
District	14	27			
Facility	7				
Community	8				
USAID/W	2				
USAID/Tz	1				
Modality	N/A				N/A
Integrated		21.4%(6)	11.5% (12)	18.8% (3)	
Stand Alone		21.4% (6)	13.5% (14)	6.3% (1)	
Mobile/outreach		17.9% (5)	54.8% (57)	--	
PITC		39.3% (11)	20.2% (21)	75% (12)	
Type of Facility	N/A				N/A
Hospital		22.2% (6)	13.5% (14)	43.8% (7)	
Health Center		25.9% (7)	8.7% (9)	31.3% (5)	
Dispensary		11.1% (3)	4.8% (5)	18.8% (3)	
VCT Centre		22.2% (6)	20.2% (21)	6.3% (1)	
Mobile		14.8% (4)	52.9% (55)	--	
Other		3.7% (1)	---	--	

**Counselors included 9 nurses, 3 midwives, 1 medical assistant, and 1 medical officer, among others, all of whom are facility-based*
~An additional four were interviewed as couples
&Data are only available for 12 participants, and do not include key populations, who were all between 19-27 years (See Annex VI)

Question 1: Has each project achieved its stated goals and objectives?

Angaza Zaidi had six main objectives:

1. *Greatly increase the number of Tanzanians who know their sero-status, have received counseling, and have been linked to relevant treatment, care, and prevention services.*
2. *Utilize new, exceptionally innovative and effective approaches to stimulate demand for and use of testing.*
3. *Ensure provision of high-quality HIV counseling and testing services, the scale-up of coverage, and greatly expand access to cost-effective counseling and testing (CT) services while ensuring that high-quality CT services are provided by skilled and/or accredited providers.*
4. *Build the capacity of local implementing organizations for sustainable delivery of quality, efficient counseling and testing services to ensure that sub-grantees have requisite technical and organizational capacity to offer quality CT.*
5. *Build and/or strengthen referral systems for achieving integrated networks of service and increased access to comprehensive HIV services that ensure referral systems are in place.*
6. *Support implementation of the national counseling and testing priorities at regional, district, and community services by supporting the URT to review and revise policies that hinder the uptake of CT services.*

Summary of Findings
The evaluation team found that Angaza Zaidi met objectives 1 to 4 and objective 6. However, the project did not ensure that referral systems are in place, and was unable to develop an effective referral system that systematically link its clients who test positive for HIV to the continuum of care and treatment services.

Overall Performance
Angaza Zaidi conducted 2,742,017 tests, exceeding the USAID target of 2.3 million set in their Performance Management Plan (PMP). Key informants energetically mentioned a number of innovative and effective approaches applied to stimulate demand for HTC:

"*House to house approach is good because you are sure to get family members. They have been doing outreach in churches, schools and events such as Mwenge day*" (KII with DACC.)

"*Angaza Zaidi were the first project to introduce the mobile [community] outreach which a lot of clients were reached, and those who live in remote areas where public transport was a problem*" (KII with a Head of Counseling and Testing at a health facility).

Throughout the governmental structures, from national to regional, to district, facility, and below, Angaza Zaidi is well-appreciated by its stakeholders. The NACP credits Angaza Zaidi with providing technical and financial assistance in developing the new National Comprehensive HTC Guidelines. RACCs and DACCs also credit Angaza Zaidi with helping them to ensure that their projects meet the national HTC guidelines.

Targeting Populations and Stimulating Demand
Angaza Zaidi project managers realized early that the key to reaching target populations within communities was to reduce stigma and ensure that people understand the importance of being tested.

The project used several innovative approaches to encourage people to test, and to improve acceptance of people living with HIV (PLHIV) by decreasing stigma within communities. As many as five of those interviewed as key informants mentioned the systemic creation of PTCs as having played an integral role in promoting HTC. The following quotes exemplify this:

"[Angaza Zaidi] focused on prevention and now people understand the importance of being tested. [There is] little need now to convince people to be tested. But stigma of AIDS is greatly reduced. Outreach activities have reached people that we professionally cannot reach because we have limitations" (KII with RMO).

"… the post-test clubs are the stimulants for other people to test for HIV, and support to others to eliminate stigma" (KII, Head of Counseling and Testing at a health facility).

Or, as another interviewee put it, "*with post-test clubs, more people got confidence and voluntarily show up for counseling and testing*" (KII with a Head of Counseling and Testing).

PTC members were also very positive about the impact of the club on their lives. When asked the reason they decided to join, their answers revealed a sense of acceptance, security away from stigma, both emotional and practical support, and an opportunity to educate their communities.

"*We decided to join club to meet friends to discuss on how to live positive and access various information about HIV and living with HIV. Also we discuss various development issues related to means to raise funds for living"* (FDG, PTC in Iringa).

"We decided to join the group for social security in which we come out of stigma, microfinance support, training and share experience to others"
(FDG, Kilimanjaro).

"*We decided to join the group for support from AMREF especially education, financial for instance in our club every three months, Tsh 300,000 is pooled in our account*" (FDG, Kilimanjaro).

"*They (Angaza Zaidi) have organized us about 54 members to establish small micro finance scheme whereby we are saving and get loans*" (FDG, Kilimanjaro).

"*We decided to join to educate the community about HIV/AIDS*" (FDG, Tabora).

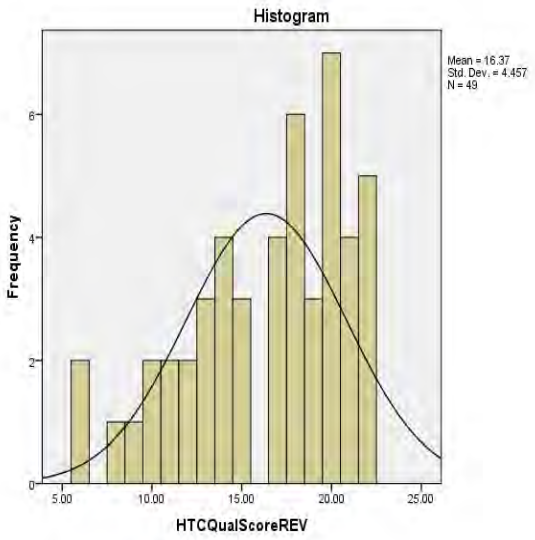
Other innovative approaches that were successful in targeting populations included integrating or referring CT clients to additional services, including male circumcision, family planning, gender-based violence counseling services, and STI diagnosis and treatment by leveraging projects implemented by AMREF and other partners.

Ensuring Quality

The Angaza Zaidi project has policies in place to ensure high quality programming through direct training and supervision of their partner Non-governmental Organizations (NGOs) and FBOs to increase their technical capacity to provide HTC services. Angaza Zaidi worked with NACP to establish accreditation criteria for HTC counselors, and to date, 328 of their partner NGO counselors have been accredited. Angaza Zaidi uses data monitoring, mystery clients, and client exit interviews to assure data and service quality, however, the data obtained are not systematically analyzed nor subsequently used. Periodically, they also conduct data quality assessments (DQAs) and changes are made based on those findings. Yet, as one key informant who had previously observed a counseling session noted, the quality of sessions delivered is questionable, with some counseling messages off topic and not reflective of populations being tested. An example was a session that placed emphasis on needle sticks and the use of clean syringes targeting the general population in Tanzania, whose risk profile does not include drug use. It is noteworthy that when

asked about the quality of their counseling, counsellors did not self-assess as stellar, giving themselves an average of 11.1(on a scale of 6 to 14, Table 4 below). Clients' perceptions of quality testing were similarly average. The team conducted exit interviews with 49 (of 104 total) clients who received HTC services that day from sites supported by Angaza Zaidi. This included 12 clients from integrated sites in hospitals, health centers, and VCT centers, 14 from standalone VCT centers, and 23 from community outreach sites. The team created an HTC Quality Score, as described earlier in the methods section. For Angaza Zaidi, average scores were 16.4 +/- 4.5, and ranged from 6 to 22. Below is a graphical depiction of the performance of this score for clients of Angaza Zaidi. (Figure 1).

Figure 1: HTC Quality Score for Angaza Zaidi



Bivariate analyses of the mean HTC Quality Score for this group (Angaza Zaidi only) found that clients with an elementary education and those with counseling sessions between 30 minutes to 1 hour had significantly higher perceptions of quality compared to their peers (18.1 +/- 4.9 vs. 14.2 +/-3.2; p=0.000; and mean = 18.8 +/-3.5 vs. 15.5 +/-4.5; p = 0.03, respectively). We did not note any statistically significant differences by modality or type of facility.

UHAI-CT had four objectives:

- *Rapidly increase access to quality HIV CT for all Tanzanians, particularly those populations most at risk for infection, as an entry point into the continuum of HIV/AIDS care and prevention;*
- *Develop providers' skills (professional and lay cadres) for quality HIV CT service delivery;*
- *Strengthen links to prevention, care and treatment services, including establishing community care and support for HIV-positive clients within HIV CT programs;*
- *Create demand for HIV CT by mobilizing underserved and most-at-risk populations.*

Summary of findings

The evaluation team found evidence to support the fact that UHAI-CT had increased access to HTC but did not systematically focus on populations most at risk. UHAI-CT exceeded its targets in number of providers trained, but did not regularly implement quality improvement systems or supportive supervision to institutionalize the practice of PITC within clinics. By the end of the project, UHAI-CT had not developed an effective referral system for linking clients who test positive for HIV to the continuum of care and treatment, and targets for demand creation were not met.

Overall Performance

By the time the evaluation took place, UHAI-CT had exceeded its target by 11.5% for the number of people tested for HIV (the actual number of people tested was 1,337,436 versus a 1.2 million target set in their PMP). More patients tested through PITC (872,030) than through community outreach (465,046). However, the team noted that they were less successful with other targets, including setting up PTCs (0 actual vs 27 target). They also awarded fewer sub grants to CSOs than planned (20 actual vs. 33), and reached only 68% of the targeted number of individuals with CT and

prevention messages through community outreach (465,406 actual vs. 681,000 target). Project staff informed the team that for the first three years, they focused on testing hard-to-reach populations. In particular, they focused on rural populations in Iringa and Njombe, two very high prevalence regions. Numbers begin to increase in years 4 and 5 once the focus changed to those most at risk, as did HIV yield.

Targeting populations and Stimulating Demand

The project's community outreach activities demonstrated flexibility by offering services in venues that ranged from peri-urban bars to village markets, to refugee camps, tents, and schools, among other sites. The team visited four community outreach events hosted by UHAI-CT and observed that some venues yielded a higher proportion of positives than others (Table 2).

Table 2: UHAI-CT Community Outreach Services Observed by the Evaluation Team

REGION	LOCATION	# TESTED	# POSITIVE	HIV PREVALENCE	Regional Prevalence
Iringa	Urban bar	269	45	16.7%	10.9%
Iringa	Village	119	30	15.1%	10.9%
Iringa	Village	115	4	3.5%	10.9%
Tanga	Fish Market	99	1	1.0%	3.5%

Notable is the outreach conducted in the bar in an urban center of Iringa that had to be extended from one to two days due to the demand it created. The team noted strong community engagement, with the community leader urging his citizens to come and get tested, and a bar owner very pleased about this temporary increase in clientele. That night, clients included several bar regulars and a few sex workers and other vulnerable populations, but mostly working class neighbors. The general atmosphere of the outreach was jovial, with a large colorful banner outside (with appropriate branding) and UHAI-CT t-shirts distributed to those who tested. Clients at this site and others commented that they prefer to get tested through outreach because of higher 'confidence' and 'respect'. They also said they liked the overall atmosphere generated by a public outreach, where there were lines of people queuing to be tested. Many said they found it easier to decide to test in a group setting versus an individual setting.

Nevertheless, the evaluation found that UHAI-CT did not systematically target those most at risk. For the first three years of project implementation, Counseling and Testing services were only offered to 226 persons considered most at risk because outreach activities targeted those hard to reach, not necessarily most at risk. However, this comprised the number and type of people they were eventually able to reach and test, and over time it became evident that those living in the rural areas of these regions were not necessarily high risk populations. Numbers begin to increase in years 4 and 5 once the focus changed to those most at risk; results for years 4 and 5 show a dramatic increase in the related targets (i.e. 18,685 key populations reached by the end of year 5, compared to 226 reached by the end of year 3). These results are summarized in Table 4 below.

Table 3. HTC among High Risk Populations Conducted by UHAI-CT

		Tanga (regional HIV prevalence from THMIS 2011/12: 3.8%)	Njombe (regional HIV prevalence from THMIS 2011/12: 15.4%)	Iringa (regional HIV prevalence from THMIS 2011/12: 10.9%)	Tabora (regional HIV prevalence from THMIS 2011/12: 5.8%)	Total MARPS	

		T&C	Positive	T&C	Positive	T&C	Positive	T&C	Positive	Tested	Positive	Rate of MARPs Positive by %
	CS/ FSW	4075	259	1647	72	7479	1317	3718	133	16919	1781	**10.5**
	MSM	297	47	0	0	0	0	36	5	333	52	**15.6**
	IDUs	901	79	37	18	425	139	70	11	1433	247	**17.2**
	Total	**5273**	**385**	**1684**	**90**	**7904**	**1456**	**3824**	**149**	**18685**	**2080**	**11.1**
	HIV Prev		7.301346		5.344418		18.42105		3.896444		11.13192	
	Source -UHAI-CT Annual report FY2013											

Ensuring Quality

UHAI-CT's quality assurance plan for community outreach followed established NACP HTC guidelines for community-based outreach activities for HTC. The team noted that the quality of counseling and testing remained consistent, despite differences in venues, although availability of behavior change communication (BCC) materials varied. For PITC, UHAI-CT support to the MoHSW included training providers according to existing guidelines, initially providing training-of-trainers for approximately 20 health providers from 5 to 8 facilities per region. They planned to conduct supportive supervision approximately after 1 month, and again after 6 months using supervision tools developed by the MoHSW, but this was not always the case. After the initial supervision visits, RACC and DACC were expected to organize further trainings until all health workers have been trained. Noteworthy is that UHAI-CT reported training 3,579 providers, exceeding the target of 3,500 trained by the end of the project. UHAI-CT's quality improvement plan included quarterly supportive supervision, together with district and regional staff, but supervision visits were not regular. As noted by several DMOs:

"*I saw them once last year, never again*" (KII, DMO).

"*UHAI-CT visited our focal person once in 2012 and none this year. Last year they looked at quality of data, but not at all facilities providing PITC. They asked how many providers providing PITC, but did not provide technical assistance to the HTC focal person*" (KII, DMO).

"*Effort has been made to support PITC but need to strengthen trainings, for example trained one TOT at regional level. No refresher, and monitoring has not been done regularly*" (KII, DACC).

Another DACC expressed frustration with their lack of involvement in the planning process for supervision and follow up:

"*The challenge is that no refresher training for follow up. Very rarely we are involved in planning*" (KII, DACC).

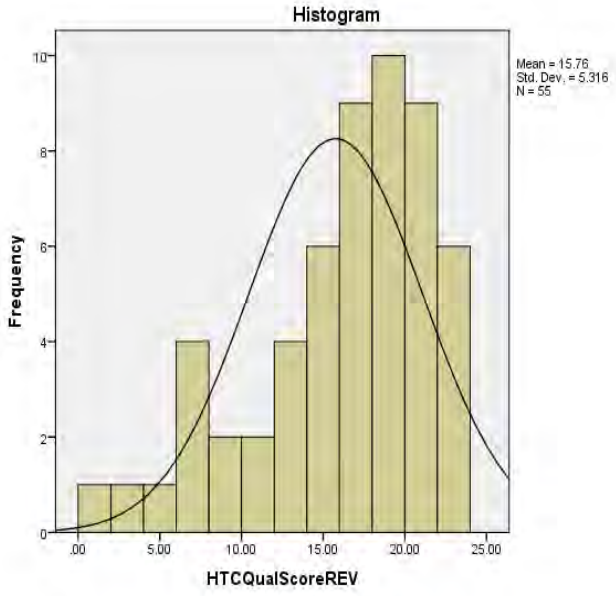
The team did not observe any trainings or supportive supervision in the field, but a number of interviews with RACCs and DACCs revealed that the project made efforts to maintain and improve the quality of PITC. One DACC reported on UHAI-CT's important role in assisting with the collection of PITC data, while another enthusiastically credited UHAI-CT with training of health staff that institutionalized PITC and supportive supervision within the region, though frequent district and regional staff turnover negatively impacted quality and continuity. Another DACC commented on the impact of supportive supervision, saying:

"*UHAI-CT came twice and helped with supportive supervision. I learned something about supportive supervision from UHAI-CT*" (KII, DACC).

UHAI-CT did have a measureable and positive influence on data quality, however. Specifically, they provided ongoing support to the Ministry to develop the data infrastructure needed to better document care processes, including differentiation between the various HTC modalities (PITC, VCT). Their efforts targeted the districts, and they helped a number of districts improve the proportion of monthly reports they received from facilities. One of the interventions that supported this activity was the Data Summit. While these were not held quarterly as envisioned, districts would gather together at least once per year, use a checklist to review data they obtained from facilities, and create action plans for making improvements. For example, using this method, the project documented improved access to PITC in one district in Tabora Region. During the Data Summit in 2010, only 75 facilities reported providing PITC. District officials created an action plan. By the next Data Summit one year later, a total of 139 facilities reported offering PITC, and by 2013, there were a total of 182 facilities offering PITC services.

To understand the clients' perspective of the quality of services they received from the UHAI-CT project, the evaluation team conducted exit interviews with 55 (of the total 104) clients who received HTC services that day from sites supported by UHAI-CT: 24 clients from outreach services, and 21 from PITC. An overall presentation of their results from the HTC Quality Score is presented in Figure 2 below. For UHAI-CT, the average score was 15.5+/- 4.8 on a scale of 1 to 22, demonstrating that clients mostly rate their experience with testing and counseling in facilities supported by the project as average. The score indicates that they did not have a great experience.

Figure 2: HTC Quality Score for UHAI-CT



Bivariate analyses of the mean HTC Quality Evaluators found that clients in this group scored significantly higher if their waiting time was less than 30 minutes (mean = 17.2 +/- 4.4 vs. 12.3 +/- 5.5, p = 0.005), and if they received individual as opposed to group counseling (16.7 +/- 5.3 vs. 13.8 +/- 4.8, p = 0.04). There were no differences noted by facility type or HIV testing modality, age, gender, marital or education status. And unlike participants in the Angaza Zaidi project, the length of the counseling session did not influence perceptions of quality of UHAI-CT's clients.

Question 2: What are each project's strengths, weaknesses, and gaps in planning, management, routine data use, and service delivery?

Angaza Zaidi

The current Angaza Zaidi project is a follow-on to an earlier project (Angaza) also led by AMREF that is credited with bringing widespread HTC to Tanzania and helping to reduce HIV-related stigma in communities. Thus over the past decade, Angaza has developed a strong brand, synonymous with quality and privacy in counseling and testing, and has gained unparalleled acceptance, as mentioned by several types of interviewees working in different locations, from health facilities, to districts and

regions.

"*Most clients who test positive in other partners are coming to Angaza for confirmation and referral*" (KII, Head of HTC).

"*Angaza Zaidi has an excellent reputation in the community. People trust and come for CT, increasing coverage*" (KII, DACC).

"*The community accepts Angaza Zaidi because of its approach of ensuring privacy and commitment*" (KII, DACC).

"*Angaza was first HTC project in Tanzania. AMREF is known and trusted by the community for testing. The majority of people like it*" (KII, DMO).

"*Angaza Zaidi is very active and focused on the business, they have got big trust from the community and AZ has become a household name for matters related to HTC*" (KII, DACC).

"*Most people think that with Angaza you are sure of confidentiality, for this reason many has trust on services provided*" (KII, RACC).

In addition to this strong history of performance, another key strength of this project is that it promotes the use of MoHSW tools to strengthen capacity, and supports this through tailored technical assistance, training, and supportive supervision. The project employs a number of quality assurance methods such as mystery clients and client exit interviews to identify needed improvements. When asked, KIIs listed the key strengths of this project as follows:

- Decentralized management of zonal offices which encourages local problem solving, capacity building and coordination;
- Participation of counselors and district officials in the development of yearly plans;
- Training counselors and ensuring their highest potential through supportive supervision;
- Innovative approaches such as house-to-house counseling and testing, use of expert clients to support those newly-tested HIV-positive persons;
- Provision of high-quality services through various avenues and in accordance with national guidelines;
- Excellent relationship with the government, working cooperatively and as a team.

A major weakness of the project, however, was limited use and reliance on programmatic data to implement decisions. Project staff noted that healthcare providers are able to use data for forecasting needs for HIV test kits, and that reports are submitted regularly from facilities to districts. At the service provider level, the team noted very little use of data for decision making, yet data is being collected and many providers say that their collected data is passed on regularly to the district level. Of all district persons interviewed, however, only two mentioned that they use the data to make any decisions, but others say they forward their data to the regions. Project staff did not report regularly using the data to guide community outreach, nor to check for saturation levels of other HTC modalities.

Other weaknesses observed were more health systems-related. Unreliable logistics and supplies—including test kits for all HTC as mentioned by thirteen KIIs from the regional, district and facility levels, and all staff interviewed from both projects—has created an air of uncertainty and hindered progress in Tanzania. Recent stock-outs were partially caused by the NACP withdrawal of the SD Bio Line test kit from Tanzania in December 2011. Replacement test kits were slow to arrive, and the NACP required half-day training on new algorithm for all testers. AMREF was able to mitigate this lack of test kits in the Angaza Zaidi project by requesting and receiving a waiver from USAID to procure test kits from the USAID-supported Supply Chain Management System (SCMS) project. These kits, once delivered, allowed them to continue functioning. Some kits were "loaned" to

RACCs to allow public service facilities to continue testing. These were greatly appreciated by the DACCs interviewed.

Because staffing of the Integrated VCT Centers is dependent upon the MoHSW for human resources, the project is vulnerable to the instability created through poorly planned reassignments of trained counselors to other activities or other geographic areas. While the Angaza Zaidi project views their training of new MoHSW staff as increasing the ministry's capacity, this disruption in deployment does not support consistent capacity at facilities or sites. The team also observed problems with project reporting, which differs between VCT (client-initiated) and PITC in VCT centers, noting that the project does not have a good system in place to prevent inaccurate categorization.

UHAI-CT

UHAI-CT has been USAID's main partner to the NACP for PITC, and as such, they have supported the NACP in laying down the infrastructure for PITC. This includes developing training materials, particularly for staff in lower-level health facilities, and actively participating in Task Forces and Working Groups on HTC in the NACP. The NACP recognizes the important role that UHAI-CT has played in expanding PITC widely in Tanzania, even under very difficult circumstances that included periodic stock-outs of HIV test kits. This was acknowledged in interviews with the NACP, who highlighted the role that UHAI-CT played in ensuring rapid and total coverage of the country when there was a need to train health care providers in implementing the new testing algorithm. UHAI-CT's role in the roll-out of PITC was also acknowledged by KII participants from the regional, district and facility levels. As several participants noted:

"Nowadays every health worker is a counselor. Even we can talk in the bars that 'why don't you come and test tomorrow'" (KII, RMO).

"*PITC is a new modality. Its effectiveness was questioned at first. Now clients prefer PITC over VCT. The Project contributed to the number of people who want testing*" (KII, DMO).

"*They introduced PITC in health facilities*" (KII, DMO).

While the feedback from the field is mixed about the quality of the working relationship between UHAI-CT and the Ministry in general, several participants noted good working relations with the government as a key strength, citing coordination meetings with DACCs to evaluate performance as an example. Government relations were strongest in the regions with UHAI-CT offices. Another strength of UHAI-CT was noted in the area of research and publications, as would be expected from a University-affiliated project. There is a wealth of academic knowledge on the UHAI-CT team, since many have led or participated in important research on HTC which will benefit the global HIV community in addition to Tanzania. Unfortunately, the results were not available for making improvements in this program.

UHAI-CT's strategy for engaging CSOs responsible for conducting the community-based outreach activity were impressive. This involved fostering a closer working relationship between CSOs and the districts and harmonizing the monitoring and evaluation of CSOs for HTC with that of health facilities so that they can be more easily absorbed by districts. Since the first grants were issued in 2010, CSOs were required to use the same reporting forms as health facilities for documenting HTC, and that reporting would be to the DACC. Before this intervention, CSOs did not report their HTC activity to the district, making it difficult for the DACC to capture all HTC activity. On the ground, the evaluation team observed the professionalism, enthusiasm and dedication that these CSOs put into controlling HIV in Tanzania by visiting four outreach events. In regions where Jhpiego had a physical presence, such as Iringa, the PITC and community outreach activities were noticeably stronger, branding was visibly present, and data management was reportedly improved. Credit has to be given to UHAI-CT for remaining steadfast despite several episodes of test kit shortages,

including the SD Bio Line recall in 2012. The NACP openly recognized efforts of UHAI-CT staff in ensuring mass training in the use of the new algorithm once new test kits were ordered.

The team did observe several weaknesses in project implementation. Despite meeting its targets, PITC performance was less than optimal. UHAI-CT reports that they were operational in 2, 532 facilities in the 9 regions where they work, yet their reach of 872,030 over the 5-year life of the project represents roughly 5 patients per facility per month. This certainly falls short of the NACP's vision for PITC to be part of the "standard of care" for all persons attending healthcare facilities, as established in the Guidelines for HTC in Clinical Settings in 2008. Data Summits were designed to facilitate review of monitoring data by districts and regions, and there were several examples where districts did act and made dramatic changes based on monitoring data presented at Data Summits sponsored by UHAI-CT. However, they did not take place with the regularity envisioned. Even in the example discussed earlier where in Tabore, the project was able to increase the number of facilities reporting PITC to the district through the Data Summit, they did not focus on increasing the number of patients who were offered PITC within each facility. When these results were discussed, the UHAI-CT team admitted that efforts to actively monitor results for improvement were irregular, thus the potential for making a substantive difference in project implementation was compromised.

According to the cooperative agreement, UHAI-CT's role is to develop capacity of MoHSW providers to ensure effective implementation of this PITC model. Yet general dissatisfaction was expressed by 6 out of 8 DACCs interviewed. They raised concerns either about inadequate number of facilities with staff trained in PITC, or in places where staff are trained, the inadequate number of health staff trained in PITC. One DACC summarized this by saying:

"*UHAI supported only 9 health facilities to provide PITC services, they could do more than that because we do have many health facilities that need that service*" (KII, DACC).

"Forty *service providers have trained from 6 health facilities out of 60 health facilities [in the district]*" (KII DACC).

"*We asked UHAI-CT for assistance in training but received no response*" (KII, DACC).

Another DACC raised the issue of staff turnover:

"*Trained GOT staff may be transferred…*" (KII, DACC).

The team found a number of inconsistencies between claims made during key informant interviews with the reality observed in the field. Relations with MoHSW officials in two regions where UHAI-CT claimed excellent partnerships were found to be non-existent, or severely strained. RACCs complained that no one had visited their projects in six months or a year, while UHAI-CT claimed that they had been visited quarterly. UHAI-CT has long boasted of its excellence in data management, but brief visits to several health centers showed gross errors in reporting. Because of the nature of purposive sampling, we acknowledge that we might have inadvertently observed outlier facilities which are not representative of the average performance across all facilities. However, the UHAI-CT team did concur that the plan for supportive supervision and quality improvement was not implemented with the rigor originally envisioned, thus explaining field findings.

Communications with USAID were inconsistent. There have been several Agreement Officer Representatives (AORs) assigned to UHAI-CT, and the PEPFAR environment in Tanzania, as in other countries, is challenging. However, in those circumstances it is even more important for projects to ensure that their project manager and other staff at USAID are very familiar with project implementation challenges and have a deep understanding and buy-in of possible

solutions. We also observed improper branding in some areas as required in the Cooperative Agreement. The CSOs operating in Iringa showed proper branding and behavior change communication (BCC) materials were available at community outreach sites. The CSO project in Tanga had much less support from UHAI-CT, and while staff at these CSOs had great enthusiasm and professionalism, there was no appropriate signage for the outreach event other than a hand-painted sheet which did not meet USAID branding and marking standards. BCC materials were not less available than what we had seen in other regions.

Nevertheless, it should be noted that throughout the life of this project, there were several periods of complete or partial stock-outs of HIV test kits that greatly affected its operation. In 2011, there were periods of complete stock-out of HIV test kits that lasted 3 months, and then a total recall of SD-Bioline test kits that lasted 6 months. Finally in April and May 2012, the NACP introduced a temporary algorithm, and UHAI-CT was instrumental in the rapid scale-up of training for using it. Towards the end of 2012, there was another severe shortage of test kits, during which time facilities were deciding on their own who should and who should not be tested. In addition, continued staffing shortages are also limiting the reach of this project. Such inconsistencies in availability of logistics, supplies, and necessary human resources for the implementation of PITC cannot be ignored for the impact they have had on continued, smooth functionality of UHAI-CT.

Question 3: How did each project strategically use different HTC modalities to achieve its goals and objects? Were these modalities effective in reaching the target populations?

Angaza Zaidi

In discussions with Project Leadership in Dar es Salam, staff reported that strategically, Stand-Alone VCT were based in high-risk, highly-populated areas with good visibility to potential clients. These types of facilities were used to attract people who self-identify as being at risk, perhaps because they are a member of one or more key vulnerable populations (e.g., CSWs, their partners, MSM, People who inject drugs [PWID]) and are willing to receive testing and counseling services. They also serve as a hub for outreach to neighboring communities. As a modality, community outreach was used to increase the number of people who receive HTC. It is a flexible modality, with potential to be highly effective in targeting groups including youth, commercial sex works, or other specialized groups. Integrated VCT, on the other hand, was used to capture people who may be coming to a health facility for other reasons also. The camouflage provided by having this modality within a facility helps to protect certain sensitivities around HTC, particularly among many clients who do not want others to know that they are getting an HIV test.

The evaluation team visited five Integrated VCT Centers in hospitals and health centers, four Stand-Alone VCT Centers, and two community outreach services supported by Angaza Zaidi. Angaza Zaidi field staff reported that, compared to other modalities, clients served by the Stand-Alone VCT Centers were more likely to be self-initiated and to be members of a key and vulnerable population, such as sex workers, MSMs, and people who inject drugs (PWID). Couple counseling was also reported more often from Stand-Alone centers. This was attributed to the religious affiliation of some of the Stand-Alone VCT center FBO partners that offer pastoral counseling to couples to get tested, although we did not see any centers directly co-located with churches.

With regards to Integrated VCT, the team observed that for a sizeable number of clients, testing was initiated by the healthcare provider. Discussions were held as to ways to differentiate this from PITC clients from outpatient and other departments referred for testing and counseling, with no clear resolution. All clients at Angaza Zaidi Integrated VCT Centers were documented in VCT books instead of PITC registers. Some of the Integrated VCT Centers offered additional health services, such as diagnosis and treatment of STIs, and family planning services.

The team observed that community outreach activities—while well-planned and organized—were not necessarily strategic in their targeting of high-risk populations. The best example of this is community outreach activities where, despite testing a relatively large population, HIV prevalence was nearly half of what is expected at the population level (summarized in Table 4). It should be noted that initially Angaza Zaidi did not have the mandate to target high-risk populations or to ensure community outreach services yield high proportions of those who test HIV-positive. Their objective was to stimulate demand for and use of testing, scale up coverage, and greatly expand access to HIV testing in the general population.

The table below summarizes cost, client perception of quality (Client Quality Score), and counselor self-assessment of quality (Counselor Quality Score) for each of the testing modalities implemented by Angaza Zaidi.

Table 4: Characteristics of HTC Modalities Used by Angaza Zaidi

	Total Expenditures	Individuals Tested	Positives Identified	HIV Prevalence	Expenditure per Test	Expenditure per Positive	Client Quality Score (range 1-22)	Counselor Quality Score (range 6-14)
Angaza Zaidi								
Stand-Alone VCT	$1,478,642	505,618	36,295	7.2%	$2.90	$40.70	17.7	11.3
Integrated VCT	$4,217,119	634,909	57,334	9.0%	$6.60	$73.60	17.1	10.7
Community Outreach	$6,715,536	1,601,491	46,879	2.9%	$4.20	$143.20	15.1	---

UHAI-CT

UHAI-CT's initial strategy for PITC in the nine regions in which they operate were to first establish PITC in facilities with CTC so that they could easily refer patients. The strategy was also to work with partners providing ART treatment and home-based care. Final selection of PITC facilities was done in collaboration with Districts, many of whom were concerned about the inclusion of facilities a bit further away. UHAI-CT's initial strategy for the Community Outreach modality was to reach harder-to-reach populations, and towards the last two years of the project, to reach those who were at greatest risk. Their strategy was to identify and work with CSOs local to the community who would, in coordination with District management, assess hot spots, and decide on which ones to focus for outreach activities.

Interviews with key informants from Jhpiego and review of the available data on persons tested through PITC in more than 2,000 facilities led the evaluation team to observe that less than 1% of patients seen at these facilities are offered counseling and testing by their provider. Instead of being considered standard of care as stated in the national guidelines, PITC is being used at times as a screening tool. This results in missed opportunities for diagnosis and eventual treatment and care of the very individuals that PITC is designed to find.

The NACP expected total coverage of the nine regions in which UHAI-CT is implemented, and highlight the fact that even now, they are not clear on how many facilities are covered under UHAI-CT. In interviews, they expressed their disappointment, but also admitted that it was never made clear to them from USAID what exactly they should expect from the project. UHAI-CT have participated in studies designed to evaluate ways of improving the effectiveness of PITC, results of which are forthcoming.

Table 5: Characteristics of HTC Modalities Used by UHAI-CT

	Total Expenditure	Individuals Tested	Positives Identifie	Expenditure per	HIV Prevalenc	Expenditure per	Client Quality	Counselor Quality

	s		d	Test	e Rate	Positive	Score (range: 1-22)	Score (range = 6-14)
UHAI-CT								
PITC	$8,134,015	872,030	78,987	$9.33	9.1%	$102.98	15.5	11.1
Community Outreach	$4,726,220	465,706	20,638	$10.15	4.4%	$229.00	15.9	10.9

With regard to the Community Outreach modality, interviews with project staff informed the team that, in the earlier years of implementation (years 1 to 3), CSOs focused outreach on hard-to-reach populations, and not on those most at risk. However, because the Cooperative Agreement explicitly requires UHAI-CT to target populations that are most at risk, the project changed course, re-oriented CSOs, resulting in a sharp increase in the number of key populations reached in years 4 and 5. According to UHAI-CT staff, outreach can be strategic in targeting populations that might not have availed themselves to VCT centers due to distance, perceived barriers to services, and social factors. UHAI-CT built capacity of CSOs for targeting key and other vulnerable populations, and the evaluation team observed community outreach activities which were targeting such groups as sex workers and clients. It is expected that effective targeting of key populations would yield higher HIV prevalence compared to the general populations. However, data presented in Table 4 above shows that only 4.4% of those who tested were HIV positive, lower than the estimated prevalence for the general population at 5.1% per the THMIS 2011/2012, and most likely due to misguided efforts in the earlier years of the project.

In a generalized epidemic like that of Tanzania, all four modalities have a role. Integrated VCT and PITC may be identifying patients who are already symptomatic, while community outreach may be reaching people who are still healthy, as summarized in a recent meta-analysis by Suthar AB, et.al, 2013. Nevertheless, results in Tables 4 and 5 suggest that Stand-Alone VCT, Integrated VCT, and PITC as HTC modalities were able to reach clients at risk for HIV, and yield a higher prevalence than found in the general population. Results for community outreach show that this modality was less effective for finding HIV-positive cases, and produced an HIV prevalence that is a little more than half of what is expected in the general population.

Question 4: What are the lessons learned from successful interventions that merit continuation or replication, better practices, significant products and tools for possible dissemination and replication?

Interviews with three stakeholders shed light on the fact that this project was designed in a different era of HIV prevention. At that time, PEPFAR was still focused on emergency response, and had an urgent need to identify HIV-positive individuals, hence, indicators focused almost exclusively on the number of people tested. Operationally, PEPFAR HTC projects tended to focus on the volume of people targeted, choosing areas and interventions (campaigns) where large groups of people were likely to accept being tested. Current PEPFAR guidance does not just focus on the total number of people reached, but also emphasizes making the linkages to care after someone tests positive for HIV. Future projects will need to consider indicators which measure these linkages as proxies to the level of quality of HTC services. While it may be unfair to judge projects in light of this shift in paradigm, one lesson learned is that implementers were not necessarily flexible to the changing priorities of USAID, and did not use data strategically to redirect efforts as indicated.

A related lesson learned from the two projects is that implementers were not analytical about the data produced and did not develop a deeper understanding of what might constitute potential red flags that required mid-course adjustments to projects. For example, results of community-based testing to high-risk populations should yield much higher prevalence than those of the general population. Yet in both projects it is clear that HIV prevalence from community outreach yielded prevalence significantly lower than that of the general population. A final lesson learned applicable to

both projects relates to the fact that systemic barriers—such as HTC commodity security and policy restrictions, including those that limit HIV testing to clinical personnel—are significant barriers to HIV testing and counseling in Tanzania.

Angaza Zaidi

There were a number of key lessons learned while implementing the Angaza Zaidi project. First, ***decentralized management*** led to higher quality of HTC. The project had 5 Area Support Offices (ASO) that coordinated activities for the 42 project sites in 18 regions. From field visits, the team observed the quality of HTC services was higher in areas with ASOs that provide regular supervision and in-service HTC training.

The project actively ***promoted income generating activities within PTCs***. Specifically, they helped PTCs to establish Village Community Banks for use by Post-Test Club members. These banks are owned by the PTC, and members are able to borrow funds from the bank, use it for income generating activities and pay it back with a low interest rate. To date, all 31 PTCs are engaged in some kind of income generating activity (the evaluation team saw a few of these in the field), and has great potential in keeping the group together once the project ends.

Another lesson learned is a 'couples-friendly' counseling environment positively facilitated counseling, testing and disclosure among couples. Angaza Zaidi worked to actively create such environments by working closely with religious organizations. A final lesson from this project is the power of ***leveraging other projects to provide more for CT clients***. The project created ONE STOP SHOP in one VCT center in Dar es Salam. Clients who come in for CT are also offered FP, GBV, and STI screening and treatment before they leave.

UHAI-CT

There were a number of key lessons learned while implementing UHAI-CT. The first was ***decentralized management***. The team found that having an office physically present within a region enhanced communications among the project's key stakeholders at the regional level and with the districts, strengthening working collaborations between the project and the various levels of the government.

Building on previous experience in Tanzania with PITC where training did not readily equate to service implementation, UHAI-CT promoted ***Startup Support*** to PITC at facilities. This process began during trainings, where providers agreed to perform certain tasks immediately upon their return and created an action plan to begin PITC. Within two weeks after the training, project staff visited the facility with a checklist (see Annex VII) used to evaluate the implementation of the agreed-upon action plan, as well as to get an overall sense about the facility, its human resources number and capacity, data management and M&E capacity, availability of necessary logistics such as test kits and other supplies, availability of guidelines. They also probed into how PITC was being implemented, whether pre-test counseling was done in a group setting, who initiated the testing, and activities that take place post-test. This Startup Support process greatly helped to jumpstart PITC, and was adapted by the Department of Reproductive and Child Health Services (RCHS) of the MoHSW in its implementation of Gender Based Violence (GBV) and Violence Against Children (VAC) activities (see Annex VIII).

Another important lesson learned is the increased efficiency and data reporting that resulted out of ***strengthening the links between CSOs and their district***. This resulted in CSOs receiving direction from districts and reporting HTC activities to districts using the same M&E process, including forms, as health facilities. Nearly half a million people received HTC through community outreach conducted by these CSOs, and if they were not using the same M&E system as health facilities and reporting to the districts, this information would be lost to districts.

Another key lesson that should be underscored is the role that key populations can play in recruiting and ensuring HTC is provided to others in their group. UHAI-CT, through CSOs, ***successfully engaged key populations such as MSM, CSWs, and PIWD to reach others***. They actively participated in community outreach, often serving as lay counselors.

A final lesson learned is the value of ***on-site training*** as an alternative to off-site training for larger hospitals where staff found it difficult to get away for any length of time. This was found to help overcome attendance barriers faced by many providers. Some of the benefits reported were the following: lower training costs (venue, per diem, and transport), higher coverage of hospital staff and less interruption of their work, and buy-in from the hospital management from the outset. However, it should be mentioned that interviews with NACP revealed that they do not encourage on-site training for HTC at this time.

Question 5: Was each project able to successfully refer newly identified HIV-positive clients to HIV care and treatment facilities? What systems were used to make these referrals?

Linking clients who test HIV positive to the continuum of care and treatment remains a challenge, and while both Angaza Zaidi and UHAI-CT referred their clients, neither were able to develop a system that tracks that referral to its point of completion. Both projects reported policy restrictions regarding patient confidentiality that prohibits identifying a HIV-positive individual and a major barrier to implementing any referral and linkages system for HIV-positive clients.

Angaza Zaidi

Project staff worked with an array of stakeholders to improve the existing referral processes for HIV, and referrals into the continuum of care for HIV-positive persons. Prevention services for HIV-negative persons, including male circumcision, condoms, family planning options, and STI symptomatic screening, are offered in all of its intervention modalities. The Angaza Zaidi staffs have also developed an inventory of providers of these services located in the area in collaboration with district and community leaders. The project worked with the NACP to develop the standard referral form and use it with a "coupon" system linked to the client by an identifying number, and used as part of its referral and feedback processes. These coupons are dropped into boxes installed by the project at Care and Treatment Clinics (CTCs), and partners are encouraged to periodically check these boxes to document whether the referred client has indeed received needed services. Unfortunately, program staff informed the evaluation team that partners do not check these boxes regularly.

Stand-alone VCT facilities work strategically with members of the PTCs to follow-up with clients who test positive. At sites with Integrated VCT, they also often escort patients who test positive for HIV to CTCs. The project has a list of all CTCs and works with clients to help identify the most appropriate location given their circumstances. Mobile service clients are encouraged to access supportive counseling while the mobile team is still in the area. However, if the client needs further services in the future, he/she needs to go to the static site for supportive counseling and referral guidance. The referral system is challenged by: clients not going to the CTC selected, not taking the referral slip to the CTC site, or wanting to attend a CTC site out of the region.

UHAI-CT

The RACCs and DACCs acknowledged UHAI-CT's support in improving referral linkages between HTC and CTCs, highlighting the fact that regular healthcare providers did not have any systems for linkage prior to UHAI-CT, and that now this is included in all PITC trainings. UHAI-CT also uses the national referral forms and has trained partner NGOs and PITC providers to use them, though most acknowledged the difficulty in providing referrals and ensuring follow-through in an anonymous program. While in theory this may work better within the same facility, the team observed that staff in outpatient departments found it difficult to escort patients to a CTC given the workload. For the

community outreach programs, we observed that follow-up and creating linkages to care is also challenging, particularly in isolated communities or with mobile populations. Jhpiego is participating in studies and pilots of various referral approaches, such as offering clients the possibility of waiving confidentiality to permit follow-up, but no universal solution has been found. The UHAI-CT project recently developed a tracking system, and tested it in four regions. This tool allows providers to track HIV-positive clients from testing to care and treatment, and encourages coordination between HTC and CTC providers. By the time of this evaluation, the results were fresh, and plans are in place to share them with the NACP.

Question 6: How has each project built capacity and/or institutionalized its practices to heighten opportunities for sustainability? Were these efforts successful?

The evaluation team found that both projects began thinking about sustainability from the onset of implementation. Both projects trained national NACP trainers to provide quality HTC using the Train the Trainer model. These trainers have since trained a number of others with funds from elsewhere. Both projects worked within existing infrastructure of the MoHSW, as opposed to creating parallel structures, especially for important functions like M&E, service delivery, and human resources.

Angaza Zaidi

Project staff proactively supported the Ministry in ways that will outlast Angaza Zaidi, and are leaving behind foundational infrastructure for future HTC activities. The NACP informed the evaluation team that Angaza Zaidi initiated discussions that led to the development of their Comprehensive Guidelines for HTC, now drafted, and soon-to-be-published. The integration of income-generating activities in PTCs as done by this project has enhanced sustainability of PTCs beyond Angaza Zaidi. Additionally, throughout the life of the project, staff have focused on building capacity of CSOs and FBOs with whom they work. Technical capacity has been built through training and continuous supervision. However, the project also actively engages CSOs and FBOs with their districts, thereby strengthening those bonds. Lastly, the project has enhanced the capacity of CBOs and FBOs for grants management and M&E.

We recorded a consensus from HTC stakeholder interviews that the Integrated VCT model has the best chance of continuing after Angaza Zaidi support ends, as the facilities are owned by the government or private organizations and staffed by health facility personnel. Indeed, 21 VCT centers were reported to have graduated from Angaza (the predecessor project) when the Project was turned over to Angaza Zaidi. Fourteen of these are still operating, including all nine of the Integrated VCT centers. Some Stand-Alone VCT Centers could likely continue after Angaza Zaidi ends, if they are partnered with large, well-financed NGOs/FBOs. They are greatly appreciated by the communities they serve. In one FGD, a member of a PTC stated "If USAID stops supporting this Project, many people will die." However, most stakeholders noted that the quality of HTC service would likely decline with the withdrawal of Angaza Zaidi support. None of the stakeholders interviewed felt that the community outreach activities would continue without continued financial and technical support.

UHAI-CT

UHAI-CT provided technical assistance to the NACP to develop the infrastructure for M&E to clarify, capture and document the number of clients who test using the various modalities offered, namely VCT, PITC, and Outreach CT. The project also influenced sustainable development at the district level. Through advocacy, 12 districts (in 6 regions) have integrated PITC into Comprehensive Council Health Plans due to advocacy from the project (4 in 2010; 8 in 2011). This has resulted in Councils using their own funds to train providers in PITC, something that can continue even when UHAI-CT is no longer around.

UHAI-CT's community outreach activities are implemented through CSOs. UHAI-CT has successfully improved the capacity of these organizations to manage their activities including organization, implementation, financial management, and proper reporting. However, with the exception of a few of the larger CSOs who have extensive financial resources, most of the activities would end if external financing was terminated. We did find that that UHAI-CT was successful in developing an on-site training approach for training facility-level service providers in HTC service delivery within the MoHSW. This approach is sustainable as long as sufficient URT resources are provided for quality supportive supervision.

Technical Issues

Evaluators note that the policy environment for HTC is quite favorable for establishing functional systems for linking HIV-positive individuals to care and treatment and monitoring their progress along the continuum of care. However, there were instances where projects were unaware of helpful policies. For example, since 2008, the NACP HTC policy has allowed for shared confidentially. As per the guidelines: ***shared confidentiality means that information is shared among health care providers dealing with the patient. Test results (positive results should be recorded) in the medical records/notes. It is important to make sure the patient/client understand the meaning of shared confidentiality in continuum of care.*** (*PITC Trainer Manual, 2009, pg. 383*). ***In clinical settings, shared confidentiality shall involve also the patient and relevant healthcare practitioners directly involved in providing care*** (*Guidelines for HTC in Clinical Settings, 2008, pg. 15*). The staff from both projects were largely unaware of these policies. They reported to the evaluation team the NACP policy on client confidentiality prevented disclosure to anyone and was the biggest barrier to their ability to develop a functional referral system.

There were other instances where the policy is favourable, but its implementation impractical. The NACP has used PITC as a standard of care since 2008. As per the official Guidelines for HTC in Clinical Settings, (2008, p. 3), "***The MoHSW has approved the adoption of PITC as part of the "standard of care" for all persons attending healthcare facilities***. (*Guidelines for HTC in Clinical Settings, 2008, pg. 3*). However, the evaluation team found that systemic barriers to the full implementation of this policy, such as lack of human resources as well as lack of test kits, were pervasive and resulted in many healthcare providers placing this policy with the more practical screening approach. UHAI-CT reported to the team that providers in fact made judgement calls as to which patients to test or treat with limited resources (test kits), and they reserved it for those who are the "most sick", though there is no algorithm to define or prioritize this population.

Lastly, there are policies that could be changed to better facilitate HTC in the future. One such policy focuses on who is allowed to conduct HIV testing. The current policy does not allow non-medical personnel to test clients for HIV. However, there are have been several recent meetings and discussions held within the MoHSW, concluding with a willingness to consider non-medical personnel conducting HIV testing if safety for both parties can be addressed. When this policy changes, it may greatly impact current bottlenecks created by insufficient human resources for HTC.

CONCLUSIONS

The evaluation team concludes that ***Angaza Zaidi and UHAI-CT projects successfully achieved many of their respective goals and targets***. Both projects intensively focused on counseling and testing, and this resulted in a large number of clients tested. Yet a lack of strategic focus in outreach activities for HTC resulted in lower than expected percentages of persons who tested HIV-positive. Together, these two projects contributed to more than 4 million people knowing their HIV status.
The team found that by training more than 3,500 healthcare providers in 9 regions where they operated, UHAI-CT supported the NACP in laying down the foundation for PITC. They

participated in the development of a number of M&E tools, and worked through CSOs and village leaders to sensitize clients to being offered testing and counselling services when they seek other health services. However, *PITC did not reach its potential***.** While UHAI-CT reports that they were operational in 2,532 facilities in the 9 regions where they work, only 5 clients per facility per month, on average, were ever offered HIV testing. Lack of test kits and insufficient human resources may have contributed, this nevertheless falls short of the NACP's vision for PITC as "standard of care" for all persons attending healthcare facilities, as per existing guidelines, and efforts from the project did not lead to substantive improvements in this area. Notwithstanding, among all models reviewed, PITC demonstrated one of the highest potentials for identifying HIV-positive clients.

Although the evaluation documents several weaknesses, both projects had more strengths than weaknesses. Angaza Zaidi implemented a strong program and had earned the trust of the public. They had strong working relationships with the Government of Tanzania throughout the continuum, from health facility to district, regions and national levels. This was facilitated by their decentralized management approach and their engagement of health facility counsellors and district officials in the development of the project's yearly work plans. They created PTCs, and used them strategically to decrease stigma and create demand for testing during community outreach. To sustain the PTCs, they fostered income generating activities. They also leveraged other AMREF projects to provide more services for their CT clients. However, a notable weakness was that the project itself, as well as the facilities it supports, had a culture of data limited to use for forecasting the number of test kits needed. In many occasions, operational data were collected but not analysed, hence insights into what to do to improve efficiency were forever lost. There were also some inconsistencies in documentation of Integrated VCT vs. PITC in Integrated VCT centers.

UHAI-CT also had great strengths. They led the roll-out of PITC in 9 regions, resulting in 2, 532 facilities offering PITC. They trained 3,532 providers, worked with village leadership to improve acceptance of PITC, and participated in the development of learning materials for lower-cadre health staff. They supported the revision and translation of PITC M&E tools and standard operating procedures. The NACP commended their efforts to support training of providers in the new testing algorithm during the period of transition from SD Bio Line. However, PITC did not meet its potential, reaching less than 1% of potential clients. They did not create a culture of data use, nor of continuous quality improvement. They also did not establish any PTC despite their Cooperative agreement stating a target of 30.

HIV prevalence data obtained suggests ***that HTC modalities were not used strategically to target and test populations at high risk for HIV.*** However, all of the HTC modalities play a significant role in increasing HTC and reaching different populations**.** Voluntary Counseling and Testing, through Integrated VCT centers in health care facilities and stand-alone centers have been shown to be effective in reaching populations who are concerned about their HIV status and are willing to make the effort to be tested. Community-based VCT takes the counseling and testing to the people and is shown to be effective at being able to test large groups of people, and by creating an atmosphere which encourages people to be tested through positive peer pressure. Both projects have greatly contributed to the reduction of stigma associated with HIV and of the social and physical barriers to receiving testing and counseling.

Key lessons learned by both projects include the necessity for a decentralized approach to project management. This allows for more regular communication with key stakeholders and regular monitoring of project implementation. With UHAI-CT, the value of start-up support was highlighted as an additional key lesson learned, while Angaza Zaidi, the value of creating linkages with other projects to provide more services to CT clients, or with other important organizations, such as churches, to create a friendly atmosphere for couples for HTC were key to project success.

Neither project created a robust, traceable linkage system to ensure HIV+ clients are

linked to care and treatment. Referrals and linkages were weak throughout project implementation, resulting in a misalignment of HTC along the continuum of prevention, care and treatment, with a number of missed opportunities for linking clients who test positive for HIV to treatment and care. It is worth noting that the technical complexity associated with strengthening linkages range from client-related issues, to health systems constraints, to implementers, to USAID/Tanzania, and even to PEPFAR/USG in Washington D.C. At the client level, acceptance of a HIV-positive status and availability of means (time, money, transport, etc.) to go to care and treatment facilities may play a role. Perceived stigma, though diminished through efforts by Angaza Zaidi, may still serve as a barrier to testing for HIV.

Both projects made measurable progress towards building capacity of local institutions and institutionalizing practices. UHAI-CT has solidified the necessary infrastructure for PITC. Specifically, a large number of providers have been trained by UHAI-CT in nine regions. UHAI-CT used these trainings to develop providers' skills for quality HTC service delivery, and used a new onsite training approach to facilitate such trainings given that the workload makes it often prohibitive for providers to attend offsite trainings. A number of M&E tools have been developed and clients are sensitized and accept the possibility of being offered testing and counselling services when they seek health services. Additionally, in 6 out of the 9 regions where they work, UHAI-CT has successfully advocated for PITC training and support to feature as a line item in budgets of Health Counsels. The result is that to date, 12 districts have funded health providers to receive PITC training. Angaza Zaidi's innovative efforts to sustain PTC through income generating activities are commendable. Both projects have strengthened the relationship between CSOs and FBOs with their District authority by creating opportunities for continuous dialogue, by ensuring that the work done by CSOs and FBOs add value to districts, and that districts are able to measure its value and strategically capitalize on their presence. The evaluation team concludes that these are all promising efforts towards sustainability.

Future projects can build on the successes of these two projects, learn from their innovations, and avoid some of the pitfalls and weaknesses they experienced. The evaluation team concluded that the current policy environment for HTC within the NACP is quite conducive, and could facilitate this process using these four modalities, as well as others. Legal barriers to disclosing a client's HIV status are non-existent, so long as the disclosure is done from one provider to another within the continuum of care. Knowing this, future projects are free to develop and test various models of robust linkages that serve the role of connecting patients to treatment, care and support. The policy for PITC is also conducive to its implementation, and changes in the policy that limits HTC to medical professionals could greatly influence its impact.

RECOMMENDATIONS

Results obtained by this evaluation are evidence that USAID and future projects will be well-placed to increase the number of people, including key and vulnerable populations, being tested and to develop functional, robust systems for smooth linkages to care. Implementation of all modalities can be further strengthened by applying modern methods for continuous quality improvement, particularly those that engage health care providers in resolving issues and increasing indicators using locally tested interventions. As exemplified by Angaza Zaidi, working closely with churches has potential for increasing couples testing, and leveraging other activities can maximally benefit clients of CT, particularly the youth. NACP would support any USAID activities toward these goals, as they summarize the majority of what the NACP shared when asked what they would like to see with the next round of funding from USAID. Movement in this direction would require interventions at the programmatic and policy level involving diplomatic dialogue between USAID and the NACP, and at times between USG and the NACP. We summarize key interventions below and provide reference to the peer review literature of similar work conducted in other countries (Annex V):

At the Programmatic level, we recommend that future projects in HTC:

- **Increase opportunities for counselling and testing, particularly among key populations.** Emphasis should be on Integrated VCT and PITC, and strategically targeted Stand-Alone VCT (hot spots, areas with high populations) in collaboration with PTCs. Community outreach should be emphasized if first time testers are the target (Suthar et al, 2013; Annex V). This can also be a power method for reaching key populations and testing them for the first time, as has been shown in a number of studies of MSM and PWID (Lahuerta M, et al, 2011, and DiFranceisco W, et al, 1998) (Annex V);
- **Strengthen capacity of the MoHSW for implementation of PITC in all facilities;**

Stakeholders agree that HIV test acceptance rates were high for those offered PITC, but the number offered PITC were very low. A recent study by Dalal et al (2011) reported PITC acceptance rates of 55%, and Integrated VCT acceptance rates of 31% in a clinic in South Africa (Annex V). In that study, top reasons for refusal were not having enough time (59%), being too sick (16%), or not interested (14%). Top reasons for accepting the test were having been tested previously for HIV (48%), thought their confidentiality would be protected (46%), or had ever been forced to have sex (58%). Thus in addition to focusing on provider capacity, efforts to strengthen capacity of the MoHSW to provide PITC should also include obtaining a deeper understanding from the perspective from potential clients of what motivates or demotivates their acceptance. Additional activities include pilot testing promising modalities from the STATUS study, and empowering providers to test, implement, and monitor local strategies to increase offering of PITC;

- **Strengthen efforts for continuous quality improvement of all modalities**. The philosophy of continuous quality improvement in HTC fosters curiosity among providers to understand how efficient they are working, whether or not they can be more effective, see more clients, provide them with better service, etc. Starting from the perspective of the client, such a philosophy encourages review of current processes, identification of bottlenecks, and developing changes to test initially on a small scale. Those that are successful can be scaled, and if facilities are engaged with each other, they can share innovative interventions to facilitate rapid spread across the country. This methodology has a proven history to improve service delivery in a number of diseases areas including HIV, and in a number of countries including Tanzania.
- Develop smooth and functional HTC-CTC linkage system with active feedback loop. In addition to developing the system, future projects should also identify factors likely to link clients to care from each modality. For example, a recent study by Hatcher et al (2011) suggest that other PLHA could serve as 'navigators', particularly for those who test HIV positive through community outreach (Annex V).
- Champion and strengthen capacity for HMIS for HTC (data collection on different modalities, strategic use of data, evidence-based decision making, etc.)
- Emphasize implementing partners' use of data for decision making, and that regular documentation of such be shared as part of their quarterly report. This should include the following:
    - Analysis of association between gender, educational background with PITC uptake, referral and enrollment into care;
    - Operations research that document and better understand outcomes of different modalities with regards to linkages to care, and eventual retention in care;
    - Adopt a proactive, innovative and flexible approach to project implementation;

At the Policy level, we recommend strategic diplomatic negotiations between USAID and NACP to:

1. Create change in existing policy to allow for non-health counsellors to perform testing and counselling;

2. Create change in existing policy that restricts access to HTC for adolescents;
3. Ensure stronger engagement throughout the continuum of project implementation;

We further recommend that USAID facilitate strategic diplomatic negotiations between USG and the NACP to: Facilitate rapid scale-up of successful interventions by enabling continuous sharing of innovations and lessons between projects; Ensure product security.

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FROM THE AMERICAN PEOPLE

EVALUATION

Performance Evaluation of USAID Testing and Counseling Projects in Tanzania

Annex Volume

February 14, 2014

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by Rachel Jean Baptiste, Charles Llewellyn, Gary Leinen, Masejo Songo, and Neema Matee of **International Business & Technical Consultants, Inc.** and Goodchance Mariki and Bahati Paul of **S.T. Associates**.

Cover photograph by Charles Llewellyn. A Community Outreach event conducted by Alpha Dance Group, a Non-Governmental Organization supported by UHAI-CT in the weekly market of Nzihi Village outside Iringa, Tanzania. During this one-day event 199 individuals were tested and 30 positive HIV cases were found and referred to Care and Treatment Centers. Group Counseling was held in the covered open area, and post-test counseling in the room with the door covered with a sheet. (Appropriate signage and branding was posted on an adjacent building.)

TABLE OF CONTENTS

ANNEX I: EVALUATION STATEMENT OF WORK

PERFORMANCE EVALUATION OF USAID TESTING AND COUNSELING PROJECTS IN TANZANIA

Purpose of the Evaluation

The main purpose of the evaluation is to assess the performance, including efficiency and quality, of two USAID-funded HIV Testing and Counseling (HTC) projects at the national, regional, facility and community-based service levels. With combined expenditures totaling between $5.0 and $6.5 million per year, these projects account for nearly half of all PEPFAR resources devoted to HTC.

It is expected that this evaluation will identify implementation gaps and challenges, propose recommendations for further improvement and direction for the remaining activity period, document lessons learned and best practices, and provide key recommendations that will inform future directions and the design of follow-on HCT projects.

The product of this evaluation will be one final report that evaluates each project's successes, shortcomings, and lessons learned over the past five years. It will be made available to the public. The report will include recommendations for improving USAID's assistance delivery in client-initiated and provider-initiated HTC in Tanzania and highlight comparative advantages in areas not addressed by other initiatives. Reported information will be disaggregated by gender, age, and geographic location when possible.

Evaluation Scope and Questions

Findings and recommendations will primarily be used to inform more strategic investments in the future focusing on sustainability and eventual United Republic of Tanzania (URT) ownership. The main questions for this project evaluation are as follows:

1. Has each project achieved its stated goals and objectives?
2. What are each project's strengths, weaknesses, and gaps in planning, management, routine data use, and service delivery?
3. How did each project strategically use different HTC modalities to achieve its goals and objects? Were these modalities effective in reaching the target populations?
4. What are the lessons learned from successful interventions that merit continuation or replication, better practices, significant products and tools for possible dissemination and replication?
5. Was each project able to successfully refer newly identified HIV-positive clients to HIV care and treatment facilities? What systems were used to these referrals?
6. How has each project built capacity and/or institutionalized its practices to heighten opportunities for sustainability? Were these efforts successful?

In order to answer these evaluation questions and provide the appropriate recommendations at the conclusion of the evaluation, the Mission provided a prioritized list of questions under four major themes for the evaluation team to consider: *Project Management, Project Accomplishments and Results, Monitoring and Evaluation and Lessons Learned*. A design matrix showing how each question will be researched is attached as Attachment 2.

- **Project Management**

  - Has the project established constructive working relationships with key stakeholders (USG partners, government, CSOs, private sector, etc.) to improve project outcomes?
  - Is USAID satisfied with communications with project staff? Is project staff satisfied with interaction with USAID? What improvements could be made for more effective communication?
  - Do work plans and budgets reflect project priorities? How are they used as project management tools?

2. Project Accomplishments and Results

- Did the project focus on the appropriate target population?
- Does the project have well-reasoned strategies to achieve its goals, objectives and indicators within the life of project given current knowledge about HIV/AIDS and the socio-demographic characteristics of the target population?
- If the project had changed and/or modified its strategy or priorities during the implementation phase, were the changes/modifications justified?
- Is there evidence that Angaza Zaidi and UHAI-CT-approach has:
  - Introduced and improved the quality and availability of HIV testing and counseling services at the health facility level?
  - Improved the quality of services at the community level?
  - Improved referral linkages between community and facility level and within the facility level?
- How cost effective has the project been? What is the approximate expenditure per person tested in each year of the project? Has this figure gotten lower over time?
- Are the testing modalities used appropriate for the epidemic Tanzanians are facing? Do HIV prevalence trends by year compare to the modality used, e.g. Stand-Alone VCT vs. PITC vs. Mobile outreach?
- How have the two project contributed in influencing HIV policy related to counseling and testing?
- What is the overall contribution of each of the projects to the overall national HIV prevention program?
- How effective are Angaza Zaidi and UHAI-CT's approaches to capacity building for local organizations? Has the project achieved its goals and objectives in this area?
- What have the projects done to implement sustainable activities? If project activities were not continued past May 2014, what activities would/would not continue to operate? To what extent would the URT have the systems and/or capacity to carry forward Angaza Zaida and UHAI-CT activities?
- Are the activities implemented by AMREF and Jhpiego in alignment with the National HIV/AIDS strategies?
- Have the project's collaborations and partnerships been successful? Does project partnership work to effectively use available skills of all partners? How has this project complemented work done under the other PEPFAR partners and avoided duplication?
- To what degree are URT and other partner's replicating/scaling-up project best practices and models from these projects?
- Is adequate technical leadership available among local project staff or from partner headquarter staff, consultants, etc.? Is headquarter staff or consultants used appropriately and judiciously?

3. Monitoring and Evaluation (M&E)

- Is the M&E plan being implemented and kept up to date? How are data being used by project management to make strategic and management decisions? With who are the data shared? How might M&E systems be improved?
- How successful have Angaza Zaidi and UHAI-CT been in providing valid and reliable strategic information? Is there a validation process in place to avoid duplication of reporting with other projects?
- How are the systems linked to and harmonized with the National M&E framework?

4. Lessons Learned

- Do the service delivery models used by AMREF and Jhpiego meet the needs of the target populations?
- What are the lessons learned from successful interventions that merit continuation or replication, better practices, significant products and tools for possible dissemination and replication?
- Assess project innovations in particular its success in strengthening partnership, scaling up HTC coverage, reaching HIV positive individuals, capacity building and integration of HTC services with district/Council HIV/AIDS plans.

5. Evaluation Timetable

The proposed timetable for the evaluation activities is attached as Attachment 1. The evaluation team anticipates having all research instruments prepared and tested by the fourth week in October 2013 and to have completed field work by the fourth week in November, in order to submit a draft report to the Mission early in December. The dissemination workshop will be provided in late January 2014.

ANNEX II: INCEPTION REPORT

(Please see separate attachment)

ANNEX III: EVALUATION METHODS AND LIMITATIONS

The Performance Evaluation of USAID Testing and Counseling (HTC) Projects in Tanzania was carried out in Tanzania over a period of two and one half months by a team of two international consultants and four national experts. The purpose was to conduct an evaluation of the USAID HTC program, including final evaluations of two USAID HTC Projects six months prior to their completion, and provide recommendations for future HTC programming. The evaluation used multiple qualitative and quantitative methods, including a review of program documents, visits to both implementing partners, AMREF for the Angaza Zaidi Project and Jhpiego for the UHAI-CT Project. The evaluation team also conducted a review of all relevant projects and URT policies and guidelines and World Health Organization reports and guidelines of HIV Testing and Counseling (HTC).

EVALUATION METHODS

The team of six was divided into two teams in order to cover four Regions: Iringa, Tanga, Kilimanjaro, and Tabora, and portions of Njombe Region. Fieldwork outside of Dar es Salaam took place over 23 days. The teams reassembled in Dar and visited clinics and HCT sites in the outlying areas of the capitol as well as conducting key informant interviews with national stakeholders, such as the NACP and project managers. See Annex III for a list of sites visited and persons interviewed.

During site visits, a series of 12 questionnaires were used to collect quantitative and qualitative data from the appropriate personnel and service delivery sites. A complete list of these instruments is found in Annex IV. All qualitative and quantitative data was analyzed using the CS Pro software program, which is also used by the NACP of Tanzania. Use of CS Pro allowed secondary analysis using the Statistical Product and Service Solutions (SPSS) and Excel.

Document Review Background documents, listed in Annex V, received from USAID/Tanzania, Angaza Zaidi, and UHAI-CT and other sources have been reviewed.

Routine Performance Data Present and past project-level data routinely collected by Angaza Zaida and UHAI-CT for their projects was reviewed and analyzed. The two projects have generated a considerable amount of data during the implementation period. The various data sources were triangulated to better support the judgments made by the Evaluation Team. In addition, site-level performance data was examined to answer specific questions related to the interview and FGDs conducted at that level.

Interviews and Focus Group Discussions Key informant interviews and/or focus group discussions with individuals and groups listed in Annex V.

Site Selection and Site Visits
Considerations for site selection were discussed with USAID and both implementing partners. Some were selected based on partner recommendations, and some on a random sample basis. Site visits were conducted at both urban and rural locations, and include the following regions: Iringa, Njombe, Tanga, Kilimanjaro, Tabora and Dar es Salaam. The sample includes a range of population and HIV-related characteristics. In each region, urban and rural pairs were sampled.
In each of these, a mix of service delivery modalities were visited. Site visits provided information on current practices and standards and allowed the consultants to talk with staff clients and other stakeholders. The focus of these visits included:

- What criteria were used in selecting community-based sites?

- Site specific data collection and record keeping processes
- Quality assurance and quality control practices
- Client information—how many clients do they see, how much time to they spend with each, are they meeting demand, do they see special populations like couples, children, or key populations?
- Service details: Where does the counseling take place within the site? Is it sufficiently private? How is pre-test counseling or information handled, and how is consent done? (This may vary between outreach and PITC.) Where does the testing take place and who conducts the rapid tests? How long do clients or patients usually wait to receive results? Is there a time difference for patients using mobile HTC?
- Are condoms available and disseminated? If not where would clients go to get them?
- How are referrals made and linkages tracked? How successful are referrals?
- How is data used by sites to inform decisions and improve services?

Data Sources Data sources varied according to each project's Monitoring and Evaluation Plan, but illustrative key sources of project data collected include:

1. National HIV counseling and testing guidelines
2. PEPFAR HTC technical considerations (for reference on PEPFAR standards)
3. Size estimates of key populations
4. HIV, STI, and behavioral surveillance data
5. Project-level formative & evaluation research
6. Monthly project reports and quarterly reports
7. Quality assurance surveys or reports
8. Government/donor/implementing partner project data (upstream indicators)
9. Behavioral Surveillance Survey (BSS) and/or project evaluation data
10. HTC site data

Data Collection Plan

National
The team conducted key informant interviews with USAID and other USG agencies, Angaza Zaidi, UHAI-CT, and URT representatives. The team focused on key policy and management personnel. Those conducted before the field research investigated broad lines of stakeholder involvement, communications, management, M&E and quality assurance systems, and data collection for measuring overall project accomplishments, while those conducted after the field research checked validity of field data and preliminary analysis of field research data. Pre and post fieldwork interviews were with different officers, depending on fieldwork findings. In addition, the team collected routine performance data to validate that provided to USAID.

Regional, District, and Local Field Research Procedures
The team was divided into two groups for purposes of field research. Each group includes one international consultant and two local experts: one provided by IBTCI and one provided by its local contractor, ST Associates. ST Associates was responsible for making local contacts for interviews and focus groups, for assistance with field data collection, for sending data back to offices in Dar es Salaam for data quality review and entry, and for preliminary data analysis. At each site visited, the teams completed the following data collection activities as appropriate:

- Regional Health Officer – key informant interview
- District Medical Officer – courtesy call

- District AIDS Control Coordinator – key informant interview
- District Health Management Team – focus group discussion
- AMREF/Jhpiego Support Offices – key informant interviews
- Facility staff – Focus group discussion (project manager, counselors, laboratory, logistics, and referrals)
- Counseling staff – focus group or key informant interview
- Clients – exit interviews
- Community health committee – focus group discussion
- Site description and mapping – limited notes where unusual
- Additional stakeholders on an opportunistic basis.

Notes were taken in each instance either on structured forms for qualitative or quantitative analysis or general discussion notes.

Parallel Data Collection
The subjects to be investigated at each level were consistent so operational and perception data can be compared between levels as much as possible. Questions, however, were tailored to the nature of respondent roles in the system.

The sample size of sites and persons interviewed is sufficiently large to capture a range of differences without becoming repetitive or hard to manage for data entry, processing, and analysis.

Data Quality
All data collection was conducted in conformity with USAID ADS 203 Data Standards (203.3.11.1 Data Quality Standards, Effective Date: 11/02/2012) in order to ensure:

- Validity: Data should clearly and adequately represent the intended result;
- Integrity: Data collected should have safeguards to minimize the risk of transcription error or data manipulation;
- Precision: Data should have a sufficient level of detail to permit management decision-making; e.g. the margin of error is less than the anticipated change;
- Reliability: Data should reflect stable and consistent data collection processes and analysis methods over time; and
- Timeliness: Data should be available at a useful frequency, should be current, and should be timely enough to influence management decision-making.

Data Analysis Plan
The following data analysis methods were employed:

1. Desk Review – Documents from AMREF's and Jhpiego's HTC projects were culled for relevant information, as were HTC related publications listed on NACP's website to identify themes and to triangulate with other data collected as part of this evaluation.

2. Secondary Data Analysis – Data collected by AMREF's Angaza Zaidi project and Jhpiego's *UHAI-CT* project were reviewed and analyzed to identify trends and correlations. These analyses look at trends over time, and differentials associated with geography, gender and age (e.g., AMREF vs. Jhpiego supported sites, rural vs. urban, regional comparisons, differences by type of health facility, static vs. mobile outreach service delivery, male vs. female, age groups, and VCT vs. PITC). Furthermore, these data were compared to NCAP's CounTest database that maintains data collected by health facilities on HTC (both VCT and PITC).

3. Health Facility Audit – This is a brief structured assessment tool that was used to gather information on HTC resources, such as test kit stocks, record keeping, location of HTC services, provision of privacy (visual and auditory), staffing, staff training, condom availability, presence of relevant behavior change communication (BCC) materials.

4. Key Informant Interviews – Semi-structured interviews were conducted with primary stakeholders, such as, representatives from USAID, AMREF, Jhpiego, MOHSW, NACP, Tanzania Commission for AIDS [TACAIDS]), and national reference laboratory. Additionally, a select number of VCT and PITC providers were interviewed. Interviews focused on assessing perceived achievements, including facilitators and obstacles to quality, effective, and efficient HTC services and outcomes, for VCT and PITC, and for static and mobile outreach services. Furthermore, stigma and discrimination, particularly related to Key populations, were explored.

5. Exit Interviews – For each site visit where HTC services are provided, 2-4 clients were interviewed about their experiences at the facility. Services received, privacy (auditory and visual), and referrals made were also noted.

6. Focus Group Discussions (FOCUS GROUP DISCUSSION) – Focus groups were convened among community members who represent the target population for *Angaza Zaidi* project and *UHAI-CT*, including most at risk populations (Key populations). In this forum we explored their issues related to client satisfaction, demand for services, stigma, gender equity, and HIV prevention practices.

The team collected qualitative data (key informant interviews and FOCUS GROUP DISCUSSIONs) in pairs, and then compared notes as a quality assurance check. The Core Team also met to review qualitative data and emerging themes (findings). Quantitative data forms were reviewed daily, as collected, for completeness. Double data entry was done with 10% of the quantitative data (mini-surveys, facility audits, and observations) to assure accuracy and validity.

EVALUATON LIMITATIONS

- A full-scale investigation of the quality of services provided by both projects requires extensive surveys and assessments, which were beyond the scope of this evaluation. Rather, the team reviewed the functioning of the existing quality assurance, training and quality improvement systems instituted by the projects.
- Similarly, a true cost effectiveness analysis is beyond the scope of the evaluation. The team

investigated existing data and total project expenditures where data are available, and made rough estimates of expenditures by modality. (However, a large Centers for Disease Control HTC costing study is just getting underway which should provide useful information).

- True studies of comparative advantage of different modalities and capability of partners, including URT, to assume specific aspects of the project require extended studies outside the scope of this evaluation. The team will rely on available data gathered to provide a preliminary assessment of these issues. (However a large multiple country study titled STATUS comparing HTC is nearing completion and will be available for Mission decision making. Interesting data was shared with the evaluation team, but could not be included in this report, as it has not been published.)
- The performance of the two projects being evaluated cannot in any strict sense be compared. Angaza Zaidi provides HTC services directly while UHAI-CT provides mainly technical assistance and training. Because the project portfolios are so different, we cannot reliably say that one has higher quality or greater efficiency than the other. The final report notes the role played by each of the projects relative to the range of service providers and models in Tanzania. In fact, one of the great contributions of this evaluation may be to stimulate a national dialogue on the comparative advantage of the various models and delivery systems in Tanzania;
- Both projects are in wind-down mode, which means that many of their key personnel have left to work on other projects. Where possible and when necessary, the former employees were contacted for interview or information.
- Key documents were not made to the team upon arrival; rather we were presented with an online list of over 215 documents, which required a tremendous amount of time to sift through in order to find documents most relevant for this evaluation.
- Insufficient time was budgeted after the fieldwork to properly prepare and analyze data.

In spite of these limitations, the team hopes the findings, conclusions, and recommendations presented in the evaluation will be useful to USAID and all HTC stakeholders to improve the chances of actually controlling HIV in Tanzania.

ANNEX IV: DATA COLLECTION INSTRUMENTS

Twelve data collection instruments are provided in this annex. These tools were pilot tested, although there were still minor adjustments made after the first couple of days of data collection in the field. The twelve questionnaires are listed below:

1. KEY INFORMANT INTERVIEW District Medical Officer _revised 31Oct
2. KEY INFORMANT INTERVIEW Head of Counseling and Testing Site _revised 31 Oct
3. KEY INFORMANT INTERVIEW Regional AIDS Control Coordinator _revised Oct 31
4. KEY INFORMANT INTERVIEW Regional Medical Officer _revised 31 Oct
5. KEY INFORMANT INTERVIEW United Republic of Tanzania Agencies _revised Oct 31
6. QUANTATIVE – EXIT INTERVIEW _revised Oct 31
7. QUANTATIVE Counselor Service Provider _revised 31 Oct
8. QUANTATIVE FACILITY AUDIT _revised 31 October
9. FOCUS GROUP DISCUSSION Council Health Management Team _revised 31 Oct
10. FOCUS GROUP DISCUSSION Post (HIV+) Test Club _revised Oct 31
11. KEY INFORMANT INTERVIEW Community Outreach (Jhpiego)_revised 31Oct
12. KEY INFORMANT INTERVIEW District AIDS Control Coordinator _revised Oct 31

PERFORMANCE EVALUATION OF USAID SUPPORTED HTC PROJECTS IN TANZANIA
DISTRICT MEDICAL OFFICER (DMO)

Key Informants Interview guide

QUESTIONNAIRE IDENTIFICATION NUMBER: |_____|_____| REGION ID NUMBER: |_____|_____|

DISTRICT ID NUMBER: |_____|_____| SEX OF RESPONDENTS: |__M___|__F___|

My name is I am here on behalf of IBTCI a consulting firm based in Washington DC, USA who has been entrusted by the USAID Tanzania to conduct performance evaluation of two HTC projects namely ANGAZA ZAIDI and UHAI-CT implemented by AMREF and JHPIEGO respectively.

We are collecting information that will help us to understand HIV testing and counseling services in Tanzania which will be used to inform USAID how they can support efforts to improve HIV testing and counseling in Tanzania

I would like you to express your views freely and openly. All information that you give is strictly confidential. We also request permission to have your name which will not appear in any reports or notes, unless it is consented.

Your participation is voluntary and there is no penalty for refusing to take part. You may refuse to answer any question in this questionnaire/interview or stop the interview at any time. You are free to ask questions at any time.

Would you be willing to participate? 1=Yes 2=No

Thank you.

_____

(Signature of interviewer certifying that informed consent has been given verbally by respondent)

INTERVIEWER: Code: [____|____] Name (Initials): _____

. DATE OF INTERVIEW: |___||___|\|___||___|\ |___||___||___||___|

Day Month Year

CHECKED BY SUPERVISOR: Signature_____Date:_____

Note to Interviewer: Ensure your responses are in project specific

A: PROJECT MANAGEMENT

1. Do you think the projects achieved HTC goals? Explain HOW?
   A) Angaza Zaidi
   B) UHAI-CT

2. What are each project's strengths, weakness and gaps in **planning and management of routine data use and service delivery?**

   A) Angaza Zaidi
   B) UHAI-CT

3. In your opinion, how have the projects established constructive working relationship with key stakeholders such as Government, like minded partners, and CSOs? [*Probe on how regular meetings for update are held and if government provides guidance and feedback*]
   A) Angaza Zaidi
   B) UHAI-CT

B: PROJECT ACCOMPLISHMENTS AND RESULTS

4. Is there evidence that each project has [*provide examples*]
   Improved the quality of HIV testing and counseling services at the health facility level?
   A) Angaza Zaidi
   B) UHAI-CT
   Improved the quality of services at the community level?
   A) Angaza Zaidi
   B) UHAI-CT

   Improved referral linkages between community and facility level ?
   A) Angaza Zaidi
   B) UHAI-CT

5. What are the HTC modalities used in your district for counseling and testing? Which modalities are more efficient in reaching the target population and why? *[Probe for AZ includes Integrated VCT, Stand alone VCT, Mobile outreach and UHAI-CT includes PITC, Community based CT]*
   A) Angaza Zaidi
   B) UHAI-CT

6. How effective is each projects contributed in influencing HIV policy related to counseling and testing? [*Probe if projects activities aligned with the National HIV/AIDS strategies, policies and guidelines*]
   A) Angaza Zaidi
   B) UHAI-CT

C: MONITORING & EVALUATION

7. How have the projects complemented work done under the other PERFAR partners to avoid duplication
   A) Angaza Zaidi
   B) UHAI-CT

D: LESSON LEARNT & SUSTAINABILITY

8. What lessons learnt and good practices (what works well) in the following projects that can be replicated in your district?
   A) Angaza Zaidi
   B) UHAI-CT

9. How has each project built capacity and/or institutionalized to ensure that HTC services are provided beyond projects phase out? (*Probe on Type of services, Target population groups, Implementing partners, Collaborators)*
   A) Angaza Zaidi
   B) UHAI-CT

READ: That question completes our interview today. Thank you very much for sharing your thoughts with me. The information you have provided has been very helpful

PERFORMANCE EVALUATION OF USAID SUPPORTED HTC PROJECTS IN TANZANIA
HEAD OF COUNSELING AND TESTING

Key Informant Interview Guide

QUESTIONNAIRE IDENTIFICATION NUMBER: |_____|_____| REGION ID NUMBER: |_____|_____|

DISTRICT ID NUMBER: |_____|_____| SEX OF RESPONDENTS: |__M___|__F___|

AGE OF RESPONDENTS: |_____|_____|

My name is I am here on behalf of IBTCI a consulting firm based in Washington DC, USA who has been entrusted by the USAID Tanzania to conduct performance evaluation of two HTC projects namely ANGAZA ZAIDI and UHAI-CT implemented by AMREF and JHPIEGO respectively.

We are collecting information that will help us to understand HIV testing and counseling services in Tanzania which will be used to inform USAID how they can support efforts to improve HIV testing and counseling in Tanzania

The discussion will last for approximately 1 hour. I would like you to express your views freely and openly. All information that you give is strictly confidential. We also request a permission to take a picture; your name and picture will not appear in any reports or notes, unless it is consented

Your participation is voluntary and there is no penalty for refusing to take part. You may refuse to answer any question in this questionnaire/interview or stop the interview at any time. You are free to ask questions at any time.

Would you be willing to participate? 1=Yes 2=No

Thank you.

_____

(Signature of interviewer certifying that informed consent has been given verbally by respondent)

INTERVIEWER: Code: [_____|_____] Name (Initials): _____

DATE OF INTERVIEW: |___||___|\|___||___|\ |___||___||___||___|

Day Month Year

CHECKED BY SUPERVISOR: Signature_____Date:_____

Note to Interviewer: Ensure your response are in project specific

1. How do the projects contribute in the achievement of HIV test and counseling? [Probe on *what are the major achievements of the project so far*]
   A) Angaza Zaidi
   B) UHAI-CT

2. What are the project's weaknesses (not working well) and gaps? [*Suggest ways on those aspects that should be modified?*]
   A) Angaza Zaidi
   B) UHAI-CT

3. What are the HTC modalities used in your site for counseling and testing? Which are effective modalities in reaching the target population and why? *[Probe for AZ includes Integrated VCT, Stand alone VCT, Mobile outreach and UHAI-CT includes PITC, Community based CT]*
   A) Angaza Zaidi
   B) UHAI-CT

4. How has the project established constructive working relationship with the key stakeholders?
   A) Angaza Zaidi
   B) UHAI-CT

5. What mechanism is in place to ensure that the referrals are effective? [*Probe if there is a verification mechanism; how is it working; who is responsible*]
   A) Angaza Zaidi
   B) UHAI-CT

6. How are data being generated? With whom are the data shared?
   A) Angaza Zaidi
   B) UHAI-CT

7. How successful have you been in providing valid and reliable data? Is there a validation process in place to avoid duplication of reporting?
   A) Angaza Zaidi
   B) UHAI-CT

8. What lessons learnt and best practices from successful interventions that can be continued or replicated even after the expiry of the donor support? [*Probe why and how these will be sustained]*
   A) Angaza Zaidi
   B) UHAI-CT

READ: That question completes our interview today. Thank you very much for sharing your thoughts with me. The information you have provided has been very helpful

PERFORMANCE EVALUATION OF USAID SUPPORTED HTC PROJECTS IN TANZANIA
REGIONAL AIDS CONTROL COORDINATOR (RACC)

Key Informants Interview guide

QUESTIONNAIRE IDENTIFICATION NUMBER: |_____|_____| REGION ID NUMBER: |_____|_____|

DISTRICT ID NUMBER: |_____|_____| FACILITY ID NUMBER |_____|_____|

SEX OF RESPONDENTS: |__M___|__F___|

My name is I am here on behalf of IBTCI a consulting firm based in Washington DC, USA who has been entrusted by the USAID Tanzania to conduct performance evaluation of two HTC projects namely ANGAZA ZAIDI and UHAI-CT implemented by AMREF and JHPIEGO respectively.

We are collecting information that will help us to understand HIV testing and counseling services in Tanzania which will be used to inform USAID how they can support efforts to improve HIV testing and counseling in Tanzania

The discussion will last for approximately 1 hour. I would like you to express your views freely and openly. All information that you give is strictly confidential. We also request permission to have your name which will not appear in any reports or notes, unless it is consented.

Your participation is voluntary and there is no penalty for refusing to take part. You may refuse to answer any question in this questionnaire/interview or stop the interview at any time. You are free to ask questions at any time.

Would you be willing to participate? 1=Yes 2=No

Thank you.

_____

(Signature of interviewer certifying that informed consent has been given verbally by respondent)

INTERVIEWER: Code: [____|____] Name (Initials): _____

DATE OF INTERVIEW: |___||___|\|___||___|\ |___||___||___||___|

Day Month Year

CHECKED BY SUPERVISOR: Signature_____Date:_____

Note to interviewer: Ensure your response are in project specific

A: PROJECT MANAGEMENT

1. Do you think the projects achieved HTC goals? Explain HOW?

A) Angaza Zaidi
B) UHAI-CT

2. What are each project's strengths, weakness and gaps in **planning and management of routine data use and service delivery?**
   A) Angaza Zaidi
   B) UHAI-CT

3. In your opinion, how have the projects established constructive working relationship with key stakeholders such as Government, like minded partners, and CSOs? [*Probe on how regular meetings for update are held and if the government provides guidance and feedback*]
   A) Angaza Zaidi
   B) UHAI-CT

B: PROJECT ACCOMPLISHMENTS AND RESULTS

4. Is there evidence that each projects have: [*provide examples*]
   Improved the quality of HIV testing and counseling services at the health facility level?
   A) Angaza Zaidi
   B) UHAI-CT

   Improved the quality of services at the community level?
   A) Angaza Zaidi
   B) UHAI-CT

   Improved referral linkage between the community and facility level?
   A) Angaza Zaidi
   B) UHAI-CT

5. What HTC modalities used in your district for counseling and testing? Which are effective modalities in reaching the target population and why? *[Probe for AZ includes Integrated VCT, Stand alone VCT, Mobile outreach and UHAI-CT includes PITC, Community based CT]*
   A) Angaza Zaidi
   B) UHAI-CT

6. How effective is each projects contributed in influencing HIV policy related to counseling and testing? *[Probe if projects activities aligned with the National HIV/AIDS strategies, policies and guidelines*]
   A) Angaza Zaidi
   B) UHAI-CT

C: MONITORING & EVALUATION

7. How have the projects complemented work done under the other PERFAR partners and avoid duplication
   A) Angaza Zaidi
   B) UHAI-CT

D: LESSON LEARNT & SUSTAINABILITY

8. What are the lessons learnt and good practices / what works well in following project that need replication in your district?
   A) Angaza Zaidi
   B) UHAI-CT

9. How has each project built capacity and/or institutionalized to ensure that HTC services are provided beyond projects phase out? *(Probe on type of services, Target population groups, Implementing partners, Collaborators)?*
   A) ANGAZA Zaidi
   B) UHAI-CT

READ: That question completes our interview today. Thank you very much for sharing your thoughts with me. The information you have provided has been very helpful.

PERFORMANCE EVALUATION OF USAID SUPPORTED HTC PROJECTS IN TANZANIA
REGIONAL MEDICAL OFFICER

Key Informants Interview

QUESTIONNAIRE IDENTIFICATION NUMBER: |_____|_____| REGION ID NUMBER: |_____|_____|

SEX OF RESPONDENTS: |__M___|__F___|

My name is I am here on behalf of IBTCI a consulting firm based in Washington DC, USA who has been entrusted by the USAID Tanzania to conduct performance evaluation of two HTC projects namely ANGAZA ZAIDI and UHAI-CT implemented by AMREF and JHPIEGO respectively.

We are collecting information that will help us to understand HIV testing and counseling services in Tanzania which will be used to inform USAID how they can support efforts to improve HIV testing and counseling in Tanzania

The interview will last for approximately 10 minutes. I would like you to express your views freely and openly. All information that you give is strictly confidential. Your name will not appear in any reports or notes, unless it is consented

Your participation is voluntary and there is no penalty for refusing to take part. You may refuse to answer any question in this questionnaire/interview or stop the interview at any time. You are free to ask questions at any time.

Would you be willing to participate? 1=Yes 2=No

Thank you.

_____

(Signature of interviewer certifying that informed consent has been given verbally by respondent)

INTERVIEWER: Code: [____|____] Name (Initials): _____

DATE OF INTERVIEW: |___||___|\|___||___|\ |___||___||___||___|

Day Month Year

CHECKED BY SUPERVISOR: Signature_____Date:_____

A: PROJECT MANAGEMENT

1. Do you think the projects achieved HTC goals? Explain HOW?
   A) Angaza Zaidi
   B) UHAI-CT

2. What is your role in supporting the projects to achieve HTC goals?

B: PROJECT ACCOMPLISHMENTS AND RESULTS

3. In your opinion, how is the project established constructive working relationship with key stakeholders such as Government, like minded partners, and CSOs?

4. What good practices (what works well) in AZ and UHAI-CT in your region?
   A) Angaza Zaidi
   B) UHAI-CT

C: MONITORING & EVALUATION

5. How have the projects complemented work done under the other PERFAR partners and avoid duplication
   A) Angaza Zaidi
   B) UHAI-CT

D: LESSON LEARNT AND SUSTAINABILITY

6. What are the lessons learnt and good practices (what works well) in following projects that need replication in your district?
   A) Angaza Zaidi .
   B) UHAI-CT

READ: That question completes our interview today. Thank you very much for sharing your thoughts with me. The information you have provided has been very helpful.

PERFORMANCE EVALUATION OF USAID SUPPORTED HTC PROJECTS IN TANZANIA
URT AGENCIES (NATIONAL)

Key Informants Interview guide

QUESTIONNAIRE IDENTIFICATION NUMBER: |_____|_____| REGION ID NUMBER: |_____|_____|

DISTRICT ID NUMBER: |_____|_____| FACILITY ID NUMBER |_____|_____|

SEX OF RESPONDENTS: |__M___|__F___|

My name is I am here on behalf of IBTCI a consulting firm based in Washington DC, USA who has been entrusted by the USAID Tanzania to conduct performance evaluation of two HTC projects namely ANGAZA ZAIDI and UHAI-CT implemented by AMREF and JHPIEGO respectively.

We are collecting information that will help us to understand HIV testing and counseling services in Tanzania which will be used to inform USAID how they can support efforts to improve HIV testing and counseling in Tanzania

The discussion will last for approximately 1 hour. I would like you to express your views freely and openly. All information that you give is strictly confidential. We also request permission to have your name which will not appear in any reports or notes, unless it is consented.

Your participation is voluntary and there is no penalty for refusing to take part. You may refuse to answer any question in this questionnaire/interview or stop the interview at any time. You are free to ask questions at any time.

Would you be willing to participate? 1=Yes 2=No

Thank you.

_____

(Signature of interviewer certifying that informed consent has been given verbally by respondent)

INTERVIEWER: Code: [____|____] Name (Initials): _____

DATE OF INTERVIEW: |___||___|\|___||___|\ |___||___||___||___|

Day Month Year

CHECKED BY SUPERVISOR: Signature_____Date:_____

Note to interviewer: Ensure your response are in project specific

A: PROJECT MANAGEMENT

1. Do you think the projects achieved HTC goals? Explain HOW?

A) Angaza Zaidi
B) UHAI-CT

2. What are each project's strengths, weakness and gaps in **planning and management of routine data use and service delivery?**
   A) Angaza Zaidi
   B) UHAI-CT

3. In your opinion, how have the projects established constructive working relationship with key stakeholders such as Government, like minded partners, and CSOs? [*Probe on how regular meeting for update and if government provide guidance and feedback*]

   C) ANGAZA Zaidi
   D) UHAI-CT

B: PROJECT ACCOMPLISHMENTS AND RESULTS

4. Is there evidence that each project has [*provide examples*]
   Improved the quality of HIV testing and counseling services at the health facility level?
   A) Angaza Zaidi
   B) UHAI-CT

   Improved the quality of services at the community level?
   A) Angaza Zaidi
   B) UHAI-CT

   Improved referral linkage between community and facility?
   A) Angaza Zaidi
   B) UHAI-CT

5. To what extent have the projects' activities been successfully integrated into national HIV framework?
   A) Angaza Zaidi
   B) UHAI-CT

6. How effective has each project contributed in influencing HIV policy related to counseling and testing? *[Probe if projects activities aligned with the National HIV/AIDS strategies, policies and guidelines*]
   A) ANGAZA Zaidi
   B) UHAI-CT

C: MONITORING & EVALUATION

7. How successful have each projects been in providing valid and reliable information? [*Probe on How have the projects complemented work done under the other PERFAR partners and avoid duplication*]
   A) Angaza Zaidi .
   B) UHAI-CT

D: LESSON LEARNT &SUSTAINABILITY

8. What lessons learnt and good practices (what works well) in following project that need replication?
   A) Angaza Zaidi .
   B) UHAI-CT

9. How has each project built capacity and/or institutionalized to ensure that HTC services are provided beyond projects phase out? *(Probe on type of services, Target population groups, Implementing partners, Collaborators)*

   A) ANGAZA Zaidi
   B) UHAI-CT

READ: That question completes our interview today. Thank you very much for sharing your thoughts with me. The information you have provided has been very helpful

PERFORMANCE EVALUATION OF USAID SUPPORTED HTC PROJECTS IN TANZANIA
EXIT INTERVIEW (COMMUNITY MEMBER)

Data Collection Form

QUESTIONNAIRE IDENTIFICATION NUMBER: |_____|_____| REGION ID NUMBER: |_____|_____|

DISTRICT ID NUMBER: |_____|_____| FACILITY ID NUMBER |_____|_____|

SEX OF RESPONDENTS: |__M___|__F___|

Type of Health Facility:
☐ **Hospital** ☐ **Health Center** ☐ **Dispensary** ☐ **VCT Centre** ☐ **Mobile site (*Specify*)…….**
☐ **other**

My name is..... I am here on behalf of IBTCI a consulting firm based in Washington DC, USA who has been entrusted by the USAID Tanzania to conduct performance evaluation of two HTC projects namely ANGAZA ZAIDI and UHAI-CT implemented by AMREF and JHPIEGO respectively.

We are collecting information that will help us to understand HIV testing and counseling services in Tanzania which will be used to inform USAID how they can support efforts to improve HIV testing and counseling in Tanzania

The interview will last for approximately 30 minutes. I would like you to express your views freely and openly. All information that you give is strictly confidential. Your name will not appear in any reports or notes, unless it is consented

Your participation is voluntary and there is no penalty for refusing to take part. You may refuse to answer any question in this questionnaire/interview or stop the interview at any time. You are free to ask questions at any time.

Would you be willing to participate? 1=Yes 2=No

Thank you.

_____
(Signature of interviewer certifying that informed consent has been given verbally by respondent)

INTERVIEWER: Code: [_____|_____] Name (Initials): _____

DATE OF INTERVIEW: |___||___|\|___||___|\ |___||___||___||___|
Day Month Year

CHECKED BY SUPERVISOR: Signature_____Date:_____

SECTION A: SOCIO-DEMOGRAPHIC PROFILE OF RESPONDENT

No.	QUESTIONS	ANSWERS	SKIP
B01	Sex of the interviewee	Male 01 Female 02	
B02	Age of interviewee in complete years	……..	
B03	Level of education	None 01 Primary 02 Secondary 03 Above secondary 04 No answer 99	
B04	Marital Status	Single 01 Married 02 Divorced 03 Widow/widower 04 Others 05	

SECTION B: VCT SERVICES

NO.	QUESTION	ANSWERS	SKIP
C01	How long did you have to wait before you were attended?	Less than 30 minutes 01 30 minutes – 1 hour 02 1 – 2 hours 03 More than 2 hours 04	
C02	Did you receive any counseling before getting tested?	Yes 01 No 02	
C03	Was the counseling conducted in group or individual counseling?	Group 01 Individual 02 Both 03	
C04	On average how long was the counseling session?	Less than 30 minutes 01 30 minutes – 1 hour 02 1 – 2 hours 03 More than 2 hours 04	
C05	Was the counseling session private?	Yes 01 No 02	C7
C06	Were the following aspects of privacy observed?	The door was closed 01 Nobody entered the room 02 Both of them 03	
C07	What aspects of privacy were not observed?	The door was opened 01 Someone enter the room 02 Both of them 03	
C08	Do you think you were given adequate information during the counseling session?	Yes 01 No 02	

C09	Did the counselor give you the opportunity to ask questions?	Yes 01 No 02	
C10	Did the counselor adequately respond to your questions?	Yes 01 No 02 Did not ask 03	
C11	Did the counselor discuss with you the benefits of testing?	Yes 01 No 02	
C12	Did the counselor discuss with you about how to share your results with family/ partner?	Yes 01 No 02	
C13	Did the counselor discuss with you your HIV infection risk?	Yes 01 No 02	
C14	Did the counselor discuss with you about any prevention measures you should take?	Yes 01 No 02	
C15	Did the counselor advice you to bring your partner?	Yes 01 No 02	
C16	Were you given any advice on the use of condoms?	Yes 01 No 02	
C17	Were you told where you can access condoms?	Yes 01 No 02	
C18	Were you given any information/skills on how to get your partner use condoms?	Yes 01 No 02	
C18	Did the counselor demonstrate how to use condoms?	Yes 01 No 02	
C19	Did the counselor give you any condoms to take with you home?	Yes 01 No 02	
C20	Did the counselor advice you to come for testing another time?	Yes 01 No 02	
C21	What was the attitude of the counselor towards you?	Friendly 01 Neutral 02 Unfriendly 03	
C22	What was the attitude of the lab technician towards you?	Friendly 01 Neutral 02 Unfriendly 03	
C23	What was the attitude of the receptionist towards you?	Friendly 01 Neutral 02 Unfriendly 03	
C24	Overall, what do you think about the services you received today?	Very good 01 Fair 02 Bad 03	
C25	Overall, do you think that your results will remain confidential between you and the counselor?	Yes 01 No 02	
C26	What can you say about the cleanness of the facility?	Very clean 01 Clean 02 Not clean 03	
C27	Will you be willing to come back to this facility?	Yes 01 No 02	C30
C28	If NO, why are you not willing to come back	……	

	to this facility?	…… …… …… …… …… …… ……	
C29	Can you advice your friends/ family to visit this facility?	Yes 01 No 02	C31
C30	If YES, what are qualities that you like about the facility?	…… …… …… …… …… …… …… ……	
C31	If NO, why are you not willing to recommend the facility to friends/family?	…… …… …… …… …… …… …… ……	

Comments and opinion

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READ: That question completes our interview today. Thank you very much for sharing your thoughts with me. The information you have provided has been very helpful

PERFORMANCE EVALUATION OF USAID SUPPORTED HTC PROJECT IN TANZANIA
COUNSELOR/SERVICE PROVIDER INTERVIEW

Data Collection Form

Q1. QUESTIONNAIRE IDENTIFICATION NUMBER: |_____|_____| Q2. REGION ID NUMBER: |_____|_____|

Q3. DISTRICT ID NUMBER: |_____|_____| Q4. FACILITY ID NUMBER |_____|_____|

Q5: SEX OF RESPONDENT: |__M___|__F___|

Type of Health Facility:
☐ **Hospital** ☐ **Health Center** ☐ **Dispensary** ☐ **VCT Centre** ☐ **Mobile site (*Specify*)…….**
☐ **Other**
Cadre:
☐ **Medical Officer** ☐ **Medical Assistant** ☐ **Nurse** ☐ **Midwife** ☐ **Other**
_____

My name is..... I am here on behalf of IBTCI a consulting firm based in Washington DC, USA who has been entrusted by the USAID Tanzania to conduct performance evaluation of two HTC projects namely ANGAZA ZAIDI and UHAI-CT implemented by AMREF and JHPIEGO respectively.

We are collecting information that will help us to understand HIV testing and counseling services in Tanzania which will be used to inform USAID how they can support efforts to improve HIV testing and counseling in Tanzania

The interview will last for approximately 40 minutes. I would like you to express your views freely and openly. All information that you give is strictly confidential. Your name will not appear in any reports or notes, unless it is consented.

Your participation is voluntary and there is no penalty for refusing to take part. You may refuse to answer any question in this questionnaire/interview or stop the interview at any time. You are free to ask questions at any time.

Would you be willing to participate? 1=Yes 2=No

Thank you.

_____
(Signature of interviewer certifying that informed consent has been given verbally by respondent)

Q5. INTERVIEWER: Code: [_____|_____] Name (Initials): _____

Q6. DATE OF INTERVIEW: |___||___|\|___||___|\ |___||___||___||___|

Day Month Year

CHECKED BY SUPERVISOR: Signature _____Date:_____

1. Do you provide HIV testing and counseling? ¨ yes ¨ no

2. Do you provide voluntary counseling and testing? ¨ yes ¨ no

3. If the above answer is Yes, what type of counseling and testing modalities to you use

   ¨ *Integrated VCT* ¨ *Stand alone VCT* ¨ *Mobile outreach* ¨*PITC* ¨*Community based CT*

4. Which are effective modalities in reaching the target population?
   ¨ *Integrated VCT* ¨ *Stand alone VCT* ¨ *Mobile outreach* ¨*PITC* ¨*Community based CT*

5. When you counsel clients, what information do you cover? (*check all that apply*)

For every box checked, how often	**Every client**	**Most clients**	**Only clients that I think don't know**	**Rarely / Seldom**	**NO**
¨ inquire about their partners' HIV status					
¨ use of condom					
¨ risk with multiple partners					
¨ reduced risk if man is circumcised					

6. What safety precautions do you take when testing clients for HIV?

For every box checked, how often?	**Always**	**Often**	**Rarely / Seldom**
¨ Wash hands before and after testing each patient			
¨ Wear fresh pair of gloves with each patient			
¨ Wear laboratory coat or apron			
¨ Dispose of contaminated sharps and waste immediately after testing			

7. If a client tests positive for HV, what do you do?
   ¨ nothing ¨ inform him/her ¨ inform and counsel ¨ refer to care and treatment
   ¨ inform posttest counsel and refer to care and treatment ¨ other
   _____

8. Tell me if you agree or not with each of the following statements? (strongly agree, agree, disagree, strongly disagree)

Statement	**1=strongly agree**	**2=agree**	**3=disagree**	**4=strongly disagree**
I believe that HIV-positive patients are the biggest threat to my safety at my place of work.				
I feel that clients who have sexual relations with				

people of the same sex (e.g. men who have sex with men) should seek health services elsewhere				
I feel that clients who are sex workers should seek health services elsewhere.				
I am comfortable providing health services to clients who are HIV-positive.				
I believe that people who are infected with HIV should not be treated in the same areas as other clients in order to protect the larger population from infection.				
I avoid touching clients for fear of becoming infected with HIV.				

9. Have you been trained on providing HTC services to clients? If Yes, How often and with who?

10. Have you received any job aid to use on your work? Yes/ No

11. What actions are being taken to ensure privacy (verifying by probing how)

12. Do you get supervision support from the project people? How and when?

13. Is there a system in place to capture the lost to follow clients? How is it applied?

14. Do you have all you need such as equipments, supplies and medicine that are needed to provide the service? Yes / NO

15. How are referrals made for newly identified HIV positive client from your unit to care and treatment facilities?

16. What mechanism is in place to ensure that the referrals are effective[*Probe if there is a verification mechanism; how is it working; who is responsible*]

17. What do you think are the weaknesses or barriers in providing HIV testing and counseling services? (Probe for the difficulties to meet the intended objectives). Please suggest in which areas the two projects could do better? *Please give specific examples per project if any.*
    A) Angaza Zaidi
    B) UHAI-CT

18. In the future do you see your center being able to run the services without assistance from Angaza Zaidi /JPIEGO? If yes how.
    A) Angaza Zaidi
    B) UHAI-CT

READ: That question completes our interview today. Thank you very much for sharing your thoughts with me. The information you have provided has been very helpful.

PERFORMANCE EVALUATION OF USAID SUPPORTED HTC PROJECT IN TANZANIA
FACILITY AUDIT
Data Collection Form

QUESTIONNAIRE IDENTIFICATION NUMBER: |_____|_____|. REGION ID NUMBER: |_____|_____|

DISTRICT ID NUMBER: |_____|_____| FACILITY ID NUMBER |_____|_____|

SEX OF RESPONDENTS: |__M___|__F___|

Type of Health Facility:
☐ Hospital ☐ Health Center ☐ Dispensary ☐ VCT center ☐ other.....

My name is..... I am here on behalf of IBTCI a consulting firm based in Washington DC, USA who has been entrusted by the USAID Tanzania to conduct performance evaluation of two HTC projects namely ANGAZA ZAIDI and UHAI-CT implemented by AMREF and JHPIEGO respectively.

We are collecting information that will help us to understand HIV testing and counseling services in Tanzania which will be used to inform USAID how they can support efforts to improve HIV testing and counseling in Tanzania

The discussion will last for approximately 1 hour. I would like you to express your views freely and openly. All information that you give is strictly confidential. We also request a permission to take a picture; your name and picture will not appear in any reports or notes, unless it is consented.

Your participation is voluntary and there is no penalty for refusing to take part. You may refuse to answer any question in this questionnaire/interview or stop the interview at any time. You are free to ask questions at any time.

Would you be willing to participate? 1=Yes 2=No

Thank you.

_____

(Signature of interviewer certifying that informed consent has been given verbally by respondent)

INTERVIEWER: Code: [_____|_____] Name (Initials): _____

DATE OF INTERVIEW: |___||___|\|___||___|\ |___||___||___||___|

Day Month Year

CHECKED BY SUPERVISOR: Signature_____Date:_____

Types of modalities in place ☐ *Integrated VCT* ☐*Stand alone VCT*

☐ *Mobile outreach UHAI-CT* ☐ *PITC*
☐*Community based CT*

1. Estimated catchment population: _____
2. Total number of staff involved in HTC: _____
3. How many have participated in trainings sponsored by
4. A) JHPIEGO
   B) AMREF
   C) TMARC
   D) AFRICARE
5. How many have participated in any training on HIV prevention and/or HTC:

Note the number by cadre:

	Number of HTC Staff	Number participating JHPIEGO trainings	*Number participating in any HTC Training from anyone*
Doctors			
Medical Assistants			
Nurses			
Midwives			
Other (specify)			

6. Does this facility offer mobile outreach HTC services? ***[Probe where do they go; how do they chose mobile outreach and how data are integrated into health facility]***
7. *If yes*, how many days per month? ___ VTC (outreach)……. ☐ PITC (outreach)…… Other……..

<u>HTC Registration Logbook & Monthly Summary</u>

8. Has HTCs been recorded every day for the last week? ☐ yes ☐ no
9. Total number of HTC recorded each day for the last week:[Verify by checking records]

   Day 1 _____ Day 2 _____ Day 3 _____ Day 4 _____
   Day 5 _____ Day 6_____

10. On average how much time (in minutes) is spent on each one counseling session?
11. If mobile outreach HTC, is there a Registration Logbook for Outreach HTC?

    ☐ yes ☐ no

12. When did you conduct your last outreach mobile

    a) Last week ☐ b) Last month ☐ c) Last quarter ☐

13. How do you rate the degree of privacy during mobile outreach HTC?

☐ Good ☐ Fair ☐ Poor ☐ Don't know

14. What do you find most enjoyable about mobile testing? What do you find most challenging about mobile testing?

15. Are condoms available in your facility? ☐ yes ☐ no

16. If not, where do the clients get them? _____

17. How do you handle data that is generated from the HTC services? How is it compiled, shared and used? *(Find out if they are in compliance with National data collection system)*

18. Are HTC national policy guidelines available for your use? ***[Verify by checking the following documents]*** *National policy guidelines for HIV testing and counseling, Training curriculum for counselors, National protocols and algorithms for HIV testing, and Data collection tools for Monitoring and Evaluation and reporting forms**]***

Infrastructure

19. Number of locations/rooms where HTC is done: _____

Room 1: ☐ visual privacy ☐ auditory privacy
Room 2: ☐ visual privacy ☐ auditory privacy
Room 3: ☐ visual privacy ☐ auditory privacy
Room 4: ☐ visual privacy ☐ auditory privacy
Room 5: ☐ visual privacy ☐ auditory privacy

HIV Prevention and Testing BCC Materials

20. Total Number (estimate) of HIV brochures/pamphlets in stock at facility _____

21. Do you ever run out of HIV brochures/pamphlets? ☐ yes ☐ no

22. Who supplies the brochures/pamphlets?

☐ [Name of Project] ☐ Another project
☐ MOHSW ☐ Don't know

23. How often do you get brochures/pamphlets re-stocked?

☐ Weekly ☐ monthly ☐ quarterly ☐ twice/year ☐ annually ☐ don't know

24. Number of client oriented HIV posters that are clearly posted for clients to see _____(***Observe***)

25. How do you describe the retention of the staff in your centre? (*Probe for employee turnover for past 3 years)*

26. How are referrals made for newly identified HIV-Positive clients from your unit to Care and treatment facilities?

27. What mechanism is in place to ensure that the referrals are effective? (Probe if there is verification mechanism, if yes describe it….how is it working, who is responsible).

28. How often do you receive supportive supervision from the CHMT?

    a) Monthly

    b) Quarterly

    c) Semi-annually

    d) Other specify……

    If yes what approach were used to provide feedback?

29. Do you have a set of HTC SOP for your service providers to use? Yes / No

READ: That question completes our interview today. Thank you very much for sharing your thoughts with me. The information you have provided has been very helpful

PERFORMANCE EVALUATION OF USAID SUPPORTED HTC PROJECTS IN TANZANIA
COUNCIL HEALTH MANAGEMENT TEAM / MUNICIPAL HEALTH MANAGEMENT TEAM (CHMT/MHMT)

Focus group discussion guide

Respondents' information

Respondent S/N	Gender	Age	Position/ designation

QUESTIONNAIRE IDENTIFICATION NUMBER: |_____|_____| REGION ID NUMBER: |_____|_____|

DISTRICT ID NUMBER: |_____|_____|

My name is..... I am here on behalf of IBTCI a consulting firm based in Washington DC, USA who has been entrusted by the USAID Tanzania to conduct performance evaluation of two HTC projects namely ANGAZA ZAIDI and UHAI-CT implemented by AMREF and JHPIEGO respectively.

We are collecting information that will help us to understand HIV testing and counseling services in Tanzania which will be used to inform USAID how they can support efforts to improve HIV testing and counseling in Tanzania

The discussion will last for approximately 1-2 hours. I would like you to express your views freely and openly. All information that you give is strictly confidential. We also request a permission to take a picture; your name and picture will not appear in any reports or notes, unless it is consented.

Your participation is voluntary and there is no penalty for refusing to take part. You may refuse to answer any question in this questionnaire/interview or stop the interview at any time. You are free to ask questions at any time.

Will all of you be willing to participate? 1=Yes 2=No

Thank you.

_____

(Signature of interviewer certifying that informed consent has been given verbally by respondent)

INTERVIEWER: Code: [____|____] Name (Initials): _____

DATE OF INTERVIEW: |___||___|\|___||___|\ |___||___||___||___|

Day Month Year

CHECKED BY SUPERVISOR: Signature_____Date:_____

Note to Interviewer: Ensure your response are in project specific

A: PROJECT MANAGEMENT

1. Do you think the projects achieved HTC goals? Explain HOW?
   A) Angaza Zaidi.
   B) UHAI-CT

2. What are each project's strengths, weakness and gaps in **planning**, **management of routine data use** and **service delivery**?
   A) Angaza Zaidi
   B) UHAI-CT

3. How has Angaza Zaidi and UHAI-CT projects addressed these gaps? *[Please give examples about what they did to address these gaps].*
   A) Gaps for Angaza Zaidi
   B) Gaps for UHAI-CT

4. In your opinion, how have the projects established constructive working relationship with key stakeholders such as Government, like minded partners, and Civil Society Organizations (CSOs)? [*Probe on how regular meeting for update and if government provide guidance and feedback*]
   A) ANGAZA Zaidi
   B) UHAI-CT

B: PROJECT ACCOMPLISHMENTS AND RESULTS

5. Is there evidence that each projects have [*provide examples*]

Improved the quality of HIV testing and counseling services at the health facility level?
A) Angaza Zaidi
B) UHAI-CT

Improved the quality of services at the community level?
A) Angaza Zaidi
B) UHAI-CT

a) Improved referral linkage between community and facility level?
A) Angaza Zaidi
B) UHAI-CT

6. What HTC modalities are used in your district for counseling and testing? Which of these modalities are more effective in reaching the target population and why? *[Probe for AZ includes Integrated VCT, Stand alone VCT, Mobile outreach and UHAI-CT includes PITC, Community based CT]*
A) Angaza Zaidi
B) UHAI-CT

7. How effective has each project contributed in influencing HIV policies related to counseling and testing? [*Probe if projects activities aligned with the National HIV/AIDS strategies, policies and guidelines*]
A) ANGAZA Zaidi
B) UHAI-CT

C: MONITORING & EVALUATION

8. To what extent have the projects services been successfully integrated into the Council/District health plans and community HIV initiatives? [*Probe on supervision, quality assurance*]
A) Angaza Zaidi
B) UHAI-CT

9. How have the projects complemented work done under the other PERFAR partners to avoid duplication?
A) Angaza Zaidi
B) UHAI-CT

10. Can we learn from your experience how you have used data produced under the projects for decision making?
A) Angaza Zaidi
B) UHAI-CT

D: LESSON LEARNT AND SUTAINABILITY

11. What lessons were learnt and what good practices (what works well) in following projects that could be replicated in your district?
A) Angaza Zaidi
B) UHAI-CT

12. How has each project built capacity and/or institutionalized to ensure that HTC services are provided beyond projects phase out? *(Probe on type of services, Target population groups, Implementing partners, Collaborators)*
A) ANGAZA Zaidi
B) UHAI-CT

READ: That question completes our interview today. Thank you very much for sharing your thoughts with me. The information you have provided has been very helpful

PERFORMANCE EVALUATION OF USAID SUPPORTED HTC PROJECTS IN TANZANIA
POST TEST CLUB

Focus Group Discussion guide

Respondents' information

Respondent S/N	Gender	Age	Position/ designation

QUESTIONNAIRE IDENTIFICATION NUMBER: |_____|_____| REGION ID NUMBER: |_____|_____|

DISTRICT ID NUMBER: |_____|_____|

My name is..... I am here on behalf of IBTCI a consulting firm based in Washington DC, USA who has been entrusted by the USAID Tanzania to conduct performance evaluation of two HTC projects namely ANGAZA ZAIDI and UHAI-CT implemented by AMREF and JHPIEGO respectively.

We are collecting information that will help us to understand HIV testing and counseling services in Tanzania which will be used to inform USAID how they can support efforts to improve HIV testing and counseling in Tanzania

The discussion will last for approximately 1-2 hours. I would like you to express your views freely and openly. All information that you give is strictly confidential. We also request permission to take a picture; your name and picture will not appear in any reports or notes, unless it is consented

Your participation is voluntary and there is no penalty for refusing to take part. You may refuse to answer any question in this questionnaire/interview or stop the interview at any time. You are free to ask questions at any time.

Would you be willing to participate? 1=Yes 2=No

Thank you.

_____

(Signature of interviewer certifying that informed consent has been given verbally by respondent)

INTERVIEWER: Code: [____|____] Name (Initials): _____

DATE OF INTERVIEW: |___||___|\|___||___|\ |___||___||___||___|

Day Month Year

CHECKED BY SUPERVISOR: Signature_____Date:_____

Note to Interviewer: Ensure your responses are project specific

1. How did you know about the Post Test Club? Is it something that the community is aware of and supportive of?

2. Why did you decide to join the Post Test Club?

3. What has been your experience as a member of the group? What are the benefits of joining the club? What are the challenges? What changes have taken place in your life as a result of being a member of the group?

4. How did you come to the decision of testing for HIV? Had you heard about ANGAZA Zaidi before taking your test? How did that influence your decision? [*Probe on the different messages, campaigns carried out by ANGAZA Zaidi*]

5. Where did you have your HIV test? Did you have any challenges when accessing VCT services? During the VCT sessions how did the counseling sessions before and after testing help you? How satisfied were you with the services rendered to you?

6. How did you access counseling and testing? *[Probe whether Angaza Zaidi includes Integrated VCT, Stand alone VCT, Mobile outreach and UHAI-CT includes PITC, Community based CT]* Which are effective modalities in reaching the target population and why?

7. How were you referred to care and treatment? What care and support services do you get in your respective community?

8. What kind of information do you access through being a member of the group and how useful is this information to you?

9. How are you involved in mobilizing other people to access VCT services/ behavioral change/ disseminating information on HIV/AIDS? How many people have you recommended to go for a test or join the club?

10. What challenges do you face in using and adhering to ARV treatment? And how is the PTC helping in addressing these challenges?

READ: That question completes our interview today. Thank you very much for sharing your thoughts with me. The information you have provided has been very helpful.

PERFORMANCE EVALUATION OF USAID SUPPORTED HTC PROJECTS IN TANZANIA

Community Outreach [i.e. markets, bars, food vendor along roads, local brew bars]

Key Informant Interview Guide

QUESTIONNAIRE IDENTIFICATION NUMBER: |_____|_____| REGION ID NUMBER: |_____|_____|

DISTRICT ID NUMBER: |_____|_____| SEX OF RESPONDENTS: |__M___|__F___|

AGE OF RESPONDENTS: |_____|_____|

My name is..... I am here on behalf of IBTCI a consulting firm based in Washington DC, USA who has been entrusted by the USAID Tanzania to conduct performance evaluation of two HTC projects namely ANGAZA ZAIDI and UHAI-CT implemented by AMREF and JHPIEGO respectively.

We are collecting information that will help us to understand HIV testing and counseling services in Tanzania which will be used to inform USAID how they can support efforts to improve HIV testing and counseling in Tanzania

The discussion will last for approximately 1 hour. I would like you to express your views freely and openly. All information that you give is strictly confidential. We also request permission to take a picture; your name and picture will not appear in any reports or notes, unless it is consented

Your participation is voluntary and there is no penalty for refusing to take part. You may refuse to answer any question in this questionnaire/interview or stop the interview at any time. You are free to ask questions at any time.

Would you be willing to participate? 1=Yes 2=No

Thank you.

_____

(Signature of interviewer certifying that informed consent has been given verbally by respondent)

INTERVIEWER: Code: [____|____] Name (Initials): _____

DATE OF INTERVIEW: |___||___|\|___||___|\ |___||___||___||___|

Day Month Year

CHECKED BY SUPERVISOR: Signature_____Date:_____

Note to Interviewer: Ensure your response are in project specific

1. How do the projects contribute in the achievement of HIV testing and counseling? [Probe on *what are the major achievements of the project so far*]

2. What are the project's weaknesses (not working well) and gaps? [*Suggest ways on those aspects that should be modified?*]

3. What testing modalities did you use for counseling and testing? Which one(s) would you like to be scaled up? [*Probe for AZ includes Integrated VCT, Stand alone VCT, Mobile outreach and UHAI-CT includes PITC, Community based CT]*

4. What do you find most enjoyable about mobile testing? What do you find most challenging about mobile testing? How do communities respond to services?

5. When an HIV positive person is identified what do you normally do? [*Probe to find out if they have effective referral system*]**.**

6. How successful has the project been providing valid and reliable strategic information? Is there a validation process in place to avoid duplication of reporting with other projects?

7. How is data generated and integrated into facility data base?

8. How do you ensure valid and reliable strategic information? Is there a validation process in place to avoid duplication of reporting?

9. What are the lessons learnt and best practices from successful interventions that need continuation after the expiry of the donor support? [*Probe why and how these will be sustained]*

READ: That question completes our interview today. Thank you very much for sharing your thoughts with me. The information you have provided has been very helpful

PERFORMANCE EVALUATION OF USAID SUPPORTED HTC PROJECTS IN TANZANIA
DISTRICT AIDS CONTROL COORDINATOR (DACC)

Key Informants Interview guide

QUESTIONNAIRE IDENTIFICATION NUMBER: |_____|_____| REGION ID NUMBER: |_____|_____|

DISTRICT ID NUMBER: |_____|_____| FACILITY ID NUMBER |_____|_____|

SEX OF RESPONDENTS: |__M___|__F___|

My name is ..... I am here on behalf of IBTCI a consulting firm based in Washington DC, USA who has been entrusted by the USAID Tanzania to conduct performance evaluation of two HTC projects namely ANGAZA ZAIDI and UHAI-CT implemented by AMREF and JHPIEGO respectively.

We are collecting information that will help us to understand HIV testing and counseling services in Tanzania which will be used to inform USAID how they can support efforts to improve HIV testing and counseling in Tanzania

I would like you to express your views freely and openly. All information that you give is strictly confidential. We also request permission to have your name which will not appear in any reports or notes, unless it is consented.

Your participation is voluntary and there is no penalty for refusing to take part. You may refuse to answer any question in this questionnaire/interview or stop the interview at any time. You are free to ask questions at any time.

Would you be willing to participate? 1=Yes 2=No

Thank you.

_____

(Signature of interviewer certifying that informed consent has been given verbally by respondent)

INTERVIEWER: Code: [____|____] Name (Initials): _____

DATE OF INTERVIEW: |___||___|\|___||___|\ |___||___||___||___|

Day Month Year

CHECKED BY SUPERVISOR: Signature_____Date:_____

Note to interviewer: Ensure your response are in project specific

A: PROJECT MANAGEMENT

1. Do you think the two projects achieved HTC goals? Explain HOW?
    A) Angaza Zaidi

Objective 1: Greatly increase the number of Tanzanians who know their sero- status, have received counseling, and have been linked to relevant treatment, care, and prevention services.

Objective 2: Utilize new, exceptionally innovative and effective approaches to stimulate demand for and use of testing.

Objective 3: Ensure provision of high quality HIV counseling and testing services, the scale up of coverage and greatly expand access to cost-effective HCT services while ensuring that high quality HCT services are provided by skilled and/or accredited providers trained according to national and international counseling and testing guidelines and standards.

Objective 4: Build the capacity of local implementing organizations for sustainable delivery of quality, efficient counseling and testing services.

Objective 5: Build and/or strengthen referral systems for achieving integrated networks of service and increased access to comprehensive HIV/AIDS services.

Objective 6: Support implementation of the national counseling and testing priorities at regional, district, and community services.

    B) UHAI-CT

Objective 1. Rapidly increase access to quality HIV CT for all Tanzanians, particularly those populations most-at-risk for infection, as an entry point into the continuum of HIV care and prevention.

Objective 2. Develop providers' skills for quality HIV CT service delivery.

Objective 3. Strengthen links to prevention, care, and treatment services, including establishing community care and support for HIV-positive clients within HIV CT projects; and;

Objective 4. Create demand for HIV CT by mobilizing communities with a special focus on underserved and most-at-risk persons.

2. What are each project's strengths, weakness and gaps in **planning and management of routine data use and service delivery?**
    A) Angaza Zaidi
    B) UHAI-CT

3. In your opinion, how have the projects established constructive working relationship with key stakeholders such as Government, like minded partners, and CSOs? [*Probe on how regular meeting for update and if government provide guidance and feedback*]
    A) ANGAZA Zaidi

B) UHAI-CT

B: PROJECT ACCOMPLISHMENTS AND RESULTS

4. Is there evidence that shows that each project has [*provide examples*]
   Improved the quality of HIV testing and counseling services at the health facility level?
   A) Angaza Zaidi
   B) UHAI-CT

   Improved the quality of services at the community level?
   A) Angaza Zaidi
   B) UHAI-CT

   Improved referral linkages between the community and facility level [*Probe how referrals are done if someone test HIV positive and if there is a mechanism for VCT to receive feedback from CTC*]
   A) Angaza Zaidi
   B) UHAI-CT

5. What HTC modalities are used in your district for counseling and testing? Which of these modalities are more effective in reaching the target population and why? *[Probe – Integrated VCT, Stand alone VCT, Mobile outreach and UHAI-CT includes PITC, Community based CT]*
   A) Angaza Zaidi
   B) UHAI-CT

6. How effective has each project contributed in influencing HIV policies related to counseling and testing? [*Probe if projects activities aligned with the National HIV/AIDS strategies, policies and guidelines*]
   A) ANGAZA Zaidi
   B) UHAI-CT

C: MONITORING & EVALUATION

7. To what extent have the projects services been successfully integrated into the Council/District health plans and community HIV initiatives? [*Probe on supervision, quality assurance*]
   A) Angaza Zaidi
   B) UHAI-CT

8. How successful has each project been in providing valid and reliable information? [*Probe on How have the projects complemented work done under the other PERFAR partners and avoid duplication*]
   A) Angaza Zaidi
   B) UHAI-CT

D: LESSON LEARNT & SUSTAINABILITY

9. What lessons learnt and good practices (what works well) by the following projects which needs replication in your district?
   A) Angaza Zaida
   B) UHAI-CT

10. How has each project built capacity and/or institutionalized to ensure that HTC services are provided beyond projects phase out? *(Probe on type of services, Target population groups, Implementing partners, Collaborators)*
    A) ANGAZA Zaidi
    B) UHAI-CT

E: FINAL COMMENTS

READ: That question completes our interview today. Thank you very much for sharing your thoughts with me. The information you have provided has been very helpful

ANNEX V: SOURCES OF INFORMATION

LIST OF PERSONS INTERVIEWED

S/N	Name	Title	Location
IRINGA REGION			
1.	Nuhu Ahmed Mwasumilue	Acting Administrative Secretary	Iringa Region
2.	Dr. Paul J. Luvanda,	Regional AIDS Control Coordinator	Iringa Region
3.	Dr. Paul Alexander	District Medical Officer (DMO)	Iringa Municipal
4.	Dr. Bonaventura Kalumbete	District AIDS Control Coordinator(DACC)	Iringa Municipal
5.	CHMT	DMO, Pharmacist, Dentist, District Health Officer and Statistics focal person	Members - Iringa Municipal
6.	Berit M. Skaare	Managing Director	UHAI – CT - Ilula Orphan Center
7.	Robert Mbungu	Project Manager	UHAI-CT - Ilula Orphan Center
8.	Boniface B. Magessa	Area Support Officer	AZ – ASO - Southern Highland
9.	Gabriel Nyunja	Assistant Project Director	AZ – ASO – Southern Highland
10.	Emmanuel Simon	Assistant Project Director	AZ – ASO – Southern Highland
11.	Christine Polepole	Site Manager for Stand-AloneStand-Alone VCT	AZ – Kitanzini Stand-AloneStand-Alone VCT
12.	Ester Mangula	In-Charge	Sabasaba Dispensary
13.	Sara Beckham	Johns Hopkins University Ph.D. Student	Studying Sex Workers and AIDS
14.	Eliza Chusi	Director	AHAI – CT – Alpha Dancing Group
15.	Sister Michela Astegiano	Director	Allamano Centre, Iringa MC
16.	Dr. Nicola La Porta	Clinic In-Charge	Allamano Centre, Iringa MC
17.	Zainabu Zambo	HBC Coordinator	Allamano Centre, Iringa MC
18.	Christopher Kunzugata	Coordinator	Allamano Centre, Iringa MC
19.	Christian Mgona	Accountant	Allamano Centre, Iringa MC
20.	PTC Members	Eight members	Kitanzini Post Test Club, Iringa MC
21.	Zaituni Msangilwa	In-charge	Igumbiro Dispensary, Iringa MC
22.	Dr. Erick Bakuza	DMO	Mufindi District Council
23.	Dr. Zena Mkumba,	Ag. DACC	Mufind District Council
24.	Felicia Mgao	Site manager	Mafinga VCT
25.	Dr Eugene Lutambi	Medical Officer in-charge	Mufindi District Hospital
26.	Mrs. Mbona	Site Manager - VCT	Mufindi District Hospital
27.	Hamza Lubungo,	Counselor volunteer	Mafinga VCT
NJOMBE REGION			
28.	Dr. Margret Msasi	DACC / ag DMO and Town Medical In-charge	Makambako HC
29.	Neema Sanga	Site Manager - VCT	Makambako HC

30.	Flora Mdugo	Counselor - VCT	Makambako HC
31.	Andrew Mwanda	Counselor - PITC	Makambako HC
32.	Linus Mzavalila	Village Executive Officer	Mlowa village, Makambako HC
33.	Rujina Mhianze	Ward Executive Officer	Mlowa ward, Makambako HC
34.	Veronica Mlelwa	Ward Education Coordinator	Mlowa ward, Makambako HC
TANGA REGION			
35.	Dr. Seleman Msanga	RACC	Tanga Region
36.	Dr. Peter Neema	DMO	Tanga Municipal
37.	Dr. Justice Munisi	DACC	Tanga Municipal
38.	Agnes Kaizi	Counseling and Testing Focal Person	Tanga Municipal
KILIMANJARO REGION			
39.	Dr. Mtumwa S. Mwamko	RMO	Kilimanjaro Region
40.	Dr. Chilangwa	RACC	Kilimanjaro Region
41.	Agnes Ndyetabura	Area Support Officer	AZ - ASO - North Eastern Zone
42.	Dr. Lucas Kiwiche	DACC	Moshi District Council
43.	Dr. Samuel Ulomi	Facility In-charge	Marangu Hospital
44.	Costancia Ephata Moshi	Site Manager	Marangu VCT
45.	Anneline S. Malisa	Counselor	Marangu VCT
46.	Dr. Ndossi Taramaeli	DACC	Mwanga District Council
47.	Dr. Alex	Coordinator PITC/CTC	Usangi District Hospital
48.	Aziza Mmbaga	Counselor	Usangi District Hospital
49.	Severa Masawe	Site Manager	Mwanga VCT
50.	Dr. Paul Shaote	DMO	Hai District Council
51.	Angelista Shirima	DACC	Hai District Council
52.	Dr. Fanuel Daudi	Facility In-charge	Hai District Hospital
53.	Felisia Daniel Ritte	Counselor	Hai District Hospital
54.	Dr. Ignatius Massawe	Facility In-charge	Kilema Hospital
55.	Rosalia G. Mosha	Counselor/Focal Person PITC	Kilema Hospital
56.	Peninah Shuma	Site Manager	Machame Hospital
TABORA REGION			
57.	Dr. Leslie Mhina	RMO	Tabora Region
58.	Grace Mmasi	RACC	Tabora Region
59.	Dr. Ruth Hullser	Facility In-charge	St. Phillip Health Centre
60.	Magdalena Nicholus	Facility In-charge	Isevya Dispensary
61.	Joyce Mkande	Counselor	Isevya Dispensary
62.	Dr. Goma Paul	Counselor	St. Phillip Health Centre
63.	Fr. Alex Nduayo	Project Manager	CSO Sub grantee of UHAI-CT TAHO/HAPO
64.	Joyce Bruno	Counselor	CSO Sub grantee of UHAI- CT, TAHO/HAPO
65.	Ezekiel Shumbi	Counselor	CSO Sub grantee of UHAI-CT, TAHO/HAPO
66.	Asifiwe C. Kinyonga	Counselor	Morovian VCT
67.	Eliud Joseph	Site Manager	Morovian VCT
68.	Dick Lucas Mlimuka	Executive Director	CSO Sub grantee of UHAI – CT

			Tabora Development Foundation Trust (TDFT)
69.	Deogratius Kahumbi	Project Coordinator	CSO Sub grantee of UHAI – CT Tabora Development Foundation Trust (TDFT)
70.	Fred Malaso	Monitoring and Evaluation Officer	CSO Sub grantee of UHAI-CT Tabora Development Foundation Trust (TDFT)
71.	Anastazia Ntiruhungwa	Counselor	CSO Sub grantee of UHAI – CT Tabora Development Foundation
72.	Joachim Milambo	Counselor	CSO Sub grantee of UHAI-CT Tabora Development Foundation
DAR ES SALAAM REGION			
73.	Christopher Sechambo	Acting DMO	Ilala Municipal Council
74.	Lilian Mnzava	DACC	Ilala Municipal Council
75.	Farida Shemkande	Site Manager	Mnazi Mmoja VCT – Ilala Municipal Council
76.	Dr. Felister Kwai	Facility In Charge	Mnazi Mmoja VCT – Ilala Municipal Council
77.	Faraja Ligate	Counsellor	Mnazi Mmoja VCT – Ilala Municipal Council
PROJECT IMPLEMENTORS			
78.	Dr. Benedicta Mduma	HIV Technical Advisor	Angaza Zaidi
79.	Dr. Ritha Noronha	Deputy Country Director	Angaza Zaidi
80.	Dr. Beatus Mboya	Chief of Party / Project Manager	Angaza Zaidi
81.	Fransic Masanja	Grant Manager	Angaza Zaidi
82.	James Chialo	TMARC focal Person	UHAI CT
83.	Fredy Msongole	Finance Manager	Accounting - UHAI CT
84.	Maryjane LaCoste	Country Director	Jhpiego
85.	Dr. Fatma Kobode	UHAI-CT COP	UHAI-CT
86.	Marya Plotkin	M&E Specialist	Jhpiego
87.	Hally Mahler	Former UHAI-CT COP	Jhpiego
88.	Respeace Mgawe	M&E Officer	Angaza Zaidi
89.	Michael Machaka	M&E Officer	Angaza Zaidi
National Level			
90.	Peris Urassa	Program Officer	NACP
91.	Maryland Ntiro	Head of Counseling and Social Support Unit	NACP
USAID			
92.	Seth Greenberg	Community Health Promotion Unit Lead	USAID/Tanzania
93.	Dr. Charlene Brown	Senior Technical Advisor, HIV Testing and Counseling	USAID/Washington
94.	Vincent J Wong	Senior Advisor, HIV Testing and Counseling	USAID/Washington

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SITES VISITED

The four weeks of field research represent up to 23 days for travel and research for each team. The sample includes:

Field Work Routes Plan - 5 Regions

Summary of Fieldwork route plan

Region	Date	Route
Iringa and Njombe	3rd – 15th November	Route 1
Tanga	16th – 22nd November	Route 1
Kilimanjaro	3rd– 9th November	Route 2
Tabora	10th – 21st November	Route 2
Dar es Salaam	25th – 26th November	Route 1 & 2

Type of sites	Total to be visited	AZ	UHAI-CT
Hospitals	7	Integrated VCT(3)	4
Health Centers	6	Integrated VCT (2)	4
Dispensaries	3	0	3
VCT (Stand-Alone)	4	4	0
Community sites evaluation (local brews, open markets, and road camp)	4	0	4
Community outreach exercise	8	2	6
Total sites	**32**	**11**	**21**

Route 1 Detailed fieldwork route plan

Region	Districts	Facility Name	Implementer	Types	Days
Travel from Dsm to Iringa Town					
Iringa	Iringa Regional Office	Iringa Municipal Council - Urban			1
		Igumbilo Dispensary	UHAI-CT	Dispensary	1
		Kitanzini VCT	AZ	Stand Alone VCT	1
		Sabasaba Dispensary	UHAI-CT	Dispensary	1
		ALPHA Dancing Group	UHAI-CT	CB – CT Exercise (Local Brew, and Nzihi village)	1

		Illula Orphanage (IOP)	UHAI-CT	CB-CT Exercise	I
Sunday - *Travel from Iringa to Mufindi District Council*				I	
	Mufindi District Council	Mafinga District Hospital	UHAI-CT	Hospital	I
		Mafinga VCT	AZ	Stand Alone VCT	I
Travel from Mufindi DC to Makambako Town Council – Njombe Region		Makambako VCT	AZ	I	
		Community Outreach – Makambako VCT	AZ	CB-CT Exercise Mlowe Village	I
		CB-CT in collaboration with TMARC	UHAI-CT	CB-CT	I
		CB-CT in collaboration with TMARC	UHAI-CT	CB-CT	I
Travel from Makambako – overnight in Morogoro					
Sunday	Arrive in Korogwe				
	Korogwe District Council DMO				0.5
		St. Raphael Hospital	UHAI-CT	Hospital	0.5
		Bakwata Dispensary	UHAI-CT	Dispensary	0.5
Tuesday	Arrive in Tanga				
	Tanga Regional	RACC, RMO			0.3
		Makororo HC	UHAI-CT	HC	0.3
		Tanga AIDS Working Group (TWAG) Outreach	UHAI-CT	HC	0.4
		Nagamiami HC	UHAI-CT	HC	0.5
		TWAG HQ	UHAI-CT	FGD	0.5
		Ngamiani HC			
	Korogwe	DACC			
Travel to Dar es Salaam					

Route 2 Detailed field work route plan

Region	Districts	Facility Name	Projects	Type of Facility	Days
***Sunday* - Travel from Dar es Salaam to Kilimanjaro**				I	

Kilimanjaro	Mwanga DC	Mwanga HC	AZ	Stand Alone VCT	I
		Usangi Hospital	UHAI-CT	Hospital	0.5
Travel to Moshi Town				I	
	Moshi Region	Moshi DC			I
		Marangu VCT Hospital	AZ	Integrated Hospital	I
		Kilema Hospital	UHAI-CT	Hospital	0.5
Travel from Marangu – Hai DC				0.5	
	Hai DC	Hai Hospital	UHAI-CT	Hospital	0.5
		Machame VCT	AZ	Hospital	I
Sunday - Travel from Hai to Manyara					
Travel from Manyara to Tabora					
Tabora	Tabora Regional	Tabora MC			I
		Isevya Dispensary	UHAI-CT	Dispensary	I
		St Philip Health Centre	UHAI-CT	HC	I
		Moravian Health Centre	AZ	HC	I
		Community Outreach – Moravian Health Centre	AZ	CB-CT Exercise	I
Sunday					**I**
		Health Action Promotion Tanzania (HAPO)	UHAI-CT	CB-CT (Local Brews Road Camp site)	I
		Community Outreach - HAPO	UHAI-CT	CB-CT Exercise	I
		Tabora Development Foundation Trust (TDFT)	UHAI-CT	CB-CT (Bars, Guest Houses)	I
		Community Outreach – (TDFT)	UHAI-CT	CB-CT Exercise	I
Travel from Tabora - Dodoma				**I**	
Travel from Dodoma – Dar es Salaam				**I**	

Dar es Salaam Detailed field work plan

Region	Districts	Facility Name	Implementer	Type of Facility	Days
Dar es Salaam	Ilala Municipal Council	Mnazi Mmoja HC	AZ	(Integrated VCT) HC	I

ANNEX VI: NOTES ON TABLE 1

COMPARISON OF COSTS AND QUALITY SCORES BY HCT IMPLEMENTING PARTNERS AND MODALITIES

	Total Expenditures 7/08 – 9/13	Individuals Tested	Positives Identified	Expenditure per Test	Expenditure per Positive	Counselor Quality Score	Client Quality Score
UHAI-CT							
PITC	$8,134,015	872,030	78,987	$9.33	$102.98	10.9	12.3
Community Outreach	$4,726,220	465,706	20,638	$10.15	$229.00	12.7	13.4
Angaza Zaidi							
Stand-Alone VCT	$1,478,642	505,618	36,295	$2.90	$40.70	10.0	13.6
Integrated VCT	$4,217,119	634,909	57,334	$6.60	$73.60	16.5	13.8
Community Outreach	$6,715,536	1,601,491	46,879	$4.20	$143.20		12.6

Table 1 provides a comparison of the different modalities used by the two projects evaluated. It should not be used as an evaluation tool as there are many differences between the implementation methodologies, but can serve as a very rough guide to the strengths and costs of each modality.

The expenditure per test and per HIV positive identified are estimates derived from taking the total expenditures of the Projects through September 2013 and dividing by the number individuals tested by the different modalities. Note that the PITC modality was based on technical assistance to that program, while all the other modalities were more project directed. UHAI-CT credited the program with all tests conducted by the PITC program in the Regions where they worked, even though most providers and facilities never saw UHAI-TC. . UHAI/CT also had multiple overheads (Jhpiego, Africare and the CSOs for Community Based VCT, compared to Angaza Zaidi.

The Quality Scores were derived through quantitative analysis of the Counselor Interview Questionnaires and the Client Exit Questionnaires using Statistical Product and Service Solutions (SPSS) and Excel. Specific questions in the sheets were selected as a quality indicators and assigned weights.

The questions included in the Client Exit Interview and Counselor Interviews and weights assigned to them are attached.

The maximum quality score for a Client exit Interview is 20. The maximum quality score for a Counselor interview is 15. One question in the Counselor interview, (fourth in Section 4) is "out of order" in that the correct answer is checking the first column. This may have caused confusion with the interviewer or the respondent.

The total score for each modality was added up and divided by the number of questionnaires per modality to get the average, or Quality Index.

The number of questionnaires for the Counselor and Client Exit Interviews are:

	Counselors	Client Exit
UHAI-CT		

PITC	13	22
Community Outreach	6	36
Angaza Zaidi		
Integrated VCT	4	12
Stand-Alone VCT	3	14
Community Outreach		24

Note that the counselors for the Angaza Zaidi Community Outreach programs are the same as in the static VCT centers. They were interviewed at the centers. There were probably not enough counselors interviewed from Angaza Zaidi to make the results statistically significant.

HTC QUALITY CATEGORIES AND ALLOCATED WEIGHTS FOR EXIT INTERVIEWS

S/N	QUALITY CATEGORY	RESPONSE		WEIGHT
C05	Was the counseling session private?	Yes No		1.0 0.0
C06	Were the following aspects of privacy observed?	The door was closed Nobody entered the room Both of them		1.0 2.0 3.0
C07	What aspects of privacy was not observed?	The door was opened Someone entered the room Both of them		0 -1.0 -2.0
C08	Do you think you were given adequate information during the counseling session?	Yes No	01 02	1 0
C09	Did the counselor give you the opportunity to ask questions?	Yes No	01 02	1 0
C10	Did the counselor adequately respond to your questions?	Yes No Did not ask	01 02 03	1 0 0.5
C11	Did the counselor discuss with you the benefits of testing?	Yes No	01 02	1 0
C12	Did the counselor discuss with you about how to share your results with family/ partner?	Yes No	01 02	1 0
C13	Did the counselor discuss with you your HIV infection risk?	Yes No	01 02	1 0
C14	Did the counselor discuss with you about any prevention measures you should take?	Yes No	01 02	1 0
C15	Did the counselor advice you to bring your partner?	Yes No	01 02	1 0
C16	Were you given any advice on the use of condoms?	Yes No	01 02	1 0
C17	Were you told where you can access condoms?	Yes No	01 02	1 0
C18	Were you given any information/skills on how to get your partner use condoms?	Yes No	01 02	1 0

C19	Did the counselor demonstrate how to use condoms?	Yes No	01 02	1 0
C20	Did the counselor give you any condoms to take with you home?	Yes No	01 02	1 0
C21	Did the counselor advice you to come for testing another time?	Yes No	01 02	1 0
C22	What was the attitude of the counselor towards you?	Friendly Neutral Unfriendly	01 02 03	1 0.5 0
C23	What was the attitude of the lab technician towards you?	Friendly Neutral Unfriendly	01 02 03	1 0.5 0
C24	What was the attitude of the receptionist towards you?	Friendly Neutral Unfriendly	01 02 03	1 0.5 0
C25	Overall, what do you think about the services you received today?	Very good Fair Bad	01 02 03	1 0.5 0
C26	Overall, do you think that your results will remain confidential between you and the counselor?	Yes No	01 02	1 0
C27	What can you say about the cleanness of the facility?	Very clean Clean Not clean	01 02 03	1 0.5 0

Reliability Alpha with this set of 25 questions = 0.76

We improved reliability by excluding the following questions because they were not adding to the reliability of the scale: C11, C24, C27, and C30.

Reliability Alpha with new set = 0.78

Score was developed by adding each question based on a weighted scoring system as can be seen (in red) above.

HTC QUALITY CATEGORIES AND ALLOCATED WEIGHTS FOR COUNSELOR INTERVIEWS

19. When you counsel clients, what information do you cover? (*check all that apply*) (***Weights marked in red***)

For every box checked, how often	**Every client**	**Most clients**	**Only clients that I think don't know**	**Rarely / Seldom**	**NO**
¨ inquire about their partners' HIV status	1	0.5	0.5	0	0
¨ use of condom	1	0.5	0.5	0	0

¨ risk with multiple partners	1	0.5	0.5	0	0
¨ reduced risk if man is circumcised	1	0.5	0.5	0	0

20. What safety precautions do you take when testing clients for HIV? (***Weights marked in red***)

For every box checked, how often?	**Always**	**Often**	**Rarely / Seldom**
¨ Wash hands before and after testing each patient	1	0.5	0
¨ Wear fresh pair of gloves with each patient	1	0.5	0
¨ Wear laboratory coat or apron	1	0.5	0
¨ Dispose of contaminated sharps and waste immediately after testing	1	0.5	0

21. If a client tests positive for HV, what do you do? (***Weights marked in red***)

0. ¨ nothing **0.5** ¨ inform him/her **0.5** ¨ inform and counsel **0.5** ¨ refer to care and treatment
1.0 ¨ inform post test counsel and refer to care and treatment

22. Tell me if you agree or not with each of the following statements? (strongly agree, agree, disagree, strongly disagree)

Statement	**1=strongly agree**	**2=agree**	**3=disagree**	**4=strongly disagree**
I believe that HIV-positive patients are the biggest threat to my safety at my place of work.	0	0	0.5	1
I feel that clients who have sexual relations with people of the same sex (e.g. men who have sex with men) should seek health services elsewhere	0	0	0.5	1
I feel that clients who are sex workers should seek health services elsewhere.	0	0	0.5	1
I am comfortable providing health services to clients who are HIV-positive.	1	0.5	0	0
I believe that people who are infected with HIV should not be treated in the same areas as other clients in order to protect the larger population from infection.	0	0	0.5	1
I avoid touching clients for fear of becoming infected with HIV.	0	0	0.5	1

ANNEX VII: UHAI-CT STARTUP SUPPORT TOOLS

Revised 6th November 2013

1. Basic information about the facility
    a. Human resources
        i. number of staff,
        ii. cadres,
        iii. how many trained for PITC, VCT, PMTCT
    b. Services provided
    c. Number of wards- IPD, OPD
2. Feedback after training
    a. Implementation of the action plan- check this/ ask them to show you
    b. Facility management
    c. Orientation of colleagues,
    d. Sensitization of the community
3. Coordination of Services
    a. Identification of focal persons
    b. Referral to CTC, VCT etc.
    c. Support meetings (internal and external)
    d. Integration of PITC services in other outreach services
    e. Outreach CTC- number of refilling sites

4. Availability and challenges of M and E tools
    a. Daily registers
    b. monthly site summary forms
    c. Form A4 (kumbukumbu ya siku ya matumizi ya vitendanishi vya upimaji wa VVU)
    d. Submission of reports to districts
5. Logistics
    a. Test Kits availability
    b. Other HIV Testing supplies
    c. Availability of M and E tools and forms
        i. referral ,
        ii. guardian consent,
        iii. anonymous card
6. Availability of Guidelines and Job Aids
    a. PITC guideline for HIV testing and counseling in clinical setting
    b. Testing algorithm
    c. Testing procedure cards
    d. Cue cards
7. Display of job aids
    a. Testing algorithm
    b. Testing procedure cards
    c. Cue cards
8. PITC model ---How????

a. Initiation
b. Use of group pre- test information
c. Testing
d. posttest counseling

9. General
    a. Maintain a clean and organized work place
    b. Adhere to safety work habits (including protective gears)
    c. Use appropriate sharps disposal containers
    d. Dispose of contaminated and non-contaminated waste in proper containers
    e. Availability of a functional incinerator
10. TB screening tool
    a. Availability
    b. Use

ANNEX VIII: START UP SUPPORT TOOL FOR GENDER BASED VIOLENCE (GBV) AND VIOLENCE AGAINST CHILDREN (VAC)

1. Basic information about the facility
    a. Human resources:
        i. Are providers trained for GBV and VAC still available at the facility?
    b. Services provided in:
        i. IPD
        ii. OPD
        iii. Where is the GBV & VAC provider positioned in each department?
    c. Linkage of facility to community
        i. Existing fora
        ii. Frequency of interaction between facility and community structures
2. Start of service for response against gender based violence (GBV) and violence against children (VAC)
    a. Have you started offering GBV and VAC services? (If the answer is NO move to 2e)
    b. If you have started, what successes have you achieved?
    c. If you have started, what challenges have you encountered?
    d. How effective have you found the use of the following Job aids (if you have used them)
        i. Flow chart for receiving a GBV client
        ii. Procedure for receiving and handling of a GBV client
        iii. Procedure for receiving and handling a child survivor
    e. If you have not started, what hurdles have you met?
3. Coordination of Services
    a. Identification of GBV & VAC Focal Persons
    b. Internal peer supervision arrangements
    c. Orientation of other staff
    d. Prepared a directory of different service providers
    e. Referral and linkages to Social Welfare, Justice, Police, Community services, safe houses and drop in center
    f. Support meetings (internal and external)
    g. Integration of GBV & VAC services in other routine facility services
4. Availability and challenges of M and E tools
    a. GBV Medical Form
    b. GBV Register
    c. GBV Consent form
5. Conditions for service provision rooms
    a. Privacy for confidentiality
    b. Enough lighting
    c. Good ventilation
    d. Relevant furniture available
    e. Running water available
    f. Safety box available
6. Logistics and supplies

a. Drugs
    i. ARV for PEP
    ii. EC drugs
    iii. Tetanus Toxoid
    iv. STI drugs
b. Facilities for collecting forensic evidence
    i. Speculum (adult & children)
    ii. Syringes (disposables)
    iii. Specimen containers
    iv. Vaginal swabs
    v. Gloves
c. Other supplies
    i. Resuscitation equipment
    ii. Surgical sutures
    iii. Dressing tray
    iv. Sanitary supplies
    v. Pregnancy test kits
    vi. Extra clothes for survivors
d. Other relevant forms
    i. HIV referral form
    ii. Parent/Guardian consent Form for Children Under 18 and Persons with Communication Disabilities
    iii. Client anonymous card
    iv. PF3

7. Availability and use of Guidelines and Job Aids
    a. National Management Guideline for the Health Sector Prevention and Response to Gender Based Violence
    b. National Policy Guideline for the Health Sector Prevention and Response to Gender Based Violence
    c. HIV Rapid Testing Algorithm
    d. Rapid Testing procedure cards
    e. Guide for Obtaining Consent From GBV and VAC Survivors
    f. Procedure for Receiving and Handling Of A GBV Client
    g. Procedure for Receiving and Handling a Child Survivor
    h. GBV Screening – Modified Abuse Assessment Screen (MAAS)
    i. Modified Child Abuse Screening Questions
    j. Warning Signs Of Child Abuse And Neglect
    k. Measures for Developing Safety of the Survivor
    l. Safety Plan Guiding Questions
    m. Adherence Counselling Tips
    n. Pre and Post Test Counselling Tips
    o. Emergency Contraception for Survivors of Sexual Violence
    p. Guide for Collection of Forensic Evidence for Survivors of Gender Based Violence
    q. Forensic Specimens

r. Guide for Providing Referral to GBV and VAC Survivors
s. Steps for Providing PEP for GBV and VAC Survivors
t. Techniques for Stress Management

8. General
    a. Maintenance of a clean and organized work place
    b. Adherence to safety work habits (including protective gears)
    c. Use of appropriate sharps disposal containers
    d. Disposal of contaminated and non-contaminated waste in proper containers
    e. Availability of a functional incinerator
9. Community Mobilization/Sensitization on GBV and VAC
    a. Use of health education on GBV and VAC
    b. Become champions of the cause for responding to GBV and VAC
    c. Orient other facility workers and encourage them to advocate for GBV and VAC

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PERFORMANCE EVALUATION OF USAID TESTING AND COUNSELING PROJECTS IN TANZANIA

DRAFT EVALUATION METHODOLOGY AND WORK PLAN

Submitted to USAID for review on 1 November 2013

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EVALUATION METHODOLOGY AND WORK PLAN FOR USAID TANZANIA'S PERFORMANCE EVALUATION OF USAID TESTING AND COUNSELING PROJECTS IN TANZANIA

CONTENTS

ACRONYMS AND ABREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical and Research Foundation
APR	Annual Progress Report
ART	Anti Retrovirus Treatment
ASO	Area Support Office
AZ	Angaza Zaidi
BCC	Behavior Change Communication
BSS	Behavioral Surveillance Survey
CBO	Community-Based Organization
CDC	Centers for Disease Control and Prevention
CICT	Client Initiated Counseling
CSO	Civil Society Organization
CSSU	Counseling and Social Support Unit
CT	Counseling and Testing/ Counseled and Tested
CTC	Care and Treatment Clinic
DACC	District AIDS Control Coordinators
DBS	Dry Blood Spot
DMO	District Medical Officer
DOD	Department of Defense
DQA	Data Quality Assessment
FBO	Faith-Based Organization
FGD	Focus Group Discussion
FP	Family Planning
GOT	Government of Tanzania
HTC	HIV Testing and Counseling
HEID	HIV Early Infant Diagnosis
HIV	Human Immunodeficiency Virus
IBTCI	International Business & Technical Consultants, Inc.
Jhpiego	A Member of the Johns Hopkins University
K P	Key Populations at Most Risk of HIV
MARP	Most At Risk Population
MOHSW	Ministry of Health and Social Welfare
M&E	Monitoring and Evaluation
MSD	Medical Stores Department

MSH	Management Sciences for Health
MSM	Men having Sex with Men
MTE	Mid-Term Evaluation
NACOPHA	National Council of People Living with HIV/AIDS
NACP	National AIDS Control Program
NGO	Non-governmental Organization
PEPFARUS	President's Emergency Plan for AIDS Relief
PITC	Provider Initiated Testing and Counseling
PLHIV	People living with HIV
PMTCT	Prevention of Mother to Child Transmission
PTC	Post Test Club
PwP	Prevention with Positives
RACC	Regional AIDS Control Coordinator
SDA	Seventh Day Adventist Church
SIS	Strategic Information Specialist
STI	Sexual Transmitted Infections
TA	Technical Assistance
TACAIDS	Tanzania Commission for AIDS
T-MARC	Tanzania Marketing and Communication Co.
THMIS	Tanzania HIV Malaria Information Survey
UHAI-CT	Universal HIV and AIDS Intervention for Counseling and Testing
USAID	United States Agency for International Development
URT	United Republic of Tanzania
USG	United States Government
USG/T	United States Government in Tanzania
VCT	Voluntary Counseling and Testing
VMMC	Voluntary Medical Male Circumcision

INTRODUCTION

The United States Agency for International Development (USAID) in Tanzania will conduct an independent external project evaluation of two HIV testing and counseling (HTC) projects namely: Angaza Zaidi, being implemented by the African Medical and Research Foundation (AMREF), and Universal HIV and AIDS Intervention for Counseling and Testing (UHAI-CT), being implemented by Jhpiego Corporation. This external project evaluation will appraise the performance of the current HTC projects in meeting their objectives and will provide recommendations to USAID for the design and implementation of follow-on activities. Both projects began in 2008 and were given 10-month extensions (AMREF - at cost; Jhpiego - no-cost) from July 2013 through May 2014.

BACKGROUND

According to the 2010 UNAIDS report on the Global AIDS Epidemic, 1.4 million Tanzanians are living with HIV. There are an estimated 86,000 AIDS-related deaths in Tanzanian each year, resulting in disruption of family structures and an increase in the number of children made orphan and/or vulnerable (OVC). Overall, 5.1% of Tanzanians age 15-49 are HIV- positive. HIV prevalence is higher among women (6.2%) than among men (3.8%). HIV prevalence is higher in urban areas for both women and men than in rural areas.

A comparison of the 2007-08 THMIS and 2011-12 THMIS HIV prevalence estimates indicate that HIV prevalence has declined slightly from 5.7% to 5.1% among adults age 15-49. Similarly, HIV prevalence has declined among women, from 6.6% to 6.2%, and among men from 4.6% to 3.8%. These declines in HIV prevalence are not statistically significant. In Mainland Tanzania, HIV prevalence among women and men ages 15-49 has decreased from 7.0% in the 2003-04 THMIS to 5.3% in the 2011-12 THMIS. The decline in total HIV prevalence between 2003-04 and 2011-12 is statistically significant. Additionally, the decline is significant among men (6.3% versus 3.9%).

In Zanzibar, the HIV epidemic is concentrated among key populations, namely people who inject drugs (PWID), female sex workers (FSWs), and men who have sex with men (MSM). HIV prevalence is estimated at 0.6 % in the sexually active population (THMIS, 2011), while recent studies of key populations in Zanzibar have estimated HIV prevalence for PWID, FSWs, and MSM at 16.0%, 10.8%, and 12.3%, respectively.

Compared to earlier years, results from the 2010 DHS suggest some successes in the response to HIV but also highlight remaining deficits. Knowledge of HIV is widespread, with 99% of respondents having heard of it. Less than half of those respondents, however, have a comprehensive knowledge of HIV transmission and prevention methods. Tanzanians are increasingly aware of opportunities for testing and learning their HIV status. Thirty percent of women and 25% of men were tested for HIV in the year preceding the survey, figures that are much higher than those recorded in previous surveys. Prevalence of male circumcision among men aged 15-49 increased five percentage points from 66.8% (2007-08 THMIS) to 72.3% (2010 DHS), with significant regional variation.

Despite systems and leadership challenges, the country has made some progress in defining a policy and strategy framework to guide stakeholders in the response to HIV. Among many key documents, the principal reference points are the National Multi-Sectoral Framework on HIV/AIDS (NMSF 2008-2012), Health Sector HIV and AIDS Strategic Plan II (2008-2012) ; Zanzibar National HIV Strategic Plan II (ZNSP II, 2011-2016), Health Sector Strategic Plan III (HSSP 2009-2015); the National Multi-Sectoral HIV Prevention Strategy (2009-2012); the National Voluntary Counseling and Testing/ Provider Initiated Testing and Counseling (VCT/PITC) guidelines, 2005 and 2009 respectively; and the National VCT/PITC Standard Operating Procedures (SOPs) (2009). The Five-Year Partnership

Framework in Support of the Tanzanian National Response to HIV and AIDS 2009- 2013 between The Government of the United Republic of Tanzania (URT) and the Government of the United States of America (Partnership Framework, or PF) defines the roles and responsibilities of the URT and USG/T in addressing HIV and is aligned with these key documents.

PEPFAR support to Tanzania has enabled a dramatic increase in the number of adults and children accessing Anti-Retroviral Treatment (ART), with approximately 353,246 individuals receiving treatment as of June 2012. During FY 2011, a total of 3.1 million individuals received HIV testing and counseling. 58,200 pregnant women received prevention of mother-to child transmission of HIV (PMTCT) services including ART, and 368,000 OVC received support. Although USG/T is by far the largest single contributor to the national HIV response, other stakeholders play key roles. In particular, the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) provides substantial support for HIV interventions in Tanzania, including commodities procurement and systems strengthening activities. Other actors include the U.N. Joint Program and the Governments of Canada, Belgium, Denmark, Japan, Netherlands, Norway, and Sweden.

OVERVIEW OF ANGAZA ZAIDI AND UHAI-CT PROJECTS

AMREF – ANGAZA ZAIDI

With funding from USAID, AMREF continues to implement the extension of a national five-year (July 2008-July 2013; extended through May 2014), $16,300,000 million project, under Cooperative Agreement Number 621-A-00-08-00018-00 with its partner Management Sciences for Health (MSH) titled "Rapid Scale-Up of Innovative HIV Counseling and Testing Approaches in Tanzania Mainland", also known as Angaza Zaidi, a Swahili phrase that means "Shed More Light." The primary goal of this project is to improve the health of Tanzanians by ensuring that they know their HIV status, take steps to protect themselves, and have better quality of life if infected. The Angaza Zaidi technical approach uses these three modalities: integrated voluntary HCT, Stand-alone HCT, and community-based HCT. Implementation is guided by strategies of targeting, decentralization and community engagement, branding, partnerships and sub-granting, advocacy and counseling and testing systems strengthening. The project objectives are as follows:

1. Greatly increase the number of Tanzanians who know their sero-status, have received counseling, and have been linked to relevant treatment, care, and prevention services.
2. Utilize new, exceptionally innovative and effective approaches to stimulate demand for and use of testing.
3. Ensure provision of high quality HIV counseling and testing services, the scale up of coverage and greatly expand access to cost-effective counseling and testing (CT) services while ensuring that high quality CT services are provided by skilled and/or accredited providers trained according to national and international counseling and testing guidelines and standards.
4. Build the capacity of local implementing organizations for sustainable delivery of quality, efficient counseling and testing services to ensure that Sub-grantees have requisite technical and organizational capacity to offer quality CT.
5. Build and/or strengthen referral systems for achieving integrated networks of service and increased access to comprehensive HIV services that ensure referral systems are in place.
6. Support implementation of the national counseling and testing priorities at regional, district, and community services by supporting the United Republic of Tanzania (URT) to review and revise policies that hinder the uptake of CT services.

The major target for this project is 2.3 million Tanzanians are reached with quality HTC services and

know their sero-status. The project focus is on the general population and some key populations in the community setting. Currently, Angaza Zaidi operates in 42 sites in 18 regions in Tanzania mainland. Regions are subdivided into intensive and basic support sites. Intensive sites receive substantial financial and technical support compared to basic support partners/regions. There are 12 intensive support regions (Dar es Salaam, Mwanza, Mara, Kilimanjaro, Arusha, Iringa, Njombe, Mbeya, Rukwa, Ruvuma, Mtwara, Lindi), and six basic support regions (Morogoro, Tabora, Manyara, Dodoma, Kigoma, and Singida). The Evaluation Team will conduct site visits in five regions: Iringa, Tabora, Tanga, Kilimanjaro, and Dar es Salaam.

JHPIEGO – UHAI-CT

With funding from USAID, Jhpiego is currently implementing a no cost extension of a national five-year (July 2008-July 2013; extended through May 2014), $16,500,000 million project titled the Universal HIV and AIDS Intervention for Counselling and Testing "UHAI-CT", under Cooperative Agreement Number 621-A-00-08-00019-00 with its partners Africare and the Tanzania Marketing and Communications Company (T-MARC) The primary goal of this project is to increase the number of Tanzanian families, couples, and individuals who know their HIV status, have received quality counseling, and have been linked to relevant HIV care, treatment, and prevention services. UHAI-CT activities are implemented using two modalities; provider initiated HCT, and community based HCT. The UHAI-CT technical approach is guided by the principles of innovation, rapid expansion, diversity of strategies, quality, sustainability, strong links to HIV care and treatment and cost effectiveness. As such, UHAI-CT expects over the life of the program to achieve the following objectives:

1. Rapidly increase access to quality of HTC for all Tanzanians, particularly those at high-risk, through national implementation of PITC and sub-granting to local civil service organizations (CSOs)—including faith-based, nongovernmental (NGO), and community-based organizations— for targeted outreach HTC services;
2. Develop providers' skills for quality HTC service delivery by using a new onsite training approach for facility- level service providers, strengthening quality improvement (QI) systems, and advocating for and supporting the shift of HTC duties to community (lay) counselors;
3. Strengthen links to prevention, care, and treatment services for adults and children, and establish community care and support for HIV-positive clients through close supervision with PEPFAR-supported care and treatment partners, the reinforcement of referrals under PITC, and the establishment of post-test support groups;
4. Create demand and mobilize communities, including high-risk populations, for HTC using mass media and interpersonal communication channels.

The major target for this project is that 1,200,000 Tanzanian clients, including adults and children, will be counseled, tested, and given their results. The project focus is on the general population at health facilities and key populations at hot spots in four regions: Iringa, Njombe, Tabora, and Dodoma. Two of these regions, specifically Iringa and Tabora, will be visited by the Evaluation Team.

PURPOSE OF THE EVALUATION

The main purpose of the evaluation is to assess the performance, including efficiency and quality, of these two USAID-funded HTC projects at the national, regional, facility and community-based service levels. With combined expenditures totaling between $5.0 and $6.5 million per year, these projects account for nearly half of all PEPFAR resources devoted to HTC.

It is expected that this evaluation will identify implementation gaps and challenges, propose recommendations for further improvement and direction for the remaining activity period, document lessons learned and best practices, and provide key recommendations that will inform future

programming directions and the design of follow-on HCT activities.

The product of this evaluation will be one final report that evaluates each project's successes, shortcomings, and lessons learned over the past five years. It will be made available to the public. The report will include recommendations for improving USAID's assistance delivery in client-initiated and provider-initiated HTC in Tanzania and highlight comparative advantages in areas not addressed by other initiatives. Reported information will be disaggregated by gender, age and geographic location when possible.

RELATIONSHIP TO USAID MISSION COUNTRY DEVELOPMENT STRATEGY (CDCS)

USAID/Tanzania's health projects are included under IR 1 ("Improved Health Status") of the second Development Objective ("Human Capital Improved").

EVALUATION TIMETABLE

The proposed timetable for the evaluation activities is attached as Annex I. The evaluation team anticipates having all research instruments prepared and tested by the fourth week in October 2013 and to have completed field work by the fourth week in November, so a draft report can be submitted to the Mission early in December. The dissemination workshop will be provided in late January 2014.

EVALUATION SCOPE AND QUESTIONS

Findings and recommendations will primarily be used to inform more strategic investments in the future focusing on sustainability and eventual URT ownership. The main questions for this program evaluation are as follows:

1. Has each project achieved its stated goals and objectives?
2. What are each project's strengths, weaknesses, and gaps in planning, management, routine data use, and service delivery?
3. How did each project strategically use different HTC modalities to achieve its goals and objects? Were these modalities effective in reaching the target populations?
4. What are the lessons learned from successful interventions that merit continuation or replication, better practices, significant products and tools for possible dissemination and replication?
5. Was each project able to successfully refer newly identified HIV-positive clients to HIV care and treatment facilities? What systems were used to these referrals?
6. How has each project built capacity and/or institutionalized its practices to heighten opportunities for sustainability? Were these efforts successful?

In order to answer these evaluation questions and to provide the appropriate recommendations at the conclusion of the evaluation, the Mission provided a prioritized list of questions under four major themes for the evaluation team to consider: *Program Management, Program Accomplishments and Results, Monitoring and Evaluation and Lessons Learned*. A design matrix showing how each question will be researched is attached as Annex II.

PROGRAM MANAGEMENT

1. Has the project established constructive working relationships with key stakeholders

(USG partners, government, CSOs, private sector, etc.) to improve program outcomes?
2. Is USAID satisfied with communications with project staff? Is project staff satisfied with interaction with USAID? What improvements could be made for more effective communication?
3. Do work plans and budgets reflect project priorities? How are they used as project management tools?

PROGRAM ACCOMPLISHMENTS AND RESULTS

1. Did the program focus on the appropriate target population?
2. Does the project have well-reasoned strategies to achieve its goals, objectives and indicators within the life of project given current knowledge about HIV/AIDS and the socio-demographic characteristics of the target population?
3. If the project had changed and/or modified its strategy or priorities during the implementation phase, were the changes/modifications justified?
4. Is there evidence that Angaza Zaidi and UHAI-CT-approach has:
   a. Introduced and improved the quality and availability of HIV testing and counseling services at the health facility level?
   b. Improved the quality of services at the community level?
   c. Improved referral linkages between community and facility level and within the facility level?
5. How cost effective has the program been? What is the approximate expenditure per person tested in each year of the project? Has this figure gotten lower over time?
6. Are the testing modalities used appropriate for the epidemic Tanzanians are facing? Do HIV prevalence trends by year compare to the modality used, e.g. stand-alone VCT vs. PITC vs. mobile outreach?
7. How have the two program contributed in influencing HIV policy related to counseling and testing?
8. What is the overall contribution of each of the programs to the overall national HIV prevention program?
9. How effective are Angaza Zaidi and UHAI-CT's approaches to capacity building for local organizations? Has the program achieved its goals and objectives in this area?
10. What have the projects done to implement sustainable activities? If project activities were not continued past May 2014, what activities would/would not continue to operate? To what extent would the URT have the systems and/or capacity to carry forward Angaza Zaida and UHAI-CT activities?
11. Are the activities implemented by AMREF and Jhpiego in alignment with the National HIV/AIDS strategies?
12. Have the project's collaborations and partnerships been successful? Does project partnership work to effectively use available skills of all partners? How has this project complemented work done under the other PEPFAR partners and avoided duplication?
13. To what degree are URT and other partner's replicating/scaling-up project best practices and models from these projects?
14. Is adequate technical leadership available among local project staff or from partner headquarter staff, consultants, etc.? Is headquarter staff or consultants used appropriately and judiciously?

MONITORING AND EVALUATION (M&E)

1. Is the M&E plan being implemented and kept up to date? How are data being used by project management to make strategic and management decisions? With who are the data shared? How might M&E systems be improved?
2. How successful have Angaza Zaidi and UHAI-CT been in providing valid and reliable strategic information? Is there a validation process in place to avoid duplication of reporting

with other programs?

3. How are the systems linked to and harmonized with the National M&E framework?

LESSONS LEARNED

1. Do the service delivery models used by AMREF and Jhpiego meet the needs of the target populations?
2. What are the lessons learned from successful interventions that merit continuation or replication, better practices, significant products and tools for possible dissemination and replication?
3. Assess program innovations in particular its success in strengthening partnership, scaling up HTC coverage, reaching HIV positive individuals, capacity building and integration of HTC services with district/Council HIV/AIDS plans.

Several limitations should be noted:

1. A full-scale investigation of the quality of services provided by both projects requires extensive surveys and assessments and will not be undertaken by the team. Rather, the team will review the functioning of the existing quality assurance and quality improvement systems instituted by the projects themselves;
2. Similarly, a true cost effectiveness analysis is beyond the scope of the evaluation. The team will investigate existing data and expenditure analyses where they are available, and make recommendations concerning the need and value of further work in this area;
3. True studies of comparative advantage and ability of partners, including URT, to assume specific aspects of the project require extended studies of the capacity of systems outside the scope of this evaluation. The team will rely on service share, geographic distribution, and capacity building data gathered to provide a preliminary assessment of these issues for further follow up by the Mission;
4. The performance of the two projects being evaluated cannot in any strict sense be compared. Angaza Zaidi provides HTC services directly while UHAI-CT provides mainly training. Because the project portfolios are so different, we cannot reliably say that one has higher quality, greater efficiency than the other. The final report can note the role played by each of the projects relative to the range of service providers and models in Tanzania. In fact, one of the great contributions of this evaluation may be to stimulate a national dialogue on the comparative advantage of the various models and delivery systems in Tanzania;

   Both projects are in wind-down mode, which means that some of their personnel have left to work on other projects. Where possible and when necessary, the former employee will be located and contacted for interview or information.

EVALUATION DESIGN

This evaluation is cross-sectional in design, and will use a mix of quantitative and qualitative data collection strategies to answer the above questions. The evaluation design matrix in Annex II shows the following for each question listed above: illustrative indicators, data collection methods and sources, any sampling that will be used, and constraints and limitations on the data that can be anticipated.

EVALUATION METHODS

The evaluation will be carried out in Tanzania by a team of international and national experts using

multiple qualitative and quantitative methods, including: review of program documents and secondary analysis of project data; key informant interviews conducted at national, regional, district, facility and community levels; focus group discussions (FGD); facility reviews; and statistical analysis as appropriate. During the team's planning period in Dar es Salaam, they produced a package of evaluation materials, including: a timeline (Annex I), a draft evaluation matrix (Annex II), data collection instruments (Annex III), field work plan (Annex IV) and, preliminary draft outline of the report (Annex V). Evaluation methods are further detailed below:

Document Review The following background documents, received from USAID/Tanzania, Angaza Zaidi, and UHAI-CT have been reviewed:

- AMREF and Jhpiego Cooperative Agreements, including modification documents
- Annual and Semi-Annual Reports
- Quarterly Reports
- Work plans
- Performance Monitoring Plan
- Field Trip Reports
- Angaza Zaidi and UHAI-CT monitoring, quality assurance and other internal reports
- Angaza Zaidi and UHAI-CT Monitoring and Evaluation data
- National HIV/AIDS Strategies
- Relevant, guidelines and standard operating procedures
- National HIV policy
- Second National Multisectoral Strategic Framework (NMSF II)
- Mkukuta II (document that guides national vision)
- Tanzania AIDS ACT, 2008

Routine Performance Data Present and past program-level data routinely collected by Angaza Zaida and UHAI-CT for their program will be reviewed and analyzed. The two projects have generated a considerable amount of data during the implementation period. The various data sources will be triangulated to better support the judgments made by the Evaluation Team. In addition, site level performance data may be examined if warranted to answer specific questions related to the interview and FGDs conducted at that level.

Interviews and/or Focus Group Discussions Key informant interviews and/or focus group discussions with:

- USAID Mission staff, including relevant members from the Health Office
- Other USG staff members, including PEPFAR and CDC
- AMREF and Jhpiego staff and sub-partners, program managers, PITC providers, CSO outreach staff, Post Test Club representatives, nurse counselors working in each of the primary HTC models, etc.
- URT representatives (MOHSW, NACP, TACAIDS, and other national, regional and local government officials)
- Beneficiaries (health center staff, clients, PLHIV, and key population representatives)
- Other donor and implementing partners (e.g. GFATM)

Site Visits Considerations for site selection have been discussed with USAID and both implementing partners. Site visits will be conducted at both urban and rural locations, and include the following regions: Iringa, Tabora, Tanga, Kilimanjaro, and Dar es Salaam (Annex IV). In each of these, a mix of service delivery modalities will be visited. Site visits will provide information on current practices and standards and allow the consultants to talk with staff. The focus of these visits will be on:

- What criteria were used in selecting community-based sites?

- Site specific data collection and record keeping processes
- Quality assurance and quality control practices
- Client information—how many clients do they see, how much time to they spend with each, are they meeting demand, do they see special populations like couples, children, or key populations?
- Service details: Where does the counseling take place within the site? Is it sufficiently private? How is pre-test counseling or information handled, and how is consent done? (This may vary between outreach and PITC.) Where does the testing take place and who conducts the rapid tests? How long do clients or patients usually wait to receive results? Is there a time difference for patients using mobile HTC?
- Are condoms available and disseminated? If not where would clients go to get them?
- How are referrals made and linkages tracked? How successful are referrals?
- How is data used by sites to inform decisions and improve services?

Data Sources Data sources will vary according to each project's Monitoring and Evaluation Plan, but illustrative key sources of project data collected include:

- National HIV counseling and testing guidelines
- PEPFAR HTC technical considerations (for reference on PEPFAR standards)
- Size estimates of key populations
- HIV, STI, and behavioral surveillance data
- Project level formative & evaluation research
- Monthly program reports and quarterly reports
- Quality assurance surveys or reports
- Government/donor/Implementing Partner program data (upstream indicators)
- Behavioral Surveillance Survey (BSS) and/or program evaluation data
- HTC site data

DATA COLLECTION PLAN

National The team will conduct key informant interviews both before and after the field research period with USAID and other USG agencies, Angaza Zaidi, UHAI-CT, and URT representatives. The team will focus on key policy and management personnel. Those conducted before the field research will investigate broad lines of stakeholder involvement, communications, management, M&E and quality assurance systems, and data collection for measuring overall project accomplishments, while those conducted after the field research will work to check validity of field data and preliminary analysis of field research data. Pre and post field work interviews may be with different officers, depending on field work findings. In addition, the team will collect routine performance data to supplement that provided by USAID. Additional documents may be required from USAID and other stakeholders for analysis and documentation, particularly in the area of M&E and services quality assurance systems.

Regional, District, and Local Field Research Procedures The Evaluation Team will divide into two groups for purposes of field research. (Annex IV) Each group will include one international expert and two local experts, one provided by IBTCI and one provided by its local contractor, ST Associates. ST Associates is responsible for making local contacts for interviews and focus groups, for assistance with field data collection, for sending data back to offices in Dar es Salaam for data quality review and entry, and for preliminary data analysis. In each site visited, the teams will complete the following data collection activities:

- Regional Health Officer – key informant interview
- District Medical Officer – courtesy call
- District AIDS Control Coordinator – key informant interview

- District Health Management Team – focus group discussion
- AMREF/Jhpiego facility procedures and setting checklist, completed with project manager/facility in-charge
- Facility staff – Focus group discussion (project manager, counselors, laboratory, logistics, and referrals)
- Counseling staff – focus group or key informant interview
- Clients – exit interviews
- Community health committee – focus group discussion
- Site description and mapping – limited notes where unusual

Parallel Data Collection The subjects to be investigated at each level will be consistent so operational and perception data can be compared between levels as much as possible. Questions, however, will be tailored to the nature of respondent roles in the system.

DATA COLLECTION INSTRUMENTS

Thirteen data collection instruments are provided in Annex III. While these tools were pilot tested, there may still be minor adjustments made after the first couple of days of data collection in the field.

SAMPLE SITE SELECTION

The table in Annex V summarizes population and HIV-related data for all of Tanzania's regions where Angaza Zaidi's 42 sites overlap with Jhpiego's sites by the zones used by the Reproductive Child Health Section of the MOHSW. Considerations for site selection have been discussed with USAID and both implementing partners. Site visits will be conducted at both urban and rural locations, and include the following regions:, Iringa, Tanga, Kilimanjaro, Tabora and Dar es Salaam (Annex IV). The sample includes a range of population and HIV-related characteristics. In each region, urban and rural pairs will be sampled.

The four weeks of field research represent up to 23 days for travel and research for each team. The sample includes:

Type of sites	Total to be visited	AZ	UHAI-CT
Hospitals	7	3	4
Health Centers	7	4	3
Dispensaries	5	1	4
VCT (Stand-alone)	4	4	0
Community sites include (local brews, open markets, and road camp)	6	2	4
Community outreach exercise	4	2	2
Total sites	**33**	**16**	**17**

In all, the sample is sufficiently large to capture a range of differences without becoming repetitive or hard to manage for data entry, processing, and analysis.

DATA QUALITY

All data collection will be conducted in conformity with USAID ADS 203 Data Standards (203.3.11.1 Data Quality Standards, Effective Date: 11/02/2012) in order to ensure:

- Validity: Data should clearly and adequately represent the intended result;

- Integrity: Data collected should have safeguards to minimize the risk of transcription error or data manipulation;
- Precision: Data should have a sufficient level of detail to permit management decision-making; e.g. the margin of error is less than the anticipated change;
- Reliability: Data should reflect stable and consistent data collection processes and analysis methods over time; and
- Timeliness: Data should be available at a useful frequency, should be current, and should be timely enough to influence management decision-making.

DATA ANALYSIS PLAN

The following data analysis methods will be employed:

1. *Desk Review* – Documents from AMREF's and Jhpiego's HTC projects will be culled for relevant information, as will HTC related publications listed on NACP's website to identify themes and to triangulate with other data collected as part of this evaluation.
2. *Secondary Data Analysis* – Data collected by AMREF's *Angaza Zaidi* project and Jhpiego's *UHAI-CT* project will be reviewed and analyzed to identify trends and correlations. These analyses will look at trends over time, and differentials associated with geography, gender and age (e.g., AMREF vs. Jhpiego supported sites, rural vs. urban, regional comparisons, differences by type of health facility, static vs. mobile outreach service delivery, male vs. female, age groups, and VCT vs. PITC). Furthermore, these data will be compared to NCAP's CounTest database that maintains data collected by health facilities on HTC (both VCT and PITC).
3. *Health Facility Audit* – This is a brief structured assessment tool that will be used to gather information on HTC resources, such as test kit stocks, record keeping, location of HTC services, provision of privacy (visual and auditory), staffing, staff training, condom availability, presence of relevant information, education and communication (IEC) materials. These data will then be correlated with existing service and performance data, and with survey data on knowledge and attitudes, and qualitative data.
4. *Key Informant Interviews* – Semi-structured interviews will be conducted with primary stakeholders, such as, representatives from USAID, AMREF, Jhpiego, MOHSW, NACP, TACAIDS), and national reference laboratory. Additionally, a select number of VCT and PITC providers will be interviewed. Interviews will focus on assessing perceived achievements, including facilitators and obstacles to quality, effective, and efficient HTC services and outcomes, for VCT and PITC, and for static and mobile outreach services. Furthermore, stigma and discrimination, particularly related to MARPs, will be explored.
5. *Exit Interviews* – For each site visit where HTC services are provided, 2-4 clients will be interviewed about their experiences at the facility. Services received, privacy (auditory and visual), and referrals made will also be noted.
6. *Focus Group Discussions (FGD)* – Focus groups will be convened among community members who represent the target population for *Angaza Zaidi* project and *UHAI-CT*, including most at risk populations (MARPs). In this forum we will explore their issues related to client satisfaction, demand for services, stigma, gender equity, and HIV prevention practices.

The team will collect qualitative data (key informant interviews and FGDs) in pairs, and will then compare notes as a quality assurance check. The Core Team will also meet to review qualitative data and emerging themes (findings). Quantitative data forms will be reviewed daily, as collected, for completeness. Double data entry will be done with 10% of the quantitative data (mini-surveys, facility audits, and observations) to assure accuracy and validity.

Confidentiality and Data Security

We will obtain verbal voluntary consent from all participants of interviews, surveys, observations and focus groups (see consent language in the attached illustrative data collection

Informed Consent Checklist

- Purposes of the evaluation
- Expected duration of the subject's participation
- description of the process/procedures of participation
- Description of any reasonably foreseeable risks or discomforts to the subject
- Description of any benefits to the subject or to others expected from the evaluation
- Description of confidentiality and maintenance of records identifying the subject
- Contact information for questions about the evaluation
- Statement that participation is voluntary, refusal to participate will involve no penalty or loss of benefits for the subject, and that the subject may discontinue participation at any time without penalty

tools in Annex III). To protect confidentiality, no respondent identifying information will be collected on the data collection forms; only information necessary for data analysis, such a provider cadre/role, site type, region, etc.
Hard copy data collection forms will be stored securely by all Team members during data collection. The Team Leader will determine the best way to store hard copy data collection forms following data collection to assure data security, and to maintain confidentiality and privacy. All electronic data will be password protected to insure data security and to maintain confidentiality.

DISSEMINATION PLAN

An important component of the evaluation is the Dissemination Workshop, as it is here that that the findings and recommendations from this evaluation will be shared with a wide group of stakeholders. The list of attendees will be finalized with USAID. This workshop will serve as a useful venue for ensuring that every stakeholder in Tanzania will receive a copy of the final evaluation report. Following the Mission's approval, the Final Evaluation Report will also be submitted to the USAID Development Clearinghouse. In addition, IBTCI may, with permission from USAID, submit evaluation findings for publication in peer review journals, and/or for presentations at relevant conferences and workshops on HIV counseling and testing in developing countries.

ANNEXES

ANNEX I: PROPOSED EVALUATION TIMETABLE

Tasks	Location	Team Leader & Senior Eval Specialist	2 Local Specialists	ST Associates	Components	Dates
Project Initiation and Document Review	Home	3 (x2)	3 (MS)	-	**Preparation**	September 30 - October 4
					USAID background documents reviewed	September 30
					Draft2 - detailed work plan/timeline	October 1
					Draft 2 - detailed evaluation plan	October 2
					Introductory team conference call	October 3
Travel to Dar es Salaam	Dar es Salaam	2 (x2)		Provide airport pickup	Hunter arrives 10-6 8:05 p.m.	October 5 – 6
					Leinen arrives 10-9 9:40 p.m.	October 8 - 9
Team Planning	Dar es Salaam	14 (GaLe) 6 (GrLu) 2 (CL)	14 (MS) 2 (NM)	Attend, 8 (x2) Can begin work October 14th provide location for planning meetings	Planning	October 7 – 22
					Team kickoff meeting	October 7

Tasks	Location	Team Leader & Senior Eval Specialist	2 Local Specialists	ST Associates	Components	Dates
					Draft 3 Detailed Work Plan	October 10-22
Draft presentation for USAID and partners	Dar es Salaam	1 (x2)	1 (x2)	1 (x2)	**Draft 3 Evaluation Plan submitted to IBTCI** Protocols/ draft data collection instruments Site selection and schedule Budget and procedures for field work Plan for data entry Schedule key informant interviews **Draft presentation for USAID and partners**	**October 23 -** ***Update IBTCI HQ***
Pre-testing of data collection tools	Dar es Salaam	3 (x2)	3 (x2)	3 (x2) Logistics, training	Field site visit protocols Key informant interviews Focus group design and guides Facility audits, observations and mini-surveys	October 24-26
Background Document Review	Home	3 (CL)			Background Document Review	October 24-26
Finalize data collection tools	Dar es Salaam	2 (x2)	2 (x2)	2 (x2)	Analyze and discuss pre-test data Finalize tools Print/copy Train data collectors	October 28-29 ***October 29 - Update IBTCI HQ***
Initial briefing with USAID, AMREF and Jhpiego	Dar es Salaam – USAID or TBD	1 (x2)	1 (x2)	Attend, provide location for meeting if needed 1 (2x)	**USAID/Partner Briefing** Present team Discuss overall goals and aspirations Relationship to government and other partners Review details of work program, evaluation plan Coordinate logistics with partners (site access) Key informant interviews FGD arrangements Health facility audit arrangements	**October 30** ***October 30 - Update IBTCI HQ***
Revise and	Dar es	1 (x2)	1 (x2)	1 (x2)	**Finalize Inception**	**October 31**

Tasks	Location	Team Leader & Senior Eval Specialist	2 Local Specialists	ST Associates	Components	Dates
finalize Inception Plan	Salaam				**Plan** Final Detailed Work Plan Final Evaluation Plan	
Deliverables A and B	Dar es Salaam	-	-	-	**Inception Plan (**work plan and evaluation plan design, methodology, tools) **approved by Mission**	**October 31** *October 21 - Update IBTCI HQ*
Travel to Field	-	1 (x2)	1 (x2)	1 (x2)		November 3
Data collection	Selected sites	17 (x2)	17 (x2)	17 (x2) Logistics Participation	Field site visits Key informant interviews Focus group discussions Facility audits, observations and mini-surveys	November 4 - November 22 *Weekly updates for IBTCI HQ*
Return to Dar es Salaam	-	1 (x2)	1 (x2)	1 (x2)		November 23
Data Collection		2 (x2)	2 (x2)	2 (x2) 1 (x4) - programmer	Key informant interviews Focus group discussions Facility audits, observations and mini-surveys	November 25 – November 26
Data analysis, synthesis of findings	Dar es Salaam	3 (x2)	3 (x2)	3 (x2)	Prepare presentation of Evaluation Results Data entry Analysis plan Review and revisions Begin writing Draft Report	November 27 – November 29 **Submit Evaluation Presentation to USAID to IBTCI for comments by COB November 29**
Revise Evaluation Presentation to USAID per comments from IBTCI	Dar es Salaam	1 (x2)	1 (x2)	1 (x2)	Revise Presentation to USAID per comments from IBTCI	November 30
Deliverable D	Dar es Salaam	1 (x2)	1 (x2)	-	**Present Evaluation Results to USAID** Findings Briefing with USAID, AMREF, Jhpiego, and other relevant stakeholders	**December 2 (TBD)** ***November 26 – Update IBTCI HQ***
First Draft report drafted by team	Dar es Salaam	2 (x2)	2 (x2)	2 (x2)	**Draft report** Review with team Additional data analysis where needed	**Submit first Draft Report to IBTCI December 3**
Team departure	Home	1 (x2)	-	-	-	December 4-5
Revised Draft Report per IBTCI comments	Dar es Salaam	1 (x2)	1 (x2)	1 (x2)	**Revise Draft Report to incorporate IBTCI comments** Findings briefing presentation prepared	December 6-8 **Submit revised Draft Report to**

Tasks	Location	Team Leader & Senior Eval Specialist	2 Local Specialists	ST Associates	Components	Dates
						IBTCI by 9:00 am EST
Deliverable C	Dar es Salaam	-	-	-	Revised Draft Report submitted to IBTCI by team	December 9th
USAID reviews draft report	Home	-	-	-	10 working days Revised Draft Report submitted to USAID by IBTCI	December 10 - 20
Report revised from home per USAID Comments	Home	4 (TL) 2 (ES)	2 (x2)	-	Report revisions, based on USAID comments, including edits and formatting	Jan 2 - 9
Deliverable E	Home	-	-	-	Delivery of Final Report, evaluation tools and other evaluation materials to USAID/Tanzania	January 10
Deliverable F	Dar es Salaam	-	2 (x2)	2 (x2)	**Dissemination Workshop preparation and facilitation**	**January 22, 2014**
Deliverable G	Home	-	-	-	Financial reports	In accordance with IQC
Upload Evaluation Report to DEC						
Total Est. LOE		117	101	92		12 weeks

ANNEX II: DESIGN MATRIX

	Priority Questions	Illustrative Indicator(s)	Data Collection Method(s)	Data Source	Sampling	Constraints / Limitations
1	Has each project achieved its stated goals and objectives?	Project targets and goals met	Document review	Angaza Zaidi & UHAI-CT work plans, PMP, and reports	Secondary data (PMP)	Quality of information within documents
		Project work plans are aligned with Tanzania & USAID strategic frameworks	Document review	Angaza Zaidi & UHAI-CT work plans, USAID strategic framework & COP, National HIV/AIDS Strategies, Nat'l HIV Policy, and other related documents	N/A	Quality of information within documents
2	What are each project's strengths, weaknesses, and gaps in planning, management, routine data use, and service delivery?	Work plans implemented as planned and on time.	Document review	Angaza Zaidi & UHAI-CT work plans, semi and annual reports	N/A	Dependent on accuracy, details and up to date each projects' work plans
		Projects maintain effective relationships with USAID, MOHSW and other key implementing partners	Key Informant Interviews (KII)	Key Informants	Representatives of USAID, MOHSW (nat'l, district, health facility), AMREF, Jhpiego, and other related projects	Dependent on willingness of informants to share what may be sensitive information
		Client satisfaction and demand for HTC	Focus Group Discussion (FDG)	FDG participants opinions	Male, female and MARP participants of FGDs	Accuracy of opinions voiced during FDG; time limitation of discussions may limit the amount & quality of information; and potential power differentials among participants in each FGD.

	Priority Questions	Illustrative Indicator(s)	Data Collection Method(s)	Data Source	Sampling	Constraints / Limitations
		Data used for planning and decision making	Key Informant Interviews	Key Informants	Representatives of Angaza Zaidi & UHAI-CT projects; USAID, and NACP, and regional and district health officials	This question is not always clear, so examples of how data were used will be sought. Including how data influenced planning and management decisions.
		Project performance indicators and data measure significant HTC outputs and outcomes that are aligned with strategic objectives of: 1) Angaza Zaidi & UHAI-CT projects; 2) USAID COP; and 3) Nat'l HIV/AIDS Strategic Plan.	Document review	Angaza Zaidi & UHAI-CT M&E Plans and quarterly & annual reports	Secondary review of PMP data	Dependent on accuracy, details and up to date each projects' work plans
		Project performance indicators and data measure significant HTC outputs and outcomes that are aligned with strategic objectives of: 1) Angaza Zaidi & UHAI-CT projects; 2) USAID COP; and 3) Nat'l HIV/AIDS Strategic Plan.	Secondary data analysis	Angaza Zaidi & UHAI-CT program data	Data fields and analyses/reports	Data quality of existing datasets (e.g., missing test data & duplicate records). Data is number of tests, not number of people tested.
3	How did each project strategically use different HTC modalities to achieve its goals and objects? Were these modalities effective in reaching the target populations?	Increased quality HTC services (disaggregated by: project, VCT/PITC, static/outreach services)	Secondary data analysis	Angaza Zaidi & UHAI-CT program data; and NCAP's CounTest	Catchment areas and target population of Angaza Zaidi & UHAI-CT	Data quality of existing datasets (e.g., missing test data & duplicate records). Data is number of tests, not number of people tested.

	Priority Questions	Illustrative Indicator(s)	Data Collection Method(s)	Data Source	Sampling	Constraints / Limitations
		Effective project innovations	Key Informant interviews	Key informants	Representatives of USAID, MOHSW (nat'l, district, health facility), AMREF, Jhpiego, |and other related projects	Effectiveness of these will be perceived, based primarily on anecdotal information, not on impact evaluation
4	What are the lessons learned from successful interventions that merit continuation or replication, better practices, significant products and tools for possible dissemination and replication?	Factors associated with successes and achievements	Key Informant interviews	Key informants	Representatives of USAID, MOHSW (nat'l, district, health facility), AMREF, Jhpiego, |and other related projects	
			Quantitative HTC data: – Secondary data analysis – Mini-Survey – Facility Audit Observations	– Angaza Zaidi & UHAI-CT projects datasets – NCAP's CounTest – Mini-Survey – Facility Audit Observations	Data will be limited to projects' target communities/ districts	Data compatibility to merge datasets to conduct correlations and/or factor analyses
5	Was each project able to successfully refer newly identified HIV-positive clients to HIV care and treatment facilities? What systems were used for these referrals?	Percent of identified HIV clients successfully referred to care and treatment facilities by project and modality.	Secondary data analysis	Angaza Zaidi & UHAI-CT program data		
			Observations/ Facility Audit		All service delivery sites visited	
			FGD	Positive Test Clubs	Angaza Zaidi Sites	Dependent on willingness of informants to share what may be sensitive information

	Priority Questions	Illustrative Indicator(s)	Data Collection Method(s)	Data Source	Sampling	Constraints / Limitations
6	How has each project built capacity and/or institutionalized its practices to heighten opportunities for sustainability? Were these efforts successful?	Local capacity is strengthened – Number of peopled trained in HTC – Quality of HTC services – Time of HTC service, including time to receive results (disaggregated by: project, VCT/PITC, static/outreach services)	Secondary data analysis	Angaza Zaidi & UHAI-CT program data	People trained by projects, in communities that Angaza Zaidi & UHAI-CT projects support	Staff turnover. People trained may no longer be HTC provider
		Local capacity is strengthened – Number of peopled trained in HTC – Quality of HTC services – Time of HTC service, including time to receive results (disaggregated by: project, VCT/PITC, static/outreach services) Client satisfaction and demand for HTC	Observations/ Facility Audit	Observation of counseling session (quality checklist)	Approx. 23 health facilities and 5 outreach sites	If clients do not consent to observe services provided then quality of services cannot be directly evaluated.
			Observations/ Facility Audit Exit Interview (Community Member)	Observation of time and motion of client HTC services, including wait time	Approx. 23 health facilities and 5 outreach sites	Some facilities may not have HTC clients during site visit
			Mini-Survey/ Counselor/Service Provider Interview Council Health Management Team / Municipal Health Management Team (CHMT/MHMT)	HTC providers CHMT	HTC providers and CHMTs at approx. 23 health facilities and 5 outreach sites	Accuracy of self reported practices and attitudes

PERFORMANCE EVALUATION TOOLS OF USAID HTC PROJECTS IN TANZANIA

1 CHMT/MHMT Focus Group Discussion Guide
2 Post Test Club Focus Group Discussion Guide
3 District AIDS Control Coordinator (DACC) Key Informants Interview Guide
4 District Medical Officer (DMO) Key Informants Interview Guide
5 Mobile Site Manager (Jhpiego) Key Informant Interview Guide
6 Program Manager (AMREF) Key Informant Interview Guide
7 Program Manager (Jhpiego) Key Informant Interview Guide
8 Regional AIDS Control Coordinator (RACC) Key Informants Interview Guide
9 Site Manager (Angaza Zaidi) Key Informant Interview Guide
10 URT Agencies (National) Key Informants Interview Guide
11 District AIDS Control Coordinator (DACC) Key Informants Interview Guide
12 Exit Interview (Community Member) Data Collection Form
13 Counselor/Service Provider Interview Data Collection Form
14 FACILITY AUDIT Data Collection Form

ANNEX III: DATA COLLECTION INSTRUMENTS

PERFORMANCE EVALUATION OF USAID SUPPORTED HTC PROJECTS IN TANZANIA

Council Health Management Team / Municipal Health Management Team (CHMT/MHMT)

Focus group discussion guide

Respondents' information

Respondent S/N	Gender	Age	Position/ designation

QUESTIONNAIRE IDENTIFICATION NUMBER: |_____|_____| REGION ID NUMBER: |_____|_____|

DISTRICT ID NUMBER: |_____|_____|

My name is..... I am here on behalf of IBTCI a consulting firm based in Washington DC, USA who has been entrusted by the USAID Tanzania to conduct performance evaluation of two HTC projects namely ANGAZA ZAIDI and UHAI-CT implemented by AMREF and JHPIEGO respectively.

We are collecting information that will help us to understand HIV testing and counseling services in Tanzania which will be used to inform USAID how they can support efforts to improve HIV testing and counseling in Tanzania

The discussion will last for approximately 1-2 hours. I would like you to express your views freely and openly. All information that you give is strictly confidential. We also request a permission to take a picture; your name and picture will not appear in any reports or notes, unless it is consented.

Your participation is voluntary and there is no penalty for refusing to take part. You may refuse to answer any question in this questionnaire/interview or stop the interview at any time. You are free to ask questions at any time.

Will all of you be willing to participate? 1=Yes 2=No

Thank you.

_____

_____

(Signature of interviewer certifying that informed consent has been given verbally by respondent)

INTERVIEWER: Code: [____|____] Name (Initials): _____

DATE OF INTERVIEW: |___||___|\|___||___|\ |___||___||___||___|

Day Month Year

CHECKED BY SUPERVISOR: Signature

_____Date:_____

Note to Interviewer: Ensure your responses are project specific

A: PROGRAM MANAGEMENT

1. Do you think the projects achieved HTC goals? Explain HOW?

   Angaza Zaidi

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   UHAI-CT

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2. What are each project's strengths, weakness and gaps in **planning**, **management of routine data use** and **service delivery**?

   Angaza Zaidi

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UHAI-CT

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3. How has Angaza Zaidi and UHAI-CT projects addressed these gaps? *[Please give examples about what they did to address these gaps]*

Gaps for Angaza Zaidi

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Gaps for UHAI-CT

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4. In your opinion, how have the projects established constructive working relationship with key stakeholders such as Government, like minded partners, and Civil Society Organizations (CSOs)? [*Probe on how regular meeting for update and if government provide guidance and feedback*]

ANGAZA Zaidi

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UHAI-CT

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B: PROGRAM ACCOMPLISHMENTS AND RESULTS

5. Is there evidence that each projects have [*provide examples*]

   a) Improved the quality of HIV testing and counseling services at the health facility level

      Angaza Zaidi

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      UHAI-CT

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   b) Improved the quality of services at the community level

      Angaza Zaidi

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      UHAI-CT

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c) Improved referral linkage between community and facility level

Angaza Zaidi

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UHAI-CT

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6. What HTC modalities are used in your district for counseling and testing? Which of these modalities are more effective in reaching the target population and why? *[Probe for AZ includes Integrated VCT, Stand alone VCT, Mobile outreach and UHAI-CT includes PITC, Community based CT]*

Angaza Zaidi

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UHAI-CT

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7. How effective has each project contributed in influencing HIV policies related to counseling and testing? [*Probe if projects activities aligned with the National HIV/AIDS strategies, policies and guidelines*]

Angaza Zaidi

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UHAI-CT

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C: MONITORING & EVALUATION

8. To what extent have the projects services been successfully integrated into the Council/District health plans and community HIV initiatives? [*Probe on supervision, quality assurance*]

Angaza Zaidi

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UHAI-CT

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9. How have the projects complemented work done under the other PERFAR partners to avoid duplication?

Angaza Zaidi

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UHAI-CT

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10. Can we learn from your experience how you have used data produced under the projects for decision making?

Angaza Zaidi

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UHAI-CT

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D: LESSON LEARNT AND SUTAINABILITY

11. What lessons were learnt and what good practices (what works well) in following projects that could be replicated in your district?

Angaza Zaidi

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UHAI-CT

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12. How has each project built capacity and/or institutionalized to ensure that HTC services are provided beyond projects phase out? *(Probe on type of services, Target population groups, Implementing partners, Collaborators)*

Angaza Zaidi

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UHAI-CT

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PERFORMANCE EVALUATION OF USAID SUPPORTED HTC PROJECTS IN TANZANIA

Post Test Club

Focus Group Discussion guide

Respondents' information

Respondent S/N	Gender	Age	Position/ designation

QUESTIONNAIRE IDENTIFICATION NUMBER: |_____|_____| REGION ID NUMBER: |_____|_____|

DISTRICT ID NUMBER: |_____|_____|

My name is..... I am here on behalf of IBTCI a consulting firm based in Washington DC, USA who has been entrusted by the USAID Tanzania to conduct performance evaluation of two HTC projects namely ANGAZA ZAIDI and UHAI-CT implemented by AMREF and JHPIEGO respectively.

We are collecting information that will help us to understand HIV testing and counseling services in Tanzania which will be used to inform USAID how they can support efforts to improve HIV testing and counseling in Tanzania

The discussion will last for approximately 1-2 hours. I would like you to express your views freely and openly. All information that you give is strictly confidential. We also request permission to take a picture; your name and picture will not appear in any reports or notes, unless it is consented

Your participation is voluntary and there is no penalty for refusing to take part. You may refuse to answer any question in this questionnaire/interview or stop the interview at any time. You are free to ask questions at any time.

Would you be willing to participate? 1=Yes 2=No

Thank you.

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(Signature of interviewer certifying that informed consent has been given verbally by respondent)

INTERVIEWER: Code: [____|____] Name (Initials): _____
DATE OF INTERVIEW: |___||___|\|___||___|\ |___||___||___||___|
Day Month Year

CHECKED BY SUPERVISOR: Signature
_____Date:_____

Note to Interviewer: Ensure your responses are in project specific

1. How did you know about the Post Test Club? Is it something that the community is aware of and supportive of?

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2. Why did you decide to join the Post Test Club?

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3. What has been your experience as a member of the group? What are the benefits of joining the club? What are the challenges? What changes have taken place in your life as a result of being a member of the group?

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4. How did you come to the decision of testing for HIV? Had you heard about ANGAZA Zaidi before taking your test? How did that influence your decision? [*Probe on the different messages, campaigns carried out by ANGAZA Zaidi*]

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5. Where did you have your HIV test? Did you have any challenges when accessing VCT services? During the VCT sessions how did the counseling sessions before and after testing help you? How satisfied were you with the services rendered to you?

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6. How did you access counseling and testing? *[Probe whether Angaza Zaidi includes Integrated VCT, Stand alone VCT, Mobile outreach and UHAI-CT includes PITC, Community based CT]* Which are effective modalities in reaching the target population and why?

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7. How were you referred to care and treatment? What care and support services do you get in your respective community?

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8. What kind of information do you access through being a member of the group and how useful is this information to you?

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9. How are you involved in mobilizing other people to access VCT services/ behavioral change/ disseminating information on HIV/AIDS? How many people have you recommended to go for a test or join the club?

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10. What challenges do you face in using and adhering to ARV treatment? And how is the PTC helping in addressing these challenges?

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READ: That question completes our interview today. Thank you very much for sharing your thoughts with me. The information you have provided has been very helpful

PERFORMANCE EVALUATION OF USAID SUPPORTED HTC PROJECTS IN TANZANIA

Community Outreach [i.e. markets, bars, food vendor along roads, local brew bars]

Key Informant Interview Guide

QUESTIONNAIRE IDENTIFICATION NUMBER: |_____|_____| REGION ID NUMBER: |_____|_____|

DISTRICT ID NUMBER: |_____|_____| SEX OF RESPONDENTS: |__M___|__F___|

AGE OF RESPONDENTS: |_____|_____|

My name is..... I am here on behalf of IBTCI a consulting firm based in Washington DC, USA who has been entrusted by the USAID Tanzania to conduct performance evaluation of two HTC projects namely ANGAZA ZAIDI and UHAI-CT implemented by AMREF and JHPIEGO respectively.

We are collecting information that will help us to understand HIV testing and counseling services in Tanzania which will be used to inform USAID how they can support efforts to improve HIV testing and counseling in Tanzania

The discussion will last for approximately 1 hour. I would like you to express your views freely and openly. All information that you give is strictly confidential. We also request permission to take a picture; your name and picture will not appear in any reports or notes, unless it is consented

Your participation is voluntary and there is no penalty for refusing to take part. You may refuse to answer any question in this questionnaire/interview or stop the interview at any time. You are free to ask questions at any time.

Would you be willing to participate? 1=Yes
2=No

Thank you.

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(Signature of interviewer certifying that informed consent has been given verbally by respondent)

INTERVIEWER: Code: [_____|_____]
Name (Initials): _____

DATE OF INTERVIEW: |___||___|\|___||___|\ |___||___||___||___|
Day Month Year

CHECKED BY SUPERVISOR:
Signature _____Date:_____

Note to Interviewer: Ensure your response are in project specific

1. How do the programs contribute in the achievement of HIV testing and counseling? [Probe on *what are the major achievements of the program so far*]

   Angaza Zaidi

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   UHAI-CT

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2. What are the project's weaknesses (not working well) and gaps? [*Suggest ways on those aspects that should be modified?*]

   Angaza Zaidi

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UHAI-CT

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3. What testing modalities did you use for counseling and testing? Which one(s) would you like to be scaled up? [*Probe for AZ includes Integrated VCT, Stand alone VCT, Mobile outreach and UHAI-CT includes PITC, Community based CT]*

Angaza Zaidi

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UHAI-CT

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4. What do you find most enjoyable about mobile testing? What do you find most challenging about mobile testing? How do communities respond to services?

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5. When an HIV positive person is identified what do you normally do? [*Probe to find out if they have effective referral system*]**.**

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6. How successful has the program been providing valid and reliable strategic information? Is there a validation process in place to avoid duplication of reporting with other programs?

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7. How is data generated and integrated into facility data base?

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8. How do you ensure valid and reliable strategic information? Is there a validation process in place to avoid duplication of reporting?

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9. What are the lessons learnt and best practices from successful interventions that need continuation after the expiry of the donor support? [*Probe why and how these will be sustained]*

Angaza Zaidi

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UHAI-CT

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READ: That question completes our interview today. Thank you very much for sharing your thoughts with me. The information you have provided has been very helpful

PERFORMANCE EVALUATION OF USAID SUPPORTED HTC PROJECTS IN TANZANIA

District Medical Officer (DMO)

Key Informants Interview guide

QUESTIONNAIRE IDENTIFICATION NUMBER: |_____|_____| REGION ID NUMBER: |_____|_____|

DISTRICT ID NUMBER: |_____|_____| SEX OF RESPONDENTS: |__M___|__F___|

My name is..... I am here on behalf of IBTCI a consulting firm based in Washington DC, USA who has been entrusted by the USAID Tanzania to conduct performance evaluation of two HTC projects namely ANGAZA ZAIDI and UHAI-CT implemented by AMREF and JHPIEGO respectively.

We are collecting information that will help us to understand HIV testing and counselling services in Tanzania which will be used to inform USAID how they can support efforts to improve HIV testing and counseling in Tanzania

I would like you to express your views freely and openly. All information that you give is strictly confidential. We also request permission to have your name which will not appear in any reports or notes, unless it is consented.

Your participation is voluntary and there is no penalty for refusing to take part. You may refuse to answer any question in this questionnaire/interview or stop the interview at any time. You are free to ask questions at any time.

Would you be willing to participate? 1=Yes 2=No

Thank you.

_____

_____

(Signature of interviewer certifying that informed consent has been given verbally by respondent)

INTERVIEWER: Code: [____|____]
Name (Initials): _____

DATE OF INTERVIEW: |___||___|\|___||___|\ |___||___||___||___|

Day Month Year

CHECKED BY SUPERVISOR:
Signature _____Date:_____

Note to Interviewer: Ensure your responses are in project specific

A: PROGRAM MANAGEMENT

1. Do you think the two projects achieved HTC goals? Explain HOW?

   Angaza Zaidi

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   UHAI-CT

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2. What are each project's strengths, weakness and gaps in **planning and management of routine data use and service delivery?**

   Angaza Zaidi

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   UHAI-CT

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3. In your opinion, how have the projects established constructive working relationship with key stakeholders such as Government, like minded partners, and CSOs? [*Probe on how regular meeting for update and if government provide guidance and feedback*]

Angaza Zaidi

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UHAI-CT

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B: PROGRAM ACCOMPLISHMENTS AND RESULTS

4. Is there evidence that shows that each project has *[provide examples]*

a) Improved the quality of HIV testing and counseling services at the health facility level?

Angaza Zaidi

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UHAI-CT

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b) Improved the quality of services at the community level?

Angaza Zaidi

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UHAI-CT

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c) Improved referral linkages between the community and facility level [*Probe how referrals are done if someone test HIV positive and if there is a mechanism for VCT to receive feedback from CTC*]

Angaza Zaidi

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UHAI-CT

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5. What HTC modalities are used in your district for counseling and testing? Which of these modalities are more effective in reaching the target population and why? *[Probe – Integrated VCT, Stand alone VCT, Mobile outreach and UHAI-CT includes PITC, Community based CT]*

Angaza Zaidi

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UHAI-CT

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6. How effective has each project contributed in influencing HIV policies related to counseling and testing? [*Probe if projects activities aligned with the National HIV/AIDS strategies, policies and guidelines*]

   Angaza Zaidi

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   UHAI-CT

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C: MONITORING & EVALUATION

7. How have the projects complemented work done under the other PERFAR partners to avoid duplication?

   Angaza Zaidi

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   UHAI-CT

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D: LESSON LEARNT & SUSTAINABILITY

8. What lessons learnt and good practices (what works well) in the following projects that can be replicated in your district?

   Angaza Zaidi

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   UHAI-CT

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9. How has each project built capacity and/or institutionalized to ensure that HTC services are provided beyond projects phase out? (*Probe on Type of services, Target population groups, Implementing partners, Collaborators)*

   Angaza Zaidi

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   UHAI-CT

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READ: That question completes our interview today. Thank you very much for sharing your thoughts with me. The information you have provided has been very helpful

PERFORMANCE EVALUATION OF USAID SUPPORTED HTC PROJECTS IN TANZANIA

District AIDS Control Coordinator (DACC)

Key Informants Interview guide

QUESTIONNAIRE IDENTIFICATION NUMBER: |_____|_____| REGION ID NUMBER: |_____|_____|

DISTRICT ID NUMBER: |_____|_____| FACILITY ID NUMBER |_____|_____|

SEX OF RESPONDENTS: |__M___|__F___|

My name is ..... I am here on behalf of IBTCI a consulting firm based in Washington DC, USA who has been entrusted by the USAID Tanzania to conduct performance evaluation of two HTC projects namely ANGAZA ZAIDI and UHAI-CT implemented by AMREF and JHPIEGO respectively.

We are collecting information that will help us to understand HIV testing and counseling services in Tanzania which will be used to inform USAID how they can support efforts to improve HIV testing and counseling in Tanzania

I would like you to express your views freely and openly. All information that you give is strictly confidential. We also request permission to have your name which will not appear in any reports or notes, unless it is consented.

Your participation is voluntary and there is no penalty for refusing to take part. You may refuse to answer any question in this questionnaire/interview or stop the interview at any time. You are free to ask questions at any time.

Would you be willing to participate? 1=Yes 2=No

Thank you.

_____

(Signature of interviewer certifying that informed consent has been given verbally by respondent)

INTERVIEWER: Code: [____|____] Name (Initials):

_____

DATE OF INTERVIEW: |___||___|\|___||___|\ |___||___||___||___|
Day Month Year

CHECKED BY SUPERVISOR: Signature
_____Date:_____

Note to interviewer: Ensure your response are in project specific

A: PROGRAM MANAGEMENT

1. Do you think the two projects achieved HTC goals? Explain HOW?

   Angaza Zaidi

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   UHAI-CT

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2. What are each project's strengths, weakness and gaps in **planning and management of routine data use and service delivery?**

   Angaza Zaidi

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   UHAI-CT

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3. In your opinion, how have the projects established constructive working relationship with key stakeholders such as Government, like minded partners, and CSOs? [*Probe on how regular meeting for update and if government provide guidance and feedback*]

Angaza Zaidi

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UHAI-CT

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B: PROGRAM ACCOMPLISHMENTS AND RESULTS

4. Is there evidence that shows that each project has *[provide examples]*

a) Improved the quality of HIV testing and counseling services at the health facility level?

Angaza Zaidi

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UHAI-CT

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b) Improved the quality of services at the community level?

Angaza Zaidi

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UHAI-CT

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c) Improved referral linkages between the community and facility level [*Probe how referrals are done if someone test HIV positive and if there is a mechanism for VCT to receive feedback from CTC*]

Angaza Zaidi

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UHAI-CT

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5. What HTC modalities are used in your district for counseling and testing? Which of these modalities are more effective in reaching the target population and why? *[Probe – Integrated VCT, Stand alone VCT, Mobile outreach and UHAI-CT includes PITC, Community based CT]*

Angaza Zaidi

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UHAI-CT

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6. How effective has each project contributed in influencing HIV policies related to counseling and testing? [*Probe if projects activities aligned with the National HIV/AIDS strategies, policies and guidelines*]

   Angaza Zaidi

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   UHAI-CT

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C: MONITORING & EVALUATION

7. To what extent have the projects services been successfully integrated into the Council/District health plans and community HIV initiatives? [*Probe on supervision, quality assurance*]

   Angaza Zaidi

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   UHAI-CT

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8. How successful has each project been in providing valid and reliable information? [*Probe on How have the projects complemented work done under the other PERFAR partners and avoid duplication*]

Angaza Zaidi

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UHAI-CT

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D: LESSON LEARNT & SUSTAINABILITY

9. What lessons learnt and good practices (what works well) by the following projects which needs replication in your district?

Angaza Zaidi

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UHAI-CT

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10. How has each project built capacity and/or institutionalized to ensure that HTC services are provided beyond projects phase out? *(Probe on type of services, Target population groups, Implementing partners, Collaborators)*

Angaza Zaidi

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UHAI-CT

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READ: That question completes our interview today. Thank you very much for sharing your thoughts with me. The information you have provided has been very helpful

PERFORMANCE EVALUATION OF USAID SUPPORTED HTC PROJECTS IN TANZANIA

Head of Counseling and Testing

Key Informant Interview Guide

QUESTIONNAIRE IDENTIFICATION NUMBER: |_____|_____| REGION ID NUMBER: |_____|_____|

DISTRICT ID NUMBER: |_____|_____| SEX OF RESPONDENTS: |__M___|__F___|

AGE OF RESPONDENTS: |_____|_____|

My name is..... I am here on behalf of IBTCI a consulting firm based in Washington DC, USA who has been entrusted by the USAID Tanzania to conduct performance evaluation of two HTC projects namely ANGAZA ZAIDI and UHAI-CT implemented by AMREF and JHPIEGO respectively.

We are collecting information that will help us to understand HIV testing and counseling services in Tanzania which will be used to inform USAID how they can support efforts to improve HIV testing and counseling in Tanzania

The discussion will last for approximately 1 hour. I would like you to express your views freely and openly. All information that you give is strictly confidential. We also request a permission to take a picture; your name and picture will not appear in any reports or notes, unless it is consented

Your participation is voluntary and there is no penalty for refusing to take part. You may refuse to answer any question in this questionnaire/interview or stop the interview at any time. You are free to ask questions at any time.

Would you be willing to participate? 1=Yes 2=No

Thank you.

_____

(Signature of interviewer certifying that informed consent has been given verbally by respondent)

INTERVIEWER: Code: [_____|_____] Name (Initials): _____
DATE OF INTERVIEW: |___||___|\|___||___|\ |___||___||___||___|
Day Month Year

CHECKED BY SUPERVISOR: Signature
_____Date:_____

Note to Interviewer: Ensure your response are in project specific

1. How do the programs contribute in the achievement of HIV test and counseling? [Probe on *what are the major achievements of the program so far*]

   Angaza Zaidi

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   UHAI-CT

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2. What are the project's weaknesses (not working well) and gaps? [Suggest ways on those aspects that should be modified?]

   Angaza Zaidi

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   UHAI-CT

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3. What are the HTC modalities used in your site for counseling and testing? Which are effective modalities in reaching the target population and why? *[Probe for AZ includes Integrated VCT, Stand alone VCT, Mobile outreach and UHAI-CT includes PITC, Community based CT]*

   Angaza Zaidi

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   UHAI-CT

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4. How has the program established constructive working relationship with the key stakeholders?

   Angaza Zaidi

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   UHAI-CT

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5. What mechanism is in place to ensure that the referrals are effective? [*Probe if there is a verification mechanism; how is it working; who is responsible*]

   Angaza Zaidi

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   UHAI-CT

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6. How are data being generated? With whom are the data shared?

   Angaza Zaidi

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   UHAI-CT

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7. How successful have you been in providing valid and reliable data? Is there a validation process in place to avoid duplication of reporting?

   Angaza Zaidi

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UHAI-CT

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8. What lessons learnt and best practices from successful interventions that can be continued or replicated even after the expiry of the donor support? [*Probe why and how these will be sustained]*

Angaza Zaidi

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UHAI-CT

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READ: That question completes our interview today. Thank you very much for sharing your thoughts with me. The information you have provided has been very helpful

PERFORMANCE EVALUATION OF USAID SUPPORTED HTC PROJECTS IN TANZANIA

Program Manager

Key Informant Interview Guide

QUESTIONNAIRE IDENTIFICATION NUMBER: |_____|_____| REGION ID NUMBER: |_____|_____|

DISTRICT ID NUMBER: |_____|_____| SEX OF RESPONDENTS: |__M___|__F___|

AGE OF RESPONDENTS: |_____|_____|

My name is..... I am here on behalf of IBTCI a consulting firm based in Washington DC, USA who has been entrusted by the USAID Tanzania to conduct performance evaluation of two HTC projects namely ANGAZA ZAIDI and UHAI-CT implemented by AMREF and JHPIEGO respectively.

We are collecting information that will help us to understand HIV testing and counseling services in Tanzania which will be used to inform USAID how they can support efforts to improve HIV testing and counseling in Tanzania

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Would you be willing to participate? 1=Yes 2=No

Thank you.

_____

(Signature of interviewer certifying that informed consent has been given verbally by respondent)

INTERVIEWER: Code: [____|____] Name (Initials):

_____

DATE OF INTERVIEW: |___||___|\|___||___|\ |___||___||___||___|
Day Month Year

CHECKED BY SUPERVISOR:
Signature _____Date:_____

Note to Interviewer: Ensure your response are in project specific

1. Has the program achieved its stated goals and objectives? HOW? [Probe on *what are the major achievements of the program so far*]

   Angaza Zaidi

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   UHAI-CT

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2. What are each project's strengths, weakness and gaps in **planning and management of routine data use and service delivery?**

   Angaza Zaidi

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   UHAI-CT

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3. Has the project changed or/and modified its strategies or priorities during the implementation? Were the changes/modifications justified? [*Probe on M&E plan, PMP, targets, indicators and etc* if changed]

Angaza Zaidi

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UHAI-CT

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4. What HTC modalities are used in your project for counseling and testing? Which of these are more effective in reaching the target population and why? *[Probe for AZ includes Integrated VCT, Stand alone VCT, Mobile outreach and UHAI-CT includes PITC, Community based CT]*

Angaza Zaidi

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UHAI-CT

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5. What can you say about communication and interaction between the program and USAID? What improvement could be made for more effective communication?

   Angaza Zaidi

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   UHAI-CT

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6. How has this program contributed to the overall national HIV prevention program and how far has it influenced HIV policy, guidelines and strategies?

   Angaza Zaidi

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   UHAI-CT

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7. How program activities in were align with the national HIV/AIDS frameworks?

   Angaza Zaidi

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UHAI-CT

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8. How has the program established constructive working relationship with the key stakeholders?

Angaza Zaidi

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UHAI-CT

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9. How successful has the program been in providing valid and reliable strategic information? Is there a validation process in place to avoid duplication of reporting with other programs?

Angaza Zaidi

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UHAI-CT

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10. How are data being used to make strategic and management decisions? With who are the data shared?

Angaza Zaidi

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UHAI-CT

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11. What lessons learnt and best practices from successful interventions that need continuation or replication even after the expiry of the donor support? [*Probe why and how these will be sustained]*

Angaza Zaidi

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UHAI-CT

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READ: That question completes our interview today. Thank you very much for sharing your thoughts with me. The information you have provided has been very helpful

PERFORMANCE EVALUATION OF USAID SUPPORTED HTC PROJECTS IN TANZANIA

Regional AIDS Control Coordinator (RACC)

Key Informants Interview guide

QUESTIONNAIRE IDENTIFICATION NUMBER: |_____|_____| REGION ID NUMBER: |_____|_____|

DISTRICT ID NUMBER: |_____|_____| FACILITY ID NUMBER |_____|_____|

SEX OF RESPONDENTS: |__M___|__F___|

My name is ..... I am here on behalf of IBTCI a consulting firm based in Washington DC, USA who has been entrusted by the USAID Tanzania to conduct performance evaluation of two HTC projects namely ANGAZA ZAIDI and UHAI-CT implemented by AMREF and JHPIEGO respectively.

We are collecting information that will help us to understand HIV testing and counseling services in Tanzania which will be used to inform USAID how they can support efforts to improve HIV testing and counseling in Tanzania

The discussion will last for approximately 1 hour. I would like you to express your views freely and openly. All information that you give is strictly confidential. We also request permission to have your name which will not appear in any reports or notes, unless it is consented.

Your participation is voluntary and there is no penalty for refusing to take part. You may refuse to answer any question in this questionnaire/interview or stop the interview at any time. You are free to ask questions at any time.

Would you be willing to participate? 1=Yes 2=No

Thank you.

_____

(Signature of interviewer certifying that informed consent has been given verbally by respondent)

INTERVIEWER: Code: [_____|_____] Name (Initials):

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DATE OF INTERVIEW: |___||___|\|___||___|\ |___||___||___||___|
Day Month Year

CHECKED BY SUPERVISOR:
Signature _____Date:_____

Note to interviewer: Ensure your response are in project specific

A: PROGRAM MANAGEMENT

1. Do you think the two projects achieved HTC goals? Explain HOW?

   Angaza Zaidi

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   UHAI-CT

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2. What are each project's strengths, weakness and gaps in **planning and management of routine data use and service delivery?**

   Angaza Zaidi

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   UHAI-CT

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3. In your opinion, how have the projects established constructive working relationship with key stakeholders such as Government, like minded partners, and CSOs? [*Probe on how regular meeting for update and if government provide guidance and feedback*]

Angaza Zaidi

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UHAI-CT

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B: PROGRAM ACCOMPLISHMENTS AND RESULTS

4. Is there evidence that shows that each project has *[provide examples]*

d) Improved the quality of HIV testing and counseling services at the health facility level?

Angaza Zaidi

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UHAI-CT

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e) Improved the quality of services at the community level?

Angaza Zaidi

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UHAI-CT

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f) Improved referral linkages between the community and facility level [*Probe how referrals are done if someone test HIV positive and if there is a mechanism for VCT to receive feedback from CTC*]

Angaza Zaidi

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UHAI-CT

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5. What HTC modalities are used in your district for counseling and testing? Which of these modalities are more effective in reaching the target population and why? *[Probe – Integrated VCT, Stand alone VCT, Mobile outreach and UHAI-CT includes PITC, Community based CT]*

Angaza Zaidi

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UHAI-CT

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6. How effective has each project contributed in influencing HIV policies related to counseling and testing? [*Probe if projects activities aligned with the National HIV/AIDS strategies, policies and guidelines*]

   Angaza Zaidi

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   UHAI-CT

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C: MONITORING & EVALUATION

7. How have the projects complemented work done under the other PERFAR partners to avoid duplication?

   Angaza Zaidi

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   UHAI-CT

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D: LESSON LEARNT & SUSTAINABILITY

8. What lessons learnt and good practices (what works well) in the following projects that can be replicated in your district?

   Angaza Zaidi

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   UHAI-CT

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9. How has each project built capacity and/or institutionalized to ensure that HTC services are provided beyond projects phase out? (*Probe on Type of services, Target population groups, Implementing partners, Collaborators)*

   Angaza Zaidi

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   UHAI-CT

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READ: That question completes our interview today. Thank you very much for sharing your thoughts with me. The information you have provided has been very helpful

PERFORMANCE EVALUATION OF USAID SUPPORTED HTC PROJECTS IN TANZANIA

RMO

Key Informants Interview

QUESTIONNAIRE IDENTIFICATION NUMBER: |_____|_____| REGION ID NUMBER: |_____|_____|

SEX OF RESPONDENTS: |__M___|__F___|

My name is..... I am here on behalf of IBTCI a consulting firm based in Washington DC, USA who has been entrusted by the USAID Tanzania to conduct performance evaluation of two HTC projects namely ANGAZA ZAIDI and UHAI-CT implemented by AMREF and JHPIEGO respectively.

We are collecting information that will help us to understand HIV testing and counseling services in Tanzania which will be used to inform USAID how they can support efforts to improve HIV testing and counseling in Tanzania

The interview will last for approximately 10 minutes. I would like you to express your views freely and openly. All information that you give is strictly confidential. Your name will not appear in any reports or notes, unless it is consented

Your participation is voluntary and there is no penalty for refusing to take part. You may refuse to answer any question in this questionnaire/interview or stop the interview at any time. You are free to ask questions at any time.

Would you be willing to participate? 1=Yes 2=No

Thank you.

_____

(Signature of interviewer certifying that informed consent has been given verbally by respondent)

INTERVIEWER: Code: [_____|_____] Name (Initials):

_____

DATE OF INTERVIEW: |___||___|\|___||___|\ |___||___||___||___|
Day Month Year

CHECKED BY SUPERVISOR:
Signature _____Date:_____

A: PROGRAM MANAGEMENT

1. Do you think the projects achieved HTC goals? Explain HOW?

   Angaza Zaidi

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   UHAI-CT

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2. What is your role in supporting the projects to achieve HTC goals

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B: PROGRAM ACCOMPLISHMENTS AND RESULTS

3. In your opinion, how is the project established constructive working relationship with key stakeholders such as Government, like minded partners, and CSOs?

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4. What good practices (what works well) in AZ and UHAI-CT in your region?

Angaza Zaidi

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UHAI-CT

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C: MONITORING & EVALUATION

5. How have the projects complemented work done under the other PERFAR partners and avoid duplication?

Angaza Zaidi

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UHAI-CT

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D: LESSON LEARNT AND SUSTAINABILITY

6. What are the lessons learnt and good practices (what works well) in following projects that need replication in your district?

   Angaza Zaidi

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   UHAI-CT

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READ: That question completes our interview today. Thank you very much for sharing your thoughts with me. The information you have provided has been very helpful.

PERFORMANCE EVALUATION OF USAID SUPPORTED HTC PROJECTS IN TANZANIA

URT Agencies (National)

Key Informants Interview guide

QUESTIONNAIRE IDENTIFICATION NUMBER: |_____|_____| REGION ID NUMBER: |_____|_____|

DISTRICT ID NUMBER: |_____|_____| FACILITY ID NUMBER |_____|_____|

SEX OF RESPONDENTS: |__M___|__F___|

My name is..... I am here on behalf of IBTCI a consulting firm based in Washington DC, USA who has been entrusted by the USAID Tanzania to conduct performance evaluation of two HTC projects namely ANGAZA ZAIDI and UHAI-CT implemented by AMREF and JHPIEGO respectively.

We are collecting information that will help us to understand HIV testing and counseling services in Tanzania which will be used to inform USAID how they can support efforts to improve HIV testing and counseling in Tanzania

The discussion will last for approximately 1 hour. I would like you to express your views freely and openly. All information that you give is strictly confidential. We also request permission to have your name which will not appear in any reports or notes, unless it is consented.

Your participation is voluntary and there is no penalty for refusing to take part. You may refuse to answer any question in this questionnaire/interview or stop the interview at any time. You are free to ask questions at any time.

Would you be willing to participate? 1=Yes 2=No

Thank you.

_____

(Signature of interviewer certifying that informed consent has been given verbally by respondent)

INTERVIEWER: Code: [_____|_____] Name (Initials):

_____

DATE OF INTERVIEW: |___||___|\|___||___|\ |___||___||___||___|
Day Month Year

CHECKED BY SUPERVISOR:
Signature _____Date:_____

Note to interviewer: Ensure your response are in project specific

A: PROGRAM MANAGEMENT

1. Do you think the projects achieved HTC goals? Explain HOW?

   Angaza Zaidi

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   UHAI-CT

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2. What are each project's strengths, weakness and gaps in **planning and management of routine data use and service delivery**

   Angaza Zaidi

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   UHAI-CT

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3. In your opinion, how have the projects established constructive working relationship with key stakeholders such as Government, like minded partners, and CSOs? [*Probe on how regular meeting for update and if government provide guidance and feedback*]

Angaza Zaidi

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UHAI-CT

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B: PROGRAM ACCOMPLISHMENTS AND RESULTS

4. Is there evidence that shows that each project has *[provide examples]*

a) Improved the quality of HIV testing and counseling services at the health facility level?

Angaza Zaidi

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UHAI-CT

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b) Improved the quality of services at the community level?

Angaza Zaidi

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UHAI-CT

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c) Improved referral linkages between the community and facility level [*Probe how referrals are done if someone test HIV positive and if there is a mechanism for VCT to receive feedback from CTC*]

Angaza Zaidi

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UHAI-CT

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5. To what extent have the projects services been successfully integrated into the national HIV framework?

Angaza Zaidi

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UHAI-CT

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6. How effective has each project contributed in influencing HIV policy related to counseling and testing? *[Probe if projects activities aligned with the National HIV/AIDS strategies, policies and guidelines*]

Angaza Zaidi

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UHAI-CT

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C: MONITORING & EVALUATION

7. How successful has each project been in providing valid and reliable information? [*Probe on How have the projects complemented work done under the other PERFAR partners and avoid duplication*]

Angaza Zaidi

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UHAI-CT

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D: LESSON LEARNT & SUSTAINABILITY

8. What lessons learnt and good practices (what works well) by the following projects which needs replication in your district?

   Angaza Zaidi

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   UHAI-CT

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9. How has each project built capacity and/or institutionalized to ensure that HTC services are provided beyond projects phase out? *(Probe on type of services, Target population groups, Implementing partners, Collaborators)*

   Angaza Zaidi

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   UHAI-CT

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READ: That question completes our interview today. Thank you very much for sharing your thoughts with me. The information you have provided has been very helpful

PERFORMANCE EVALUATION OF USAID SUPPORTED HTC PROJECTS IN TANZANIA

Exit Interview (Community Member)

Data Collection Form

QUESTIONNAIRE IDENTIFICATION NUMBER: |_____|_____| REGION ID NUMBER: |_____|_____|

DISTRICT ID NUMBER: |_____|_____| FACILITY ID NUMBER |_____|_____|

SEX OF RESPONDENTS: |__M___|__F___|

Type of Health Facility:
☐ Hospital ☐ Health Center ☐ Dispensary ☐ VCT Centre ☐ Mobile site (*Specify*)…….
☐ other

My name is..... I am here on behalf of IBTCI a consulting firm based in Washington DC, USA who has been entrusted by the USAID Tanzania to conduct performance evaluation of two HTC projects namely ANGAZA ZAIDI and UHAI-CT implemented by AMREF and JHPIEGO respectively.

We are collecting information that will help us to understand HIV testing and counseling services in Tanzania which will be used to inform USAID how they can support efforts to improve HIV testing and counseling in Tanzania

The interview will last for approximately 30 minutes. I would like you to express your views freely and openly. All information that you give is strictly confidential. Your name will not appear in any reports or notes, unless it is consented

Your participation is voluntary and there is no penalty for refusing to take part. You may refuse to answer any question in this questionnaire/interview or stop the interview at any time. You are free to ask questions at any time.

Would you be willing to participate? 1=Yes 2=No

Thank you.

_____

(Signature of interviewer certifying that informed consent has been given verbally by respondent)

INTERVIEWER: Code: [_____|_____] Name (Initials): _____

DATE OF INTERVIEW: |___||___|\|___||___|\ |___||___||___||___|
Day Month Year

CHECKED BY SUPERVISOR:
Signature _____Date:_____

SECTION A: SOCIO-DEMOGRAPHIC PROFILE OF RESPONDENT

No.	QUESTIONS	ANSWERS	SKIP
B01	Sex of the interviewee	Male 01 Female 02	
B02	Age of interviewee in complete years	……..	
B03	Level of education	None 01 Primary 02 Secondary 03 Above secondary 04 No answer 99	
B04	Marital Status	Single 01 Married 02 Divorced 03 Widow/widower 04 Others 05	

SECTION B: VCT SERVICES

NO.	QUESTION	ANSWERS	SKIP
C01	How long did you have to wait before you were attended?	Less than 30 minutes 01 30 minutes – 1 hour 02 1 – 2 hours 03 More than 2 hours 04	
C02	Did you receive any counseling before getting tested?	Yes 01 No 02	
C03	Was the counseling conducted in group or individual counseling?	Group 01 Individual 02 Both 03	
C04	On average how long was the counseling session?	Less than 30 minutes 01 30 minutes – 1 hour 02 1 – 2 hours 03 More than 2 hours 04	
C05	Was the counseling session private?	Yes 01 No 02 →	C7
C06	Were the following aspects of privacy observed?	The door was closed 01 Nobody entered the room 02 Both of them 03	
C07	What aspects of privacy were not observed?	The door was opened 01 Someone enter the room 02 Both of them 03	
C08	Do you think you were given adequate information during the counseling session?	Yes 01 No 02	
C09	Did the counselor give you the opportunity to ask questions?	Yes 01 No 02	
C10	Did the counselor adequately respond to your questions?	Yes 01 No 02 Did not ask 03	
C11	Did the counselor discuss with you the benefits of testing?	Yes 01 No 02	
C12	Did the counselor discuss with you	Yes 01	

	about how to share your results with family/ partner?	No 02	
C13	Did the counselor discuss with you your HIV infection risk?	Yes 01 No 02	
C14	Did the counselor discuss with you about any prevention measures you should take?	Yes 01 No 02	
C15	Did the counselor advice you to bring your partner?	Yes 01 No 02	
C16	Were you given any advice on the use of condoms?	Yes 01 No 02	
C17	Were you told where you can access condoms?	Yes 01 No 02	
C18	Were you given any information/skills on how to get your partner use condoms?	Yes 01 No 02	
C18	Did the counselor demonstrate how to use condoms?	Yes 01 No 02	
C19	Did the counselor give you any condoms to take with you home?	Yes 01 No 02	
C20	Did the counselor advice you to come for testing another time?	Yes 01 No 02	
C21	What was the attitude of the counselor towards you?	Friendly 01 Neutral 02 Unfriendly 03	
C22	What was the attitude of the lab technician towards you?	Friendly 01 Neutral 02 Unfriendly 03	
C23	What was the attitude of the receptionist towards you?	Friendly 01 Neutral 02 Unfriendly 03	
C24	Overall, what do you think about the services you received today?	Very good 01 Fair 02 Bad 03	
C25	Overall, do you think that your results will remain confidential between you and the counselor?	Yes 01 No 02	
C26	What can you say about the cleanness of the facility?	Very clean 01 Clean 02 Not clean 03	
C27	Will you be willing to come back to this facility?	Yes 01 → No 02	C30
C28	If NO, why are you not willing to come back to this facility?	…… …… …… ……	
C29	Can you advice your friends/ family to visit this facility?	Yes 01 No 02 →	C31
C30	If YES, what are qualities that you like about the facility?	…… …… …… ……	

C31	If NO, why are you not willing to recommend the facility to friends/family?	…… …… …… ……	

Comments and opinion

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READ: That question completes our interview today. Thank you very much for sharing your thoughts with me. The information you have provided has been very helpful

PERFORMANCE EVALUATION OF USAID SUPPORTED HTC PROJECT IN TANZANIA

Counselor/service provider Interview

Data Collection Form

Q1. QUESTIONNAIRE IDENTIFICATION NUMBER: |_____|_____| Q2. REGION ID NUMBER: |_____|_____|

Q3. DISTRICT ID NUMBER: |_____|_____| Q4. FACILITY ID NUMBER |_____|_____|

Q5: SEX OF RESPONDENT: |__M___|__F___|

Type of Health Facility:
☐ **Hospital** ☐ **Health Center** ☐ **Dispensary** ☐ **VCT Centre** ☐ **Mobile site (*Specify*)…….**
☐ **Other**

Cadre:
☐ **Medical Officer** ☐ **Medical Assistant** ☐ **Nurse** ☐ **Midwife** ☐ **Other**

_____

My name is..... I am here on behalf of IBTCI a consulting firm based in Washington DC, USA who has been entrusted by the USAID Tanzania to conduct performance evaluation of two HTC projects namely ANGAZA ZAIDI and UHAI-CT implemented by AMREF and JHPIEGO respectively.

We are collecting information that will help us to understand HIV testing and counseling services in Tanzania which will be used to inform USAID how they can support efforts to improve HIV testing and counseling in Tanzania

The interview will last for approximately 40 minutes. I would like you to express your views freely and openly. All information that you give is strictly confidential. Your name will not appear in any reports or notes, unless it is consented.

Your participation is voluntary and there is no penalty for refusing to take part. You may refuse to answer any question in this questionnaire/interview or stop the interview at any time. You are free to ask questions at any time.

Would you be willing to participate? 1=Yes 2=No

Thank you.

_____

(Signature of interviewer certifying that informed consent has been given verbally by respondent)

Q5. INTERVIEWER: Code: [_____|_____]
Name (Initials): _____
Q6. DATE OF INTERVIEW: |___||___|\|___||___|\ |___||___||___||___|
Day Month Year

CHECKED BY SUPERVISOR:
Signature _____Date:_____

1. Do you provide HIV testing and counseling? ☐ yes ☐ no

2. Do you provide voluntary counseling and testing? ☐ yes ☐ no

3. If the above answer is Yes, what type of counseling and testing modalities to you use

☐ *Integrated VCT* ☐ *Stand alone VCT* ☐ *Mobile outreach* ☐*PITC* ☐*Community based CT*

4. Which are effective modalities in reaching the target population?

☐ *Integrated VCT* ☐ *Stand alone VCT* ☐ *Mobile outreach* ☐*PITC* ☐*Community based CT*

5. When you counsel clients, what information do you cover? (*check all that apply*)

For every box checked, how often	**Every client**	**Most clients**	**Only clients that I think don't know**	**Rarely / Seldom**	**NO**
☐ inquire about their partners' HIV status					
☐ use of condom					
☐ risk with multiple partners					
☐ reduced risk if man is circumcised					

6. What safety precautions do you take when testing clients for HIV?

For every box checked, how often?	**Always**	**Often**	**Rarely / Seldom**
☐ Wash hands before and after testing each patient			
☐ Wear fresh pair of gloves with each patient			
☐ Wear laboratory coat or apron			
☐ Dispose of contaminated sharps and waste immediately after testing			

7. If a client tests positive for HV, what do you do?

   ☐ nothing ☐ inform him/her ☐ inform and counsel ☐ refer to care and treatment ☐ inform post test counsel and refer to care and treatment
   ☐ other _____

8. Tell me if you agree or not with each of the following statements? (strongly agree, agree, disagree, strongly disagree)

Statement	**1=strongly agree**	**2=agree**	**3=disagree**	**4=strongly disagree**
I believe that HIV-positive patients are the biggest threat to my safety at my place of work.				
I feel that clients who have sexual relations with people of the same sex (e.g. men who have sex with men)				

should seek health services elsewhere				
I feel that clients who are sex workers should seek health services elsewhere.				
I am comfortable providing health services to clients who are HIV-positive.				
I believe that people who are infected with HIV should not be treated in the same areas as other clients in order to protect the larger population from infection.				
I avoid touching clients for fear of becoming infected with HIV.				

9. Have you been trained on providing HTC services to clients? If yes, how often and with who?

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10. Have you received any job aid to use on your work? Yes/ No

11. What actions are being taken to ensure privacy (verifying by probing how)

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12. Do you get supervision support from the program people? How and when?

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13. Is there a system in place to capture the lost to follow clients? How is it applied?

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14. Do you have all you need such as equipment, supplies and medicine that are needed to provide the service? Yes / NO

15. How are referrals made for newly identified HIV positive client from your unit to care and treatment facilities?

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16. What mechanism is in place to ensure that the referrals are effective[*Probe if there is a verification mechanism; how is it working; who is responsible*]

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17. What do you think are the weaknesses or barriers in providing HIV testing and counseling services? (Probe for the difficulties to meet the intended objectives). Please suggest in which areas the two projects could do better? *Please give specific examples per project if any.*

    Angaza Zaidi

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    UHAI-CT

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18. In the future do you see your center being able to run the services without assistance from Angaza Zaidi /JPIEGO? If yes how.
    Angaza Zaidi

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    UHAI-CT

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READ: That question completes our interview today. Thank you very much for sharing your thoughts with me. The information you have provided has been very helpful.

PERFORMANCE EVALUATION OF USAID SUPPORTED HTC PROJECT IN TANZANIA

FACILITY AUDIT

Data Collection Form

QUESTIONNAIRE IDENTIFICATION NUMBER: |_____|_____|. REGION ID NUMBER: |_____|_____|

DISTRICT ID NUMBER: |_____|_____| FACILITY ID NUMBER |_____|_____|

SEX OF RESPONDENTS: |__M___|__F___|

Type of Health Facility:
☐ Hospital ☐ Health Center☐ Dispensary ☐ VCT centre ☐ other.....

My name is..... I am here on behalf of IBTCI a consulting firm based in Washington DC, USA who has been entrusted by the USAID Tanzania to conduct performance evaluation of two HTC projects namely ANGAZA ZAIDI and UHAI-CT implemented by AMREF and JHPIEGO respectively.

We are collecting information that will help us to understand HIV testing and counseling services in Tanzania which will be used to inform USAID how they can support efforts to improve HIV testing and counseling in Tanzania

The discussion will last for approximately 1 hour. I would like you to express your views freely and openly. All information that you give is strictly confidential. We also request a permission to take a picture; your name and picture will not appear in any reports or notes, unless it is consented.

Your participation is voluntary and there is no penalty for refusing to take part. You may refuse to answer any question in this questionnaire/interview or stop the interview at any time. You are free to ask questions at any time.

Would you be willing to participate? 1=Yes 2=No

Thank you.

_____

_____
(Signature of interviewer certifying that informed consent has been given verbally by respondent)

INTERVIEWER: Code: [_____|_____] Name (Initials):

_____

DATE OF INTERVIEW: |___||___|\|___||___|\ |___||___||___||___|
Day Month Year

CHECKED BY SUPERVISOR:
Signature _____Date:_____

Types of modalities in place☐ *Integrated VCT* ☐*Stand alone VCT*
☐ *Mobile outreach UHAI-CT* ☐ *PITC*
☐*Community based CT*

1. Estimated catchment population: _____

2. Total number of staff involved in HTC: _____

3. How many have participated in trainings sponsored by
A) JHPIEGO …….
B) AMREF……..
C) TMARC……
D) AFRICARE…….

4. How many have participated in any training on HIV prevention and/or HTC:

Note the number by cadre:

	Number of HTC Staff	Number participating in JHPIEGO trainings	*Number participating in any HTC Training from anyone*
Doctors			
Medical Assistants			
Nurses			
Midwives			
Other (specify)			

5. Does this facility offer mobile outreach HTC services? ***[Probe where do they go; how do they chose mobile outreach and how data are integrated into health facility]***
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6. *If yes*, how many days per month? ___ VTC (outreach)……. ☐ PITC (outreach)…… Other…….

<u>HTC Registration Logbook & Monthly Summary</u>

7. Have HTCs been recorded every day for the last week? ☐ yes ☐ no

8. Total number of HTC recorded each day for the last week:[Verify by checking records]
Day 1 _____ Day 2 _____ Day 3 _____ Day 4 _____
Day 5 _____ Day 6_____

9. On average how much time (in minutes) is spent on each one counseling session?
……

10. If mobile outreach HTC, is there a Registration Logbook for Outreach HTC?
☐ yes ☐ no

11. When did you conduct your last outreach mobile
a) Last week ☐ b) Last month ☐ c) Last quarter ☐

12. How do you rate the degree of privacy during mobile outreach HTC?
☐ Good ☐ fair ☐ Poor ☐ don't know

13. What do you find most enjoyable about mobile testing? What do you find most challenging about mobile testing?

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14. Are condoms available in your facility? ☐ yes ☐ no

15.If not, where do the clients get them? _____

16. How do you handle data that is generated from the HTC services? How is it compiled, shared and used? *(Find out if they are in compliance with National data collection system)*

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17.Are HTC national policy guidelines available for your use? ***[Verify by checking the following documents]*** *National policy guidelines for HIV testing and counseling, Training curriculum for counselors, National protocols and algorithms for HIV testing, and Data collection tools for Monitoring and Evaluation and reporting forms**]***

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Infrastructure

18. Number of locations/rooms where HTC is done: _____

Room 1: ☐ visual privacy ☐ auditory privacy
Room 2: ☐ visual privacy ☐ auditory privacy
Room 3: ☐ visual privacy ☐ auditory privacy
Room 4: ☐ visual privacy ☐ auditory privacy
Room 5: ☐ visual privacy ☐ auditory privacy

HIV Prevention and Testing IEC Materials

19. Total Number (estimate) of HIV brochures/pamphlets in stock at facility _____

20. Do you ever run out of HIV brochures/pamphlets? ☐ yes ☐ no

21. Who supplies the brochures/pamphlets?

☐ [Name of Project] ☐ Another project
☐ MOHSW ☐ Don't know

22. How often do you get brochures/pamphlets re-stocked?

☐ Weekly ☐ monthly ☐ quarterly ☐ twice/year ☐ annually ☐ don't know

23. Number of client oriented HIV posters that are clearly posted for clients to see _____(***Observe*****)**

24. How do you describe the retention of the staff in your centre? (*Probe for employee turnover for past 3 years)*

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25. How are referrals made for newly identified HIV-Positive clients from your unit to Care and treatment facilities?

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26. What mechanism is in place to ensure that the referrals are effective? (Probe if there is verification mechanism, if yes describe it….how is it working, who is responsible).

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27. How often do you receive supportive supervision from the CHMT?

a) Monthly
b) Quarterly
c) Semi-annually
d) Other specify……

If yes what approach were used to provide feedback?

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28. Do you have a set of HTC SOP for your service providers to use?
Yes / No

READ: That question completes our interview today. Thank you very much for sharing your thoughts with me. The information you have provided has been very helpful

ANNEX IV: FIELD WORK PLAN

Summary of Field work route plan

Region	Date	Route
Iringa	3rd – 15th November	Route 1
Tanga	16th – 22nd November	Route 1
Kilimanjaro	3rd– 9th November	Route 2
Tabora	10th – 21st November	Route 2
DSM	25th – 26th November	Route 1 & 2

Type of sites	Total to be visited	AZ	UHAI-CT
Hospitals	7	3	4
Health Centers	7	4	3
Dispensaries	5	1	4
VCT (Stand-alone)	4	4	0
Community sites include (local brews, open markets, and road camp)	6	2	4
Community outreach exercise	4	2	2
Total sites	**33**	**16**	**17**

DETAILED FIELD WORK ROUTE PLAN

Route I

Region	Districts	Facility Name	Projects	Type of Facility	Days	Dates
Sunday - *Travel from Dsm to Iringa Town*					I	3rd Nov
Iringa	Iringa Regional Office	Iringa Municipal Council – Urban			I	4th Nov
		Igumbilo Dispensary	UHAI-CT	Dispensary	I	5th Nov
		Iringa Municipal	AZ I	Stand Alone VCT	I	6th Nov
		Sabasaba Dispensary	UHAI-CT	Dispensary	I	7th Nov
		ALPHA Dancing Group	UHAI-CT	Auction Market (Mnadani)	I	8th Nov
Sunday - *Travel from Iringa to Mufindi District Council*					I	**9th Nov**
	Mufindi District Council	Mafinga District Hospital	UHAI-CT	Hospital	I	10th Nov
		Mafinga VCT	AZ	Stand Alone VCT	I	11th Nov
Travel from Mufindi DC to Makambako Town Council					0.5	12th Nov
	Njombe Region	Makambako VCT	AZ	HC	0.5	12th Nov
Travel from Makambako					0.5	13th Nov
	Njombe Town Council	Community Outreach – Makambako VCT	AZ	CB-CT Exercise Mlowe Village	0.5	13th Nov
		CB-CT in collaboration with TMARC	UHAI-CT	CB-CT	I	14th Nov
		CB-CT in collaboration with TMARC	UHAI-CT	CB-CT	I	15th Nov
Travel from Makambako – Tanga					I	16th Nov
Sunday					I	**17th Nov**
	Tanga Regional	Tanga Town MC			I	18th Nov
		Ngamiani HC	UHAI-CT	HC	0.5	19th Nov
		Makorora HC	UHAI-CT	HC	0.5	19th Nov
		Tanga AIDS Working Group (TWAG)	UHAI-CT	CB-CT (Brothels, Beach)	I	20th Nov

Travel to Korogwe					1	21st Nov
	Korogwe District Council	St. Raphael Hospital	UHAI-CT	Hospital	0.5	22ndNov
		Bakwata Dispensary	UHAI-CT	Dispensary	0.5	22nd Nov
Travel to Dar es Salaam					1	23rd Nov

Route 2

Region	Districts	Facility Name	Projects	Type of Facility	Days	Dates
Sunday - *Travel from Dar es Salaam to Kilimanjaro*					1	**3th Nov**
	Mwanga DC	Mwanga HC	AZ	HC	1	4th Nov
		Usangi Hospital	UHAI-CT	Dispensary	0.5	5th Nov
Travel to Moshi Town					1	5th Nov
	Moshi Region	Moshi DC			1	6th Nov
		Marangu VCT Hospital	AZ	Integrated Hospital	1	7th Nov
		Kilema Hospital	UHAI-CT	Hospital	0.5	7th Nov
Travel Marangu – Hai DC					0.5	8th Nov
	Hai DC	Hai Hospital	UHAI-CT	Hospital	0.5	8th Nov
		Machame VCT	AZ	Hospital	1	9th Nov
Sunday - *Travel from Hai to Manyara*					1	**10th Nov**
Travel from Manyara to Tabora						11th Nov
	Tabora Regional	Tabora MC			1	12th Nov
		Isevya Dispensary	UHAI-CT	Dispensary	1	13th Nov
		St Philip Health Centre	UHAI-CT	HC	1	14th Nov
		Moravian Health Centre	AZ	HC	1	15th Nov
		Community Outreach – Moravian Health Centre	AZ	CB-CT Exercise	1	16th Nov
Sunday					1	**17th Nov**
		Health Action Promotion Tanzania (HAPO)	UHAI-CT	CB-CT (Local Brews Road Camp site)	1	18th Nov
		Community Outreach - HAPO	UHAI-CT	CB-CT Exercise	1	19th Nov

		Tabora Development Foundation Trust (TDFT)	UHAI-CT	CB-CT (Bars, Guest Houses)	1	20th Nov
		Community Outreach – (TDFT)	UHAI-CT	CB-CT Exercise	1	21st Nov
Travel from Tabora - Dodoma					1	22th Nov
Travel from Dodoma – Dar es Salaam					1	23rd Nov

Dar es Salaam

Region	**Districts**	**Facility Name**	**Projects**	**Type of Facility**	**Days**	**Dates**
Route 1						
Dar es Salaam	Ilala Municipal Council	AZ ATC	AZ	Stand Alone VCT	1	25th Nov
		Mnazi Mmoja HC	AZ	Integrated HC	1	26th
Route 2						
Dar es Salaam	Temeke MC	Temeke VCT	AZ	Integrated Hospital	1	25th Nov
		Mwananyamala VCT	AZ	Stand Alone VCT	1	26th Nov

ANNEX V: POPULATION AND HIV-RELATED DATA FOR ALL OF TANZANIA'S REGIONS WHERE ANGAZA ZAIDI'S SITES OVERLAP WITH UHAI-CT'S SITES

Region	Population	HIV Prevalence	Testing Prevalence M/F	Risky Behavior M/F	Male Circumcision	AMREF Sites	Jhpiego Sites
Western Zone				M - 17 % F - 2.5%			
Tabora	2,291,623	5.1%	M(29.2%) F(59.5%)	-	42.8%	1	75
Northern Zone				M - 17.2% F - 2.0%			
Kilimanjaro	1,640,087	3.8%	M(29.0%) F(72.5%)	-	97.0%	4	91
Tanga	2,045,205	2.4%	M(32.6%) F(61.4%)	-	95.0%	0	45
Manyara	1,425,131	1.5%	M(24.6%) F(55.2%)	-	97.3%	0	85
Central Zone				M3 - 1.7% F - 3.4%			
Dodoma	2,083,588	2.9%	M(24.8%) F(49.7%)	-	96.9%	1	32
Singida	1,370,637	3.3%	M(31.5%) F(54.1%)	-	90.9%	1	26
Southern Highlands				M - 17.6% F - 2.7%			
Iringa	941,238	9.1%	M(21.7%) F(65.0%)	-	37.7%	3	93
Njombe	702,097	14.8%	M(65%) W(74%)	-	49%	1	28
Lake Zone				M - 25% F - 4.4%			
Kagera	2,458,023	4.8%	M(23.7%) F(58.5%)	-	26.4%	0	0
Mwanza	2,772,509	4.2%	M(16%) F(50.6%)	-	54.1%	5	0
Mara	1,743,830	4.5%	M(29.7%) F(57.4%)	-	89.0%	4	0
Eastern				M - 16.2% F – 3.4%			
Morogoro	2,218,492	3.8%	M(22.0%) F(52.6%)	-	93.1%	1	0

Region	Population	HIV Prevalence	Testing Prevalence M/F	Risky Behavior M/F	Male Circumcision	AMREF Sites	Jhpiego Sites
Southern Zone				M – 27.9% F – 8.6%			
Ruvuma	1,376,891	7.0%	M(45.3%) F(70.7%)	-	68.9%	2	0

ANNEX VI: DRAFT OUTLINE OF THE EVALUATION REPORT

Performance Evaluation of USAID HIV Testing and Counseling Projects in Tanzania

Acronyms

Table of Contents

Executive Summary

I. Introduction
   A. Purpose
   B. Audience
   C. Task

II. Background
   A. Overview of the HTC program in Tanzania
   B. USAID HTC strategy
   C. Activities implemented in response to the problem
   D. Description of each project
   E. Purpose of the evaluation

III. Methodology
   A. Evaluation Methods
   B. Constraints and gaps

IV. Findings/Conclusions/Recommendations

V. Issues
   A. Technical
   B. Administrative

VI. Lessons Learned

References (bibliographical documentation, meetings, interviews and focus group discussions)

Annexes (evaluation methods, schedules, interview lists and table)