PERFORMANCE EVALUATION OF USAID/ZIMBABWE'S FAMILIES AND COMMUNITIES FOR THE ELIMINATION OF HIV (FACE-HIV) PROJECT

Task Order: AID-613-TO-16-00005
Contract No: AID-OAA-I-15-00028

EVALUATION REPORT

January 2017

This publication was produced for review by the United States Agency for International Development. It was prepared by The Mitchell Group, Inc. with assistance from JIMAT. The core evaluation team was comprised of Dr. Ruth Hope (Team Leader) and Nyasha Madzingira (Evaluation Specialist)

PERFORMANCE EVALUATION OF USAID/ZIMBABWE'S FAMILIES AND COMMUNITIES FOR THE ELIMINATION OF HIV (FACE-HIV) PROJECT

PERFORMED UNDER TASK ORDER NO. AID-613-TO-16-00005
PPL/LER MONITORING & EVALUATION IDIQ
CONTRACT NO. AID-OAA-I-15-00028

Evaluation Report

January 2017

DISCLAIMER

The authors' views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

TABLE OF CONTENTS

ABBREVIATIONS & ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal care
ART	Anti-retroviral therapy
CARG	Community ART Refill Group
CDC	Centers for Disease Control
COP	Country Operational Plan
CRF	Clinical Referral Coordinator
DBS	Dried blood spot
DEC	Development Experience Clearinghouse
DQA	Data quality assessment
FGD	Focus Group Discussion
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EID	Early infant diagnosis [of HIV infection]
eMTCT	Elimination of Mother-to-Child Transmission (of HIV)
FACE-HIV	Families and Communities for the Elimination of HIV
FACE-Ped HIV	Families and Communities for the Elimination of Pediatric HIV
FCH	Family and Child Health
FY	Financial Year
GOZ	Government of Zimbabwe
HIV	Human Immunodeficiency Virus
HTS	HIV Testing Services
IP	Implementing Partner
I-TECH	The International Training and Education Center for Health
KII	Key informant interview
MCHIP	Maternal and Child Health Integrated Program
MDRTB	Multiple drug resistant tuberculosis
M&E	Monitoring and evaluation
MNCH	Maternal, Neonatal and Child Health
MOHCC	Ministry of Health and Child Care

MSF	Médicine Sans Frontier
OI	Opportunistic infection
OPHID	Organization for Public Health Interventions and Development
PEPFAR	President's Emergency Plan for AIDS Relief
PITC	Provider-initiated testing and counseling [for HIV infection]
PLHIV	People living with HIV
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PSZ	Population Services Zimbabwe
QA	Quality Assurance
QI	Quality Improvement
SAfAIDS	Southern Africa AIDS Dissemination Services
SIE	Strategic Information and Evaluation
SIMS	Site Improvement through System Monitoring
SOW	Scope of Work
SRH	Sexual and Reproductive Health
TA	Technical Assistance
TB	Tuberculosis
UNAIDS	United Nations Programme on AIDS
USAID	United States Agency for International Development
USG	United States Government
WHO	World Health Organization
ZAPPT	Zimbabwe AIDS Prevention Programme Trust
ZNASP	Zimbabwe National Strategic Plan on HIV and AIDS
ZNNP	Zimbabwe National Network for People Living with HIV

EXECUTIVE SUMMARY

EVALUATION PURPOSE AND EVALUATION QUESTIONS

The specific evaluation purpose is to

- *assess* the project performance since the PEPFAR Pivot & the broadened scope from the FACE-PED HIV project
- *recommend* any necessary design changes and help guide implementation during the last year of the project to maximize results
- *inform* future project design.

The FACE-HIV evaluation seeks to answer the following questions:

1. How can the FACE-HIV activity design and implementation be enhanced to increase efficiency and effectiveness in contributing to current PEPFAR priorities to reach the UNAIDS fast track targets of 90-90-90 by 2020?

   1.1 What design and implementation aspects of the FACE-HIV project are critical to achieving intended results? Why?

   1.2. What design and implementation aspects of the project are not achieving intended results?

   1.3 What alternative approaches and strategies could achieve better results?

   1.4 What is the nature of the linkages and synergies with other USG and non-USG partners?

2. What are the major challenges faced by the FACE-HIV activity in delivering HIV services (HTS, ART, TB/HIV, eMTCT, care, support, retention, and adherence) and how can USAID address these challenges?

   2.1 How successfully has the implementing partner managed changes in USAID requirements related to the PEPFAR Pivot? Have the changes affected project performance?

The primary users of this report include USAID/Zimbabwe in particular the PEPFAR Team; the Zimbabwe Ministry of Health and Child Care (MOHCC); and the FACE-HIV implementing partners: the Organization for Public Health Interventions and Development (OPHID) Trust, Kapnek Trust and Zimbabwe AIDS Prevention Programme Trust (ZAPPT).

PROJECT BACKGROUND

In 2011, prevention of mother-to-child transmission of HIV (PMTCT) was a vital component of Zimbabwe's National Health Strategy and the Zimbabwe National Strategic Plan on HIV and AIDS (ZNASP 2010-2015). The PMTCT program aimed to eliminate new HIV infections among children by 2015, and keep mothers, children and families alive by implementing PMTCT services based on the four prongs of WHO's comprehensive approach. However, UNAIDS estimated that in 2011 only 54% of pregnant women living with HIV received antiretrovirals for PMTCT, and only 29% of HIV exposed infants had a virological test for HIV within two months of birth, and that there were 15,000 new pediatric HIV infections. The FACE-Ped HIV project was designed to work with the MOHCC to strengthen and expand access to Zimbabwean services for the elimination of mother-to-child transmission of HIV and provisions for pediatric AIDS care and treatment throughout Zimbabwe. In response to the "PEPFAR Pivot", that rationalized USG technical assistance and eliminated duplication of effort, and focused USG support in the dis-

tricts with greatest epidemiological need, FACE-Ped HIV transformed into FACE-HIV, a project supporting the Ministry of Health and Child Care (MOHCC) to provide comprehensive HIV/TB services in 22 PEPFAR priority districts in five provinces in the southern half of Zimbabwe.

EVALUATION DESIGN, METHODS AND LIMITATIONS

The evaluation was conducted by The Mitchell Group, Inc. (TMG) under the USAID/Zimbabwe PPL/LER Monitoring & Evaluation IDIQ, Contract Number SOL-613-16-00010. TMG provided an Overall Team Leader and Evaluation Methodology Expert, an Evaluation Team Leader/HIV expert and a senior Zimbabwean HIV Specialist to the FACE-HIV evaluation. The Evaluation Team Leader and Senior Zimbabwean HIV Specialist had no real or potential conflicts of interest to disclose. The evaluation team received logistics and other in-country support—including translation of tools into Shona and Ndebele—from TMG's local partner JIMAT Development Consultants. The evaluators were assisted by two JIMAT enumerators/Focal Group Discussion specialists who were native Shona speakers throughout the field work. For Bulawayo and Matabeleland, two JIMAT Ndebele enumerators/Focal Group Discussion specialists joined the team. The Evaluation Team Leader/HIV expert was responsible for developing the evaluation tools, with feedback from the Zimbabwean HIV specialist and had overall responsibility for the evaluation report.

The evaluation used a snap-shot cross-section design to answer the descriptive and normative questions about FACE-HIV Project achievement. Field data collection was in Zimbabwe in September and October 2016. A variety of descriptive and normative evaluation methods and approaches were used to collect and analyze information relevant to the evaluation objectives, and questions outlined in the Scope of Work. These included 1. Review and Analysis of Background Materials; 2. Review of USAID SIMS Assessment reports; 3. Site Visits; 4. Key Informant Interviews; 5. Focus Group Discussions; and 6. Reanalysis of Secondary Sources.

Absence of a comparison group for data analysis is noted as potential data limitations for the evaluation. The field data collection provided a snapshot of current HIV service delivery and quality of services provided in a rapidly changing environment. The health care workers in the districts visited were being paid monthly—sometimes days later than the due date but always within a month—although municipal managers reported salary payments were six months in arrears, with the arrears being used to offset rents for staff accommodation in government housing. The major challenge reported by health workers was cashing their paychecks because of the severe shortage of cash in Zimbabwe.

FINDINGS AND CONCLUSIONS

1. **HOW CAN THE FACE-HIV ACTIVITY DESIGN AND IMPLEMENTATION BE ENHANCED TO INCREASE EFFICIENCY AND EFFECTIVENESS IN CONTRIBUTING TO CURRENT PEPFAR PRIORITIES TO REACH THE UNAIDS FAST TRACK TARGETS OF 90-90-90 BY 2020?**

The activity is pragmatically deploying locum nurses to government direct service delivery positions in PEPFAR priority districts and facilities. The evaluation found three models for selection of locum nurses, two of which involve hiring nurses on their time off. The third model rehires recently retired nurses. Hiring nurses on their time off is problematic as these nurses are not getting the full rest and recuperation between shifts/during the year and, despite the financial incentive, might lead to more rapid burnout. The evaluation found this model also demotivates health workers in facilities that "do not receive the benefit" of the additional financial incentives. Hiring nurses on their time off is thus undesirable and should be avoided. There are many unemployed nurses in Zimbabwe—including many newly qualified nurses who do not find employment for 3 or 4 years. Hiring these nurses, or rehiring recently retired nurses avoids the

problems of hiring nurses on their time off but might also lead to challenges as project hires are paid regularly and on time each month.

The evaluation found that volunteers living with HIV are underutilized by the project. The activity would be more effective if there was far greater deployment of volunteers living with HIV throughout. In line with experience in other PEPFAR countries, with training volunteers could offer task sharing for lower level tasks from the nursing staff, including reporting. They could provide in the facility and community more intense, consistent and comprehensive support for adherence and living positively, as well as for PMTCT throughout the cascade and involvement of men in PMTCT.

The linkages with the community—over the continuum of HIV/TB services from prevention to treatment adherence—were found to be weak. The activity design would be more effective if community partners were included in the consortium and FACE-HIV was responsible for implementation in the community.

The evaluators assess the FACE-HIV staffing in the field as relatively light compared to USAID-funded comprehensive HIV projects elsewhere in Africa. Although OPHID report it has taken steps to decentralize staff to district level, the project would be more efficient with additional technical staff and management staff at subnational level for oversight of the expanding personnel and more intensive programming for attaining project targets.

1.1 What design and implementation aspects of the FACE-HIV project are critical to achieving intended results? Why?

The evaluation found that secondment of technical staff to the MOHCC at National level is vital for effective activity implementation and for wider effectiveness of the Zimbabwean public health services as the MOHCC budget constrains its hiring for these directorate level positions.

"*Treat all*", the local name for WHO Test and start strategy, is critical to achieving the second 90 of UNAIDS' fast track 90:90:90 targets as it reduces the loss of clients living with HIV after testing and before initiation on antiretroviral therapy (ART). The evaluation found that "*treat all*" has also reduced challenges for staff delivering PMTCT services, as male partners living with HIV are now also initiated on ART without delays for CD4 counts.

1.2. What design and implementation aspects of the project are not achieving intended results?

FACE-HIV as currently being implemented is not demonstrating achievement of the third 90 of UNAIDS' fast track 90:90:90 targets. In part, the achievements are not being verified by low levels of virologic testing. In border areas where many are migrant workers to South Africa and Botswana, clients only return home annually and can only be tested annually. However, throughout Zimbabwe routine 6-monthly use of virological monitoring of treatment is under-utilized, in part because of limited access to testing and FACE-HIV achieved only X% of its COP15 targets. Although, availability of virological testing and transportation of specimens and results were not an issue *in the facilities visited,* FACE-HIV managers reported access to testing is limiting the project more generally. The MOHCC is working on a scale-up plan, and provision of new testing equipment.

1.3 What alternative approaches and strategies could achieve better results?

As noted in 1. above, volunteers living with HIV are underutilized. Greater deployment of volunteers living with HIV offering "expert client" and "mentor mother" services—as have proven successful in other PEPFAR countries—would likely increase achievements of results from testing through to treatment and adherence.

1.4 What is the nature of the linkages and synergies with other USG and non-USG partners

The evaluation found that the activity benefits from infrastructure and service provisions established by other development partners including the World Bank and DFID, and MSF. The field project links with

FHI 360 and PSI in relation to HTS in the community where these implementing partners have programs. The linkages are fostered in review meetings.

2. WHAT ARE THE MAJOR CHALLENGES FACED BY THE FACE-HIV ACTIVITY IN DELIVERING HIV SERVICES (HTS, ART, TB/HIV, EMTCT, CARE, SUPPORT, RETENTION, ADHERENCE) AND HOW CAN USAID ADDRESS THESE CHALLENGES?

The evaluation identified that the major challenge to service delivery is congestion in health facilities. This might be reduced by strengthening local leadership and facility management leading to introduction of appointment systems with a time as well as date given for follow up review. Initially there could be morning and afternoon scheduling of appointments, but this could potentially progress to two-hour block. Use of a timed appointment system could potentially reduce congestion as would timely opening of facilities. Although Community ART Resupply Groups (CARGs) are in line with MOHCC policy, the evaluation found that these are not widespread at project sites. Greater use of CARGs might also greatly reduces congestion in ART clinics.

Low yield of positive clients from HTS was found to be another challenge. Higher yields might be obtained by better targeting of testing but high PEPFAR targets have encouraged testing all at facilities irrespective of risk. High PEPFAR testing targets may have also led to retesting of known PLHIV and reporting them as new clients. However, the evaluators learned that apostolic faith followers living with HIV consult prophets who claim "cures". This also contributes to known PLHIV being retested and presenting as new clients.

The evaluation found that follow up of pre-ART clients has been a challenge but introduction of '*treat all*' has resolved this. Similarly, involving men in PMTCT has been problematic when partners living with HIV were not eligible for treatment. The introduction of '*treat all'* has also resolved this.

There is under reporting of infants having early infant diagnosis and receiving their results in addition to the loss of exposed infants to follow up at facilities.

Reporting quality is an issue identified by the evaluation, particularly at lower volume sites where service providers are also doing the reporting. Beitbridge General Hospital and Mpilo Teaching Hospital reported within 5% accuracy. Apart from one new site where the reporting was clearly being undertaken by someone who did not understand the process, the reporting is probably near to as good as it can be. Given the environment of busy clinics and overworked service providers, missing one or two items from a report may well be the standard that can be realistically achieved by service providers.

USAID might address the challenges by inclusion of community partners and community activities in the FACE-HIV scope of work; and by negotiation with the Office of the Global AIDS coordinator on Testing targets. While high targets can be stimulation to good performance, experience in family planning globally has demonstrated two important lessons: *setting very high targets* can lead to fraudulent or unethical actions and *provision of incentives* can also lead to fraudulent actions in false inflation of results.

2.1 How successfully has the implementing partner managed changes in USAID requirements related to the PEPFAR Pivot? Have the changes affected project performance?

The evaluation confirms that the FACE consortium has changed sub partners, programming has restructured geographically, staff have moved from provinces no longer supported by USAID, and two additional technical staff are hired to address the wider aspects of HIV/TB services supported by FACE-HIV. This happened rapidly from mid-December 2015, albeit with a dip in performance on PMTCT indicators at the beginning of 2016. The partners have well demonstrated their flexibility in accomplishing this upheaval and the relevance of the model of implementation to the wider aspects of HIV/TB services.

RECOMMENDATIONS

The evaluation findings and conclusions support the following key recommendations

(1) The IP should increase the project staffing at sub-national level to provide stronger technical management and oversight of both the proposed increase in deployment of locum nurses and the intensified programming required to achieve the required results. This is particularly necessary for achieving the third 90 of UNAIDS' fast track 90:90:90 targets.

(2) Use of volunteers living with HIV as expert clients and mentor mothers should be rapidly scaled up in FACE-HIV supported facilities and the community to increase achievement of results from testing through to adherence—across all three of UNAIDS' fast track 90:90:90 targets. There are PEPFAR partner models for use of volunteers in other southern African countries that could be adapted and implemented in Zimbabwe.

(3) USAID/Z future HIV/TB project designs might be more effective and implementation more efficiently managed if the activity design is integrated across the spectrum of services at the facility and in the community. Activities might include community partners and community activities within the manageable interest of the lead implementing partner for unified technical leadership and responsibility for delivering results across the spectrum of care and treatment services.

(4) FACE-HIV should include programming to strengthen local leadership and management of services to support timed appointment systems, initiating and utilizing CARGs, and greater involvement of volunteers living with HIV with task shifting to relieve health workers of lower level tasks including reporting.

    (4.1) Emphasis on improving quality of reporting needs to continue, but should be part of this wider approach to strengthening local leadership, management and task shifting. Trained volunteers living with HIV might provide more accurate monthly reports than busy health workers.

EVALUATION PURPOSE & EVALUATION QUESTIONS

Evaluation Purpose

The Families and Communities for the Elimination of HIV (FACE-HIV) project ends in September 2017 and USAID/Zimbabwe is in process of designing a follow-on activity. The timing of the evaluation of the activity a year earlier, allows for (a) identification of lessons for fine-tuning and strengthening implementation in the final year to maximize achievement of results; as well as for (b) identification of what will need sustaining beyond the end of the current project, along with priorities for the design of future USAID investments addressing HIV and tuberculosis (TB) in Zimbabwe.

The specific evaluation purpose is to

- *assess* the project performance since the PEPFAR Pivot & the broadened scope from the FACE-PED HIV project
- *recommend* any necessary design changes and help guide implementation during the last year of the project to maximize results
- *inform* future project design

The primary users of this report include USAID/Zimbabwe in particular the PEPFAR Team; the Zimbabwe Ministry of Health and Child Care (MOHCC); and the FACE-HIV implementing partners: the Organization for Public Health Interventions and Development (OPHID) Trust, Kapnek Trust and Zimbabwe AIDS Prevention Programme Trust (ZAPPT). All USAID's HIV activities are in line with the Government of Zimbabwe (GOZ) national health priorities and are implemented to improve delivery of public health services. It is expected that recommendations that will help guide the current activity during the final year will be agreed by USAID/Zimbabwe and implemented by the FACE-HIV consortium, within current agreements with the MOHCC. Recommendations for the design of a follow-on activity with improved effectiveness and efficiency towards achieving USAID/Zimbabwe's PEPFAR objectives are provided in line with the current United States Administration thinking and priorities. The evaluation might also be used to inform future strategies for other similar programs.

Evaluation Questions

The FACE-HIV evaluation seeks to answer the following questions:

1. How can the FACE-HIV activity design and implementation be enhanced to increase efficiency and effectiveness in contributing to current PEPFAR priorities to reach the UNAIDS fast track targets of 90-90-90 by 2020?

    1.1 What design and implementation aspects of the FACE-HIV project are critical to achieving intended results? Why?

    1.2. What design and implementation aspects of the project are not achieving intended results?

    1.3 What alternative approaches and strategies could achieve better results?

    1.4 What is the nature of the linkages and synergies with other USG and non-USG partners?

2. What are the major challenges faced by the FACE-HIV activity in delivering HIV services (HTS, ART, TB/HIV, eMTCT, care, support, retention, and adherence) and how can USAID address these challenges?

    2.1 How successfully has the implementing partner managed changes in USAID requirements related to the PEPFAR Pivot? Have the changes affected project performance?

PROJECT BACKGROUND

The Development Context

By 2006 there was evidence of a significant decline in the national HIV prevalence in Zimbabwe; HIV prevalence among women (15–49 years) attending antenatal clinics had fallen from 30% in 2000 to 18% in 2006. The trend reflected a combination of very high mortality and declining HIV incidence, related in part to behavior change.1 The World Health Report for 2006 gave the average life expectancy at birth in Zimbabwe as 36 years. Female life expectancy was 34 years, down from 36 in 2003, and male life expectancy was 37 years, unchanged from 2003. By 2011, Zimbabwe had an estimated population of 13.6 million; UNAIDS2 estimated 1 million persons age 15 and above were living with HIV, 7.6% of young women aged 15-24 and 3.6 % of young men aged 15-24 were living with HIV, and the adult HIV prevalence was estimated to be 14.9%. Life expectancy at birth had increased to about 55.95. With evidence of success in prevention through behavior change, UNAIDS estimated new infections were 74,000 down from 140,000 in 2001. Prevention of mother-to-child transmission of HIV (PMTCT) was a vital component of Zimbabwe's National Health Strategy and the Zimbabwe National Strategic Plan on HIV and AIDS (ZNASP 2010-2015). The PMTCT program aimed to eliminate new HIV infections among children by 2015, and keep mothers, children and families alive by implementing PMTCT services based on the four prongs of WHO's comprehensive approach. However, UNAIDS estimated that in 2011 only 54% of pregnant women living with HIV received antiretrovirals for PMTCT, and only 29% of HIV exposed infants had a virological test for HIV within two months of birth, and that there were 15,000 new pediatric HIV infections.[3]

The FACE-Pediatric HIV Project

The FACE-HIV Project was launched as the Families and Communities for the Elimination of Pediatric HIV (FACE-PED HIV) in October 2012 under a five-year Cooperative Agreement, number AID-613-A-12-00003. The project is led by OPHID Trust and initially included a consortium of Zimbabwean, regional and international partners. Initially the project focused on supporting national policy and strengthened services for elimination of mother to child transmission of HIV (eMTCT) and for pediatric AIDS care and treatment throughout all 10 provinces and 65 districts of Zimbabwe. However, **the agreement was modified in December 2015 to incorporate changes as part of a United States Government (USG) portfolio-wide rationalization of its HIV and TB programs, funded under PEPFAR, resulting from the "PEPFAR Pivot"**. At that time, FACE-PED HIV became FACE-HIV; the regional and the international partner were dropped from the consortium, and ZAPPT was added; and the focus of the project expanded to strengthening comprehensive HIV/TB services in 22 PEPFAR priority districts in five provinces, and Chitungwiza.

The FACE-Ped HIV project was designed to work with the MOHCC to strengthen and expand access to Zimbabwean services for the elimination of mother-to-child transmission of HIV and provisions for pediatric AIDS care and treatment throughout Zimbabwe. [Table 1, below, provides the FACE-Ped results framework.] The strategic focuses were to maximize quality and coverage of integrated, comprehensive eMTCT and maternal, neonatal and child health (MNCH) services; to scale up post-natal care including prevention, and pediatric AIDS care and treatment; and to capitalize on community capacities to enhance supply, uptake and retention of mothers, infants and families in care and treatment. The consortium included OPHID Trust, JK KAPNEK Trust, Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) and Southern Africa AIDS Dissemination Services (SAfAIDS), a regional non-profit organization based in

[1] UNAIDS (2007) *AIDS Epidemic Update*
[2] UNAIDS (2012) *Global Report on the AIDS Epidemic*
[3] *ibid*

Harare. FACE-PED HIV collaborated with various AIDS service organizations, Zimbabwe National Network for People Living with HIV (ZNNP+), private sector organizations, and USAID Zimbabwe's Maternal and Child Health Integrated Program (MCHIP) on strengthening the continuum of prevention, care and support services in the community.

Table 1: The FACE-Ped HIV Project Results Framework

Goal: Eliminate new HIV infections in children and improve survival of mothers and children in line with the National Strategic Plan for Eliminating new Infections in Children and Keeping Mothers and Families Alive 2011-2015				
Strategic Objective 1: Provision of technical and other assistance to the national level PMTCT program	*Strategic Objective 2*: Strengthen provision of clinical services for comprehensive PMTCT	*Strategic Objective 3:* Strengthen pediatric HIV services	*Strategic Objective 4:* Conduct operations research to inform evidence-based policies and program strategies	*Strategic Objective 5:* Strengthen continuum of care for mother, infant and family
Key Activities: • Support for key positions at MOHCC • TA to the National PMTCT program • Collaboration within MOHCC • Coordination between PMTCT/MOHCC	*Key Activities*: • Strengthen leadership and ownership at provincial, district and local levels • Provide in-service training and mentorship for health workers • Facilitate implementation of pre-service training programs • Integrated HIV care into maternal services • Integrate HIV care into other health services	*Key Activities*: • Strengthen early diagnosis • Support clinical mentorship/training for health workers • Expand provider initiated testing and counseling for children • Decentralize pediatric ART services	*Key Activities*: • Develop national research agenda for PMTCT and HIV pediatric care and treatment • Targeted research to strengthen quality and delivery of integrated PMTCT and pediatric HIV care • Documentation and dissemination of promising practices	*Key Activities*: • Build capacity of village health workers • Link with infant feeding and nutrition programs • Integrate PMTCT and HIV services with family planning and adolescent sexual and reproductive health programs • Increase men's involvement in PMTCT and pediatric HIV care and treatment

In Year 1, FACE-Ped HIV supported delivery of WHO Option A PMTCT services at 1440 sites and pediatric AIDS services at 563 sites, and assisted the MOHCC in preparation for roll-out of WHO's Option B+. The project provided national level program support, technical assistance (TA) for adaptation of the new WHO guidelines, and development of training materials and job aids for offering Option B+ services at facilities country-wide. FACE-Ped HIV, in Year 2, supported the national transition to offering Option B+ services in 1442 sites, provided TA for revision of the of HIV Treatment and Care Guidelines for Children, for development of M&E tools, development of a quality improvement (QI) "step by step" guide, revision of the National eMTCT Strategy, and development of the National Pediatric AIDS Care Strategy. In Year 3, FACE-Ped HIV supported revisions, editing, and printing of Operational Service Delivery Manual and technically supported the planning and roll-out of Accelerated Plan to scale up Pediatric ART, in 1373 sites.

Throughout the first three years, FACE-Ped HIV supported coordination of MOHCC services at provincial and district level, and assisted the MOHCC to build the capacity of health care providers through training workshops, supportive supervision and on the job skills strengthening including provision of job aids, algorithms and guidelines. Training front line nurses to initiate pediatric ART enabled the MOHCC to decentralize pediatric AIDS services, although there was some resistance from pediatricians in teaching hospitals. Decentralization of pediatric AIDS services greatly helped families living with HIV in rural areas as both parents and children could be initiated on ART and followed up at the same facility.

Table 2: The Updated Results Framework for FACE-HIV

Goal: To reduce new HIV infections and HIV-related morbidity and mortality and improve quality of life for all People living with HIV (PLHIV) in line with the National HIV Care and Treatment Strategic Plan (2013-2017).				
Strategic Objective 1: Provision of technical and other assistance to the national level of the HIV/TB programs	Strategic Objective 2: Strengthen provision of clinical services for comprehensive HIV/TB Services	Strategic Objective 3: Strengthen pediatric and adolescent HIV and sexually and reproductive health (SRH) services	Strategic Objective 4: Strengthen and improve generation, dissemination and use of strategic information	Strategic Objective 5: Strengthen continuum of care for mother, infant and family

In year 4, in response to the "PEPFAR Pivot" that rationalized USG technical assistance, eliminated duplication of effort, and focused USG support in the districts with greatest epidemiological need, FACE-Ped HIV transformed into FACE-HIV, a project supporting the MOHCC to provide comprehensive HIV/TB services in 22 PEPFAR priority districts in five provinces in the southern half of Zimbabwe. This involved transitioning previously supported sites in the five Northern provinces to CDC/PEPFAR partner I-TECH, where the sites were in PEPFAR priority districts, and to the MOHCC where the sites were not PEPFAR priorities. It also involved a change of FACE-HIV partner supporting sites in Bulawayo and Matabeleland South that had previously been supported by KAPNEK Trust but after the Pivot have been supported by OPHID Trust. [Table 2 provides the updated results framework.]

EVALUATION DESIGN, METHODS & LIMITATIONS

The evaluation was one of three evaluations conducted by The Mitchell Group, Inc. (TMG) under the USAID/Zimbabwe PPL/LER Monitoring & Evaluation IDIQ, Contract Number SOL-613-16-00010. TMG provided an Overall Team Leader and Evaluation Methodology Expert to the three evaluations, an Evaluation Team Leader/HIV expert and a senior Zimbabwean HIV Specialist—a PhD Demographer—to the FACE-HIV evaluation. The Evaluation Team Leader and Senior Zimbabwean HIV Specialist had no real or potential conflicts of interest to disclose. The evaluation team received logistics and other in-country support—including translation of tools into Shona and Ndebele—from TMG's local partner JIMAT Development Consultants.

Throughout the field data collection, the evaluators were assisted by two male JIMAT enumerators/Focal Group Discussion specialists who were native Shona speakers. For the data collection in Bulawayo and Matabeleland, a female and a male JIMAT enumerator/Focal Group Discussion specialist, each a native Ndebele speaker, also assisted the evaluators. The Evaluation Team Leader/HIV expert was responsible for developing the evaluation tools, with feedback from the Zimbabwean HIV specialist and had overall responsibility for the evaluation report. The quantitative analysis of the evaluation data was conducted by the Zimbabwean HIV specialist in consultation with the Evaluation Team Leader.

Design

The evaluation used a snap-shot cross-section design to answer the descriptive and normative questions about FACE-HIV Project achievement. Consideration was given to how FACE-HIV is being implemented; how it is perceived and valued; whether FACE-HIV is achieving its expected results and PEPFAR targets. The evaluation also considered how the 'PEPFAR Pivot' impacted project design, management and implementation and used limited before-after comparisons for analysis of the impact of 'PEPFAR Pivot' on performance.

Methodology

Evaluation performance period

The field evaluation was conducted in September and October 2016 with development and pretesting of instruments, data collection and presentation of preliminary findings over a six-week period in October in Zimbabwe. The analysis of the findings and report drafting was undertaken in the home office in November and December.

Evaluation team

The two evaluators (an international consultant evaluation team leader and a Zimbabwean demographer/HIV program specialist) were assisted throughout the field data collection by two Shona speaking enumerators/focal group discussion (FGD) specialists. An additional two Ndebele speaking enumerators/FGD specialists joined the team for the week in Bulawayo and Matabeleland South. Together, the two evaluators provided both national and international HIV, TB and public health expertise, knowledge of PEPFAR programs and the Zimbabwean health service delivery system.

Sample selection

The evaluation field work was conducted in one district in each of the five provinces FACE-HIV is implemented, plus an additional district in Midlands. The districts were chosen through a random sample in each province. In the Midlands, the initial district randomly identified is supported by ZAPPT and, at USAID/Zimbabwe's request, a second district was included as all the other districts in the province are supported by Kapnek Trust. In Matabeleland South, Beitbridge, a border district, was purposively select-

ed to provide evidence of the challenges of providing services to populations mobile across country borders. Within the districts, the sample was stratified to ensure a representative mix of facilities with a workable itinerary within the evaluation timeline. A summary of the sample is provided in Table 3.

Table 3 Districts and Facilities Sampled

Kwe Kwe	3 hospitals: 1 district, 1 general, 1 mission	2 new clinics
Gweru	1 provincial hospital	2 clinic/polyclinic
Bulawayo	1 teaching hospital	2 clinics
Beitbridge	1 district hospital	2 clinics
Gutu	2 hospitals: 1 rural hospital 1 mission hospital	1 clinic
Makoni	1 district hospital: For the pretest of the evaluation tools	4 clinics

The evaluation team leader developed the evaluation instruments during the first two weeks in country. **Field testing of the draft instruments was carried out in Rusape General Hospital, Makoni District, Manicaland**.

Data Collection Methods

Table 4, below, provides the Methodological Design Matrix for the FACE-HIV Performance Evaluation. A variety of methods and approaches were used to collect and analyze information relevant to the evaluation's objectives, and questions outlined in the Scope of Work (SOW). The evaluation methods and approaches include:

1. Review and Analysis of Background Materials: Documents relevant to the FACE-Ped HIV and FACE-HIV Project were identified for review and analysis. These included the FACE-Ped HIV program description from the Cooperative Agreement; technical and training materials; PEPFAR/Zimbabwe County Operational Plans; PEPFAR Zimbabwe Strategic Direction Summary; the National Elimination of Mother to Child

MAP OF ZIMBABWE SHOWING THE PROVINCES

Since the "PEPFAR Pivot", FACE-HIV supports: **Midlands**, **Bulawayo**, **Matabeleland South**, **Masvingo**, **Manicaland** and **Chitungwiza**

TABLE 4: METHOGOLOGICAL DESIGN MATRIX -- FACE-HIV PERFORMANCE EVALUATION

Evaluation Questions	Type of answer needed (e.g., descriptive, comparative, normative, cause & effect, etc.)	Data sources/ collection methods	Baseline data	Sampling or selection criteria	Data Analysis Method(s)	Potential Data Limitations
1. How can the FACE-HIV activity design and implementation be enhanced to increase efficiency and effectiveness in contributing to current PEPFAR priorities to reach the UNAIDS fast track targets of 90-90-90 by 20						
1.1 What design and implementation aspects of the FACE-HIV project are critical to achieving intended results? Why?	Normative assessment of the strengths and weaknesses of the current activity design and implementation approach based on descriptive assessment of qualitative and quantitative data collected	Desk review and comparison of M&E plan activity targets with results, and cost data by type of support, district and other relevant attributes; KIIs with IP and sub-awardee staff, MOHCC provincial and district staff and national stakeholders; interviews with USAID staff; FGDs with beneficiaries; review of secondary data as appropriate	TBD	IP and sub-awardee staff interviews representative of both field and home office staff and consultants; review of activity performance data and if available, cost data, by type of support, district and other relevant attributes; review of secondary data as available and applicable	Coded information from KIIs and FGDs on activity strengths, weaknesses, bottlenecks and how the project overcame them will allow qualitative data analysis, triangulated through comparison of targets with results, and with secondary data; and of costs per type of support or district	Collection of qualitative data may reduce subjectivity as a basis for findings and conclusions, but is still small-sample in nature; review of secondary data will depend on availability and applicability; cost effectiiveness analysis by type of support or district will depend on the availability from cost data from the implementer
1.2 What design and implementation aspects of the project are not achieving intended results?	Normative assessment of the extent to which the current activity design and implementation is addressing PEPFAR implementation standards for each of the technical areas identified based on descriptive assessment of qualitative and quantitative data collected	Desk review and comparison of M&E plan activity targets with results;Rapid Facility Assessments (RFAs) of MNCH and OIART clinics, and (if possible) Maternity Wards; KIIs with IP and sub-awardee staff, MOHCC provincial and district staff and national stakeholders; interviews with USAID staff; FGDs with beneficiaries; review of secondary data as appropriate	TBD	IP and sub-awardee staff interviews representative of both field and home office staff and consultants; review of activity performance data and if available, cost data, by type of support, district and other relevant attributes; review of secondary data as available and applicable	Coded information from KIIs and FGDs on adequacy of how technical areas are being addressed will allow qualitative data analysis, triangulated through reference to secondary data where appropriate	Collection of qualitative data may reduce subjectivity as a basis for findings and conclusions, but is still small-sample in nature; review of secondary data will depend on availability and applicability
1.3 What alternative approaches and strategies could achieve better results?	Normative assessment of the extent to which the current activity design and implementation is achieving targets compared with global and regional best practice	Desk review; KIIs with FACE-HIV staff, national stakeholders, and USAID staff	TBD	IP interviews representative of field and home office staff; review of activity performance data and if available, cost data, by type of support, district and other relevant attributes; review of secondary data as available and applicable	Coded information from KIIs on activity strengths, weaknesses, bottlenecks and how the project overcame them will allow qualitative data analysis, triangulated through comparison of targets with results, and with secondary data; and of costs per type of support or district	
1.4 What is the nature of linkages and synergies with other USG and non-USG partners?	Normative assessment of the nature of key relations with partners and stakeholders	KIIs with IP and sub-awardee staff, MOHCC provincial and district staff and national stakeholders; interviews with USAID staff; FGDs with beneficiaries	TBD	IP and sub-awardee staff interviews representative of both field and home office staff and consultants	Coded information from KIIs and FGDs on responses to questions about the nature of key relations will allow qualitative data analysis	Collection of qualitative data may reduce subjectivity as a basis for findings and conclusions, but is still small-sample in nature
2. What strategic changes are necessary to increase effectiveness and efficiency towards reaching PEPFAR goals?	Descriptive assessment of major challenges faced by FACE-HIV in delivering FP services, with normative assessment of proposed approaches to address the challenges supported by reference to evidence from qualitative and quantitative data collected	Desk review; KIIs with FACE-HIV staff, national stakeholders, and USAID staff; FGDs with beneficiaties	None	FACE-HIV staff interviews representative of both field and home office staff and consultants; review of activity performance data and if available, cost, by type of support, district and other relevant attributes	Coded information from KIIs and FGDs on activity strengths, weaknesses, bottlenecks and how the project overcame them will allow qualitative data analysis, triangulated through comparison of targets with results, and of costs per type of support or district	Collection of qualitative data may reduce subjectivity as a basis for findings and conclusions, but is still small-sample in nature; cost effectiiveness analysis by type of support or district will depend on the availability from cost data from the implementer

Transmission of HIV (eMTCT) Strategic Plan 2011-2015; National ART Strategic Plan; national TB strategic Plan; and other documents related to the project. A complete list of documents consulted is included as Annex III.

2. Review of USAID SIMS Assessment reports: The evaluators reviewed data provided by USAID/Zimbabwe and FACE-HIV related to SIMS assessments at Project supported facilities in April, June and July 2016. This provided some comparative data in order to answer the evaluation questions.

3. Site Visits: The five evaluation Provinces have 22 supported districts and a total of 330 FACE-HIV-supported health facilities, out of which 21 were selected in the stratified sample. The evaluation team visited all 21 facilities identified in the sample over the three-week period October 3 -21, 2016. The evaluators interviewed 44 providers and walked through their clinical service delivery area using a service delivery checklist; and conducted 71 client exit surveys.

4. Key Informant Interviews: The Team interviewed 49 key informants from National to local levels. The full schedule including details of sites visited and details of persons contacted during the evaluation is in Annex IV. (Please note that in order to ensure confidentiality, the list does not include names of health care workers and the clients interviewed at health facilities or the participants in the focus group discussions as agreed with the respondents at the time. The full evaluation instruments including key informant questionnaires, survey protocols, guides, and facility checklists are in Annex II.

5. Focus Group Discussions: A total of 11 FGDs were conducted with HIV support group members—at FACE-HIV supported facilities but the support groups were not necessary established by FACE-HIV—consisting of between eight and twelve participants living with HIV. Three of the FGDs were with adolescents and young people under 24 years.

6. Reanalysis of Secondary Sources: The secondary sources consulted included FACE-Ped HIV and FACE HIV quarterly and annual reports; PMP; project annual work plans; FACE-Ped HIV research papers and FACE-HIV assessments; the UNAIDS and WHO publications, and GOZ reports accessible on line.

The evaluation team met with USAID at the beginning and conclusion of the assignment and presented findings in a full exit meeting debrief with the USAID. They also conducted a presentation of the findings for validation by the FACE-HIV consortium partners and other PEPFAR implementing partners.

Limitations of the Evaluation

Limited baseline data and absence of a comparison group for data analysis are noted as potential data limitations for the evaluation. The evaluators mitigated these limitations through reference to the project M&E plan and cost data, and applicable secondary data, to the extent that these were available. The field data collection provided *a snapshot* of current HIV service delivery and quality of services provided in a rapidly changing environment. For example, '*treat all*' was being rolled out during the evaluation; locum nurses were being introduced, with varying models; and there was uneven deployment of volunteers (CRFs). Although the field data could not provide evidence of trends, comparisons are drawn with evidence from earlier Site Improvement through System Monitoring (SIMS) assessments.

As public sector service delivery staff were key informants and vital sources of information while conducting the clinical assessments, there is the possibility that poor staff morale might impact the quality of data collected at clinics. The provincial and district managers reported that *in the districts visited* health workers were being paid monthly—sometimes days later than the due date but always within a month. For some municipal/city health workers, *salary payments were six months in arrears*. Salary arrears were being used to offset current rents for government accommodation, and the managers did not think this was affecting morale. Health workers often volunteered that their salaries were not motivating factors; they were just grateful to have a job. The major challenge health workers reported was *cashing their paychecks*—rural staff had to travel in to urban centers, stand in line often for hours, to withdraw a maxi-

mum of US$100 and sometimes only US$20 because of the severe shortage of cash in Zimbabwe. Absence to cash paychecks had some impact on data collection where staff were unavailable after clinics—or wanted to rush away. The evaluators worked around the availability of staff respondents at facilities and, for example in Kwe Kwe, there were relatively few instruments completed in the afternoons.

The evaluators, the local evaluation partner JIMAT, and USAID/Zimbabwe were unable to secure a key informant meeting with the MOHCC Director AIDS and TB, although the Directorate is a key stakeholder.

FINDINGS, CONCLUSIONS & RECOMMENDATIONS

Findings

HOW CAN THE FACE-HIV ACTIVITY DESIGN AND IMPLEMENTATION BE ENHANCED TO INCREASE EFFICIENCY AND EFFECTIVENESS IN CONTRIBUTING TO CURRENT PEPFAR PRIORITIES TO REACH THE UNAIDS FAST TRACK TARGETS OF 90-90-90 BY 2020?

Pertinent Evaluation Findings:

Evidence from multiple data sources **all indicate** that the FACE-HIV project is designed to build health care worker capacity and support the MOHCC, at all levels from national to facility, to consistently provide integrated quality HIV/TB services. FACE-HIV has supported the introduction of QI processes and data validation processes that **many health worker respondents emphasized** have improved their effectiveness. Although FACE-HIV currently seconds technical and support staff to the Directorate of HIV/TB, has deployed locum nurses for direct service delivery at health facilities, and is currently expanding the deployment of locum nurses, all the positions filled by locums are government positions. OPHID leadership, Provincial Medical Directors and a provincial hospital medical superintendent informed the evaluators that government positions across Zimbabwe are unfilled because of a cap on the proportion of the budget [40%] that can be used for human resources that was imposed in response to the dire economic situation. Although deploying a large cadre of locum nurses to government direct service delivery positions is an unusual use of PEPFAR funds, it is pragmatic: project results could not be achieved with the chronic and severe crisis in human resources in the Zimbabwean public health service. As HIV/TB services are integrated at primary care level, the deployment of locum nurses **additionally improves availability of wider MNCH** and general outpatient services.

A consistent finding across all districts and facilities is that there is **no perception of a parallel, implementing partner led project**. The FACE-HIV consortium partners have all successfully fostered their activities as support to and enabling of the existing GOZ health system and health services. There were **zero complaints** from health care workers that FACE-HIV project or FACE-HIV Consortium partners were increasing health care worker burden of work without remuneration.[4]

Locum nurses providing direct patient care

There were **complaints from health workers in facilities that have "not had the benefit of locums"**. KIIs with FACE-HIV senior staff and discussions with field staff confirmed field findings that there were different models for deploying locum nurses. Locums in Bulawayo urban district were recently retired nurses identified by the city nursing directorate. Deployment of these nurses was universally liked by the receiving facilities and the nursing directorate. Whereas in Beitbridge district, FACE-HIV was paying nurses to work (generally two days a week) on their days off. The staff took it in turns to work on their days off, two or three staff worked one week and a different two or three staff worked the following week. The staff appreciated the extra remuneration and this acted as a motivator. However, staff in facilities that did not have opportunity to work on their days off, were vocal in their complaints that they were demotivated by not receiving "the benefit".

[4] In the Evaluation Team Leader's experience, this is a common complaint about many PEPFAR care and treatment projects in other countries in Africa.

Volunteers

The evaluators met with two volunteers, known as clinical referral coordinators or CRFs, deployed by the project in Gweru at the Provincial Hospital and learned of many more volunteers working elsewhere. The original concept for CRFs was developed by ZAPPT in Chitungwiza to be "patient navigators" who guide clients from the entry point where they are tested and found to be living with HIV, through large complex sites, and reduce loss of clients before they are linked to care/treatment. The role had been expanded by the two volunteers interviewed to also providing client support for adherence & retention, and promotion of Option B+ for positive pregnant women in antenatal clinics (ANC). Elsewhere, CRFs provide a link to communities for defaulter tracing and also follow up clients who test positive ("index cases) to their homes to support household HIV counseling and referrals for testing. Some assist in ART clinics with registration and observations, and some provide "health talks" and motivational speeches to clients gathered at the beginning of the day before the clinics start reviewing clients.

In Bulawayo and Beitbridge, health workers in ANC reported that they had a "mentor mother", a volunteer living with HIV who had been through PMTCT services and who motivate newly diagnosed pregnant women and their partners to accept Option B+. These mentor mothers had been trained and deployed by Medicine Sans Frontiers (MSF) and at least one volunteer in Bulawayo and another in Beitbridge continued to regularly attend the ANC and provide support to women to adhere to their ART, even though the volunteers no longer received stipends and other support from MSF.

Staff at another rural facility proudly described their own "mentor family" who supported PMTCT and pediatric HIV care and treatment at the facility and in their community. The mothed tested positive during her fourth pregnancy and when her husband and three children were tested, they were all found to be positive. The mother accepted Option B+ and had a health fourth child, and again Option B+ in her fifth pregnancy and has a healthy fifth child. What the health workers found remarkable—and helpful—was that the parents were open about their own status and the older three children's status with the children. The parents regularly volunteer in both ANC and the ART clinic, supporting acceptance and adherence to treatment, and also promoting full disclosure within the family. The three children living with HIV are active with children and adolescents living with HIV who, in common with practice in many facilities, have treatment follow up on Saturdays. Child and adolescent follow up clinics are held at the weekend so that the young people do not miss school and can also meet socially and provide peer psychosocial support.

FACE-HIV Project staffing

Currently, FACE HIV employs only one technical advisor—a physician—at national level and one technical officer—also a physician—across the whole project supporting implementation in a rapidly changing policy environment, with roll out of 'treat all', decentralization of pediatric HIV service, and, most importantly, increasing performance towards achieving the second and third 90s in the UNAIDS fast track targets of 90:90:90 by 2020. OPHID and Kapnek deploy a provincial manager [a nurse] and provincial SIE officer in each province they support with district level managers and SIE officers covering one or two districts. Kapnek also employs two QI officers. ZAPPT employs an overall program manager, a program officer for each of its districts [Chitungwiza and Gweru] and an SIE manager covering both districts. Although deploying nurses as provincial managers is appropriate to provide technical assistance to a nurse led HIV services, and was acceptable to the Zimbabwean provincial and district managers, the number of staff deployed seems relatively light for the intensity of the work being undertaken, and in comparison with USAID-funded comprehensive HIV projects elsewhere in Africa that heavily deploy physicians. Provincial managers reported being stretched, and two had limited availability to meet with the evaluation team. For one district manager to cover effectively for example Makoni and Mutasa in Manicaland, two of the three districts USAID reported as worst performing, and foster stronger performance requires a great amount of dynamism. There does not appear to be currently enough management capacity at provincial level for effective oversight of the larger numbers of locum nurses being recruited and deployed in Year 5.

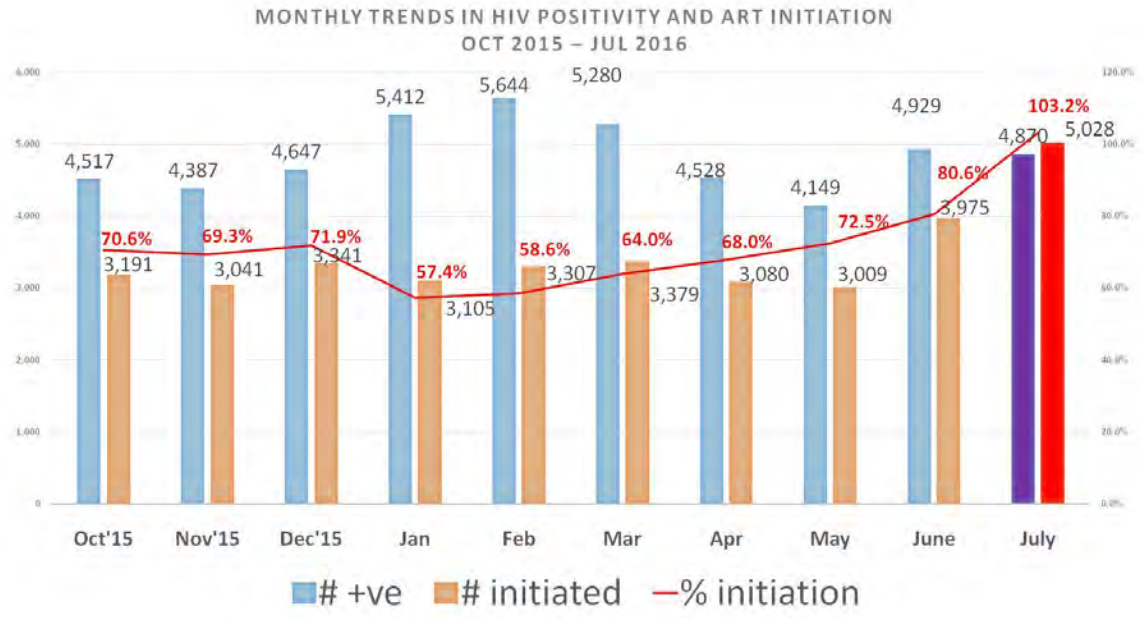
1.1 WHAT DESIGN AND IMPLEMENTATION ASPECTS OF THE FACE-HIV PROJECT ARE CRITICAL TO ACHIEVING INTENDED RESULTS? WHY?

Pertinent Evaluation Findings:

OPHID staff report that secondment of technical staff that are embedded in the MOHCC Directorate of HIV/TB is critical to the success of the FACE-HIV project. The embedded technical staff have ensured strategic direction and support for implementation of new policies, endorsed by WHO, for both eMTCT and HIV/TB care and treatment.

Project support to the MOHCC to pilot '*treat all*', followed by support to the roll out of '*treat all*' is critical to achieving the intended results. A large majority of health care workers interviewed and clients in the FGDs endorsed this approach as it resolves issues raised since the introduction of Option B+ for eMTCT. It was hugely problematic for providers to test and treat positive pregnant women for life but test and refer the woman's positive partner to the pre-ART clinic where the partner was told first that they had to wait for their CD4 count result and then, often, that their CD4 count was above the threshold for treatment.

Figure 1:



In general, despite PEPFAR's emphasis on retaining clients over the continuum of care from diagnosis through to end care, globally many positive clients are lost to follow up after diagnosis and registering in pre-ART. Distance to health care centers, transportation costs, male gender, younger age, unemployment, and lower levels of education may contribute to attrition in pre-ART care. Another common barrier is stigma and fear of disclosure of HIV status.[5] Prophylactic treatment with cotrimoxazole does not increase retention but treating TB coinfection has been shown to increase retention in pre-ART. The FACE-HIV project experienced a "treatment gap" with loss of clients after diagnosis. A few health care workers not-

[5] Bergmann, Heather, Heather Pitorak, and Helen Cornman. 2013. *Linkage and Retention in Pre-ART Care: Best Practices and Experiences from Fourteen Countries*. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

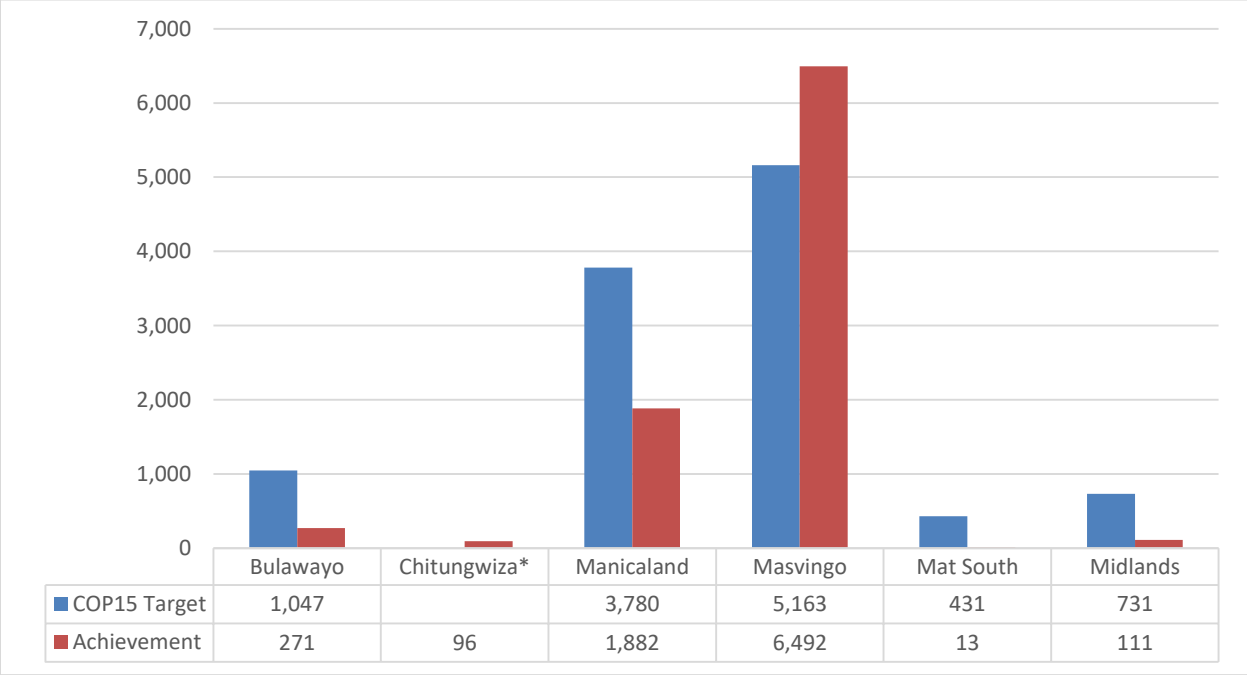
ed that point of care CD4 machines being down [for lack of reagents, lack of quality assurance specimens, or lack of maintenance] increased the treatment gap even for clients who were later found to be eligible for enrollment on ART. [See **Figure 1, Monthly Trends in Positivity and ART Initiation**, below.]

FACE-HIV introduced volunteer CRFs to guide clients from diagnosis at various entry points, to registering in pre-ART and enrollment on ART for clients with a CD4 count of less than 500. However, facility-based CRFs guiding clients through the process from diagnosis to enrollment on ART are inadequate as a strategy to increase retention in pre-ART. Introduction of '*treat all*' has resolved the treatment gap and FACE-HIV *results in Figure 1 from July 2016 for initiating treatment are inflated because of the "mop up" of pre-ART clients*. OPHID and Kapnek directors both report that the deployment of locum nurses was critical to facilities' ability to review clients registered as pre-ART and enroll them on ART.

1.2. WHAT DESIGN AND IMPLEMENTATION ASPECTS OF THE PROJECT ARE NOT ACHIEVING INTENDED RESULTS?

Pertinent Evaluation Findings:

Figure 2: Comparison of Achievement Against COP15 Target for Viral Load Suppression (showing number of clients with viral loads conducted in the past 12 months with a viral load <1,000 copies/ml)



	Bulawayo	Chitungwiza*	Manicaland	Masvingo	Mat South	Midlands
COP15 Target	1,047		3,780	5,163	431	731
Achievement	271	96	1,882	6,492	13	111

To date, FACE-HIV is not achieving its target results for reaching the third 90 of the UNAIDS fast track targets of 90-90-90 by 2020. The third 90 requires that 90% of all people receiving ART have viral suppression by 2020. While Zimbabwe has adopted viral load as a gold standard to monitor patients on ART, very few individuals (less than 5% in 2015) received a viral load test. The FACE-HIV project achieved only 13.4% of their target for COP15. Three of the provinces (Chitungwiza, Masvingo and the Midlands) reported no cases that had viral load tests (see Figure 2 above). **In practice, viral load testing in Zimbabwe is generally targeted, meaning that those who are tested for viral load are the ones already presenting with signs of failing treatment**. The MOHCC reported that in 2015 73% of all adults and chil-

dren receiving ART had durable suppression[6] although the MOHCC doesn't state the evidence for this. The field evaluation found that at the FACE-HIV supported sites *visited by the evaluators* virologic testing is largely available, with transport also available to move samples to centers that offer the test. Health workers at facilities in Beitbridge reported that they are only able to obtain annual virologic tests on their clients who work in South Africa—they predict a surge in tests around the Christmas-new Year Holidays when migrant workers return home. It was not immediately obvious at the sites visited why in FACE-HIV supported sites across the project, ART clients are not being routinely tested. However, FACE-HIV senior managers report that the MOHCC is working on a scale-up plan, new testing equipment was installed in October 2016. A 'hub and spoke' model for referral of samples from peripheral clinics to facilities with testing capacity was set up November-December 2016, after the evaluation field work.

At output level, the FACE-HIV project supported the sensitization of 76 nurses from 22 sites, and 19 other health care workers (10 Primary counsellors and 6 CRFs and 3 nurses) regarding the importance of viral load for monitoring patients' treatment. In Chitungwiza, 25 senior managers and doctors were sensitized on viral load management while in Gweru, 76 health workers who included nurses and primary counsellors from 17 facilities were sensitized. [7] FACE-HIV has also developed job aids to support increased uptake of viral load testing as the services become available.

One gap in the implementation identified during the field evaluation, and in line with SIMS assessment findings, is that no sites reported that they link infected children with existing social welfare structures & processes [e.g. Child Case Care Workers]. In general, the links with the community for prevention care and support, focused HTS, tracing defaulters are weak. The FACE-HIV project is very handicapped in this respect by being a facility-based PEPFAR implementing partner—whereas the FACE-Ped HIV consortium included community partners and the programming included community activities. The linkages with other partners, including FHI 360 and PSI that have their own high PEPFAR targets, have proven less effective than working with consortium community partners. See 1.4 below.

1.3 WHAT ALTERNATIVE APPROACHES AND STRATEGIES COULD ACHIEVE BETTER RESULTS?

Pertinent Evaluation Findings:

As noted in response to Question 1, above, FACE-HIV has deployed volunteer CRFs, mainly in large complex facilities with multiple entry points. The volunteers are not deployed in large number—Mpilo Hospital, for example, only has one and staff there want more. Although, some of these CRFs are performing more than "patient navigator" services, overall FACE-HIV underutilizes volunteers living with HIV. There are well documented roles for volunteers living with HIV in HIV services in countries in Southern Africa and elsewhere on the continent. Mentor mothers commonly provide much of the counseling and adherence support for positive pregnant women, and in Swaziland there has been task shifting from nursing staff to trained mentor mothers who perform clinical observations in outpatients, and HTS, as well as health education talks. One FACE-HIV district level staff has experience working with MSF mentor mothers and is enthusiastic about the potential for mentor mothers—and mentor fathers—working in FACE-HIV supported facilities. Several facility staff also have experience of MSF mentor mothers and would like more such volunteers working in their ANC/FCH clinics. Some FACE-HIV staff have heard the term "expert client" and associate it with CRF. However, expert clients elsewhere have a far greater role in direct client support and even for completion of registers and client dockets. Some CRFs follow up

[6] MOHCC, 2016. Global AIDS Progress Report 2016. Zimbabwe Country Report Jan 2015 to December 2015.
[7] OPHID Quarterly Report. PY4. Quarter 2 April 2016

defaulters in the community and a few follow up "index cases" in their homes and motivate family members to accept HTS. However, this role for CRFs is not widespread and there is scope to deploy far more CRFs and expand upon both the facility-based counseling and adherence support and community-based activities.

1.4 WHAT IS THE NATURE OF THE LINKAGES AND SYNERGIES WITH OTHER USG AND NON-USG PARTNERS?

Pertinent Evaluation Findings:

The field evaluation found strong evidence that the FACE-HIV project capitalizes on a generally very good standard of basic health care provision at facility level, which is supported by a number of development partners as well as the MOHCC. Although it was only a snapshot of standards at facilities, overall health systems worked. Health facilities were uniformly clean, with excellent standards of hygiene and sanitation compared with other countries in the region. All the rural facilities had ventilated improved pit latrines that were clean and used; many had a handwashing faucet nearby the latrines. Many of the facilities had excellent solid waste management areas—some provided by RBF and others by MSF. In Bulawayo, urban medical waste is bagged, sharps boxed, and transported to a central incinerating facility. Gweru Provincial Hospital also had a central solid waste management area and incinerator that accepted bagged and boxed medical waste from other facilities. At Mkoba Polyclinic, the solid waste management facility was burning wood pruned from the trees in the grounds. The manager informed the evaluators, that he had not cut the wood. He said "Parks Department come every year to prune the trees" and all he did was sort the kindling from the larger wood and move it into the waste management compound.

All the consulting rooms seen during the field evaluation—with the exception of one facility—were clean and tidy. All the delivery rooms were clean and hygienic with functioning autoclaves [some used on bottle gas burners, others on electric rings and some on firewood outside] and had delivery packs and clean linen: in sharp contrast to the state of most delivery rooms seen by the evaluators in other African countries. Rusape general hospital maternity ward was very busy, conducting a caesarian section on the morning of the evaluation visit, followed by a breach delivery and then an ambulance arrived from a peripheral hospital with a patient in difficulty in labor, accompanied by a nurse. Yet the facility was clean, and cleaned by a nursing aid between deliveries, and there was plenty of clean linen and delivery kits in the store. There was also delivery room laundry drying outside on a washing line.

Logistics and supply systems were working. None of the facilities visited had stockouts of ARVs or (opportunistic infection) OI drugs at the time of the evaluation, and non-reported having stockouts in the previous months. Some had stock that had run low but reported that they call the district nursing officer when stocks are low and that they always get a resupply before running out. Some facilities reported that point of care CD4 analyzers were not working because of lack of reagents or lack of QA samples but all had working arrangements for transporting specimens to facilities with working CD4 analyzers. Where Riders for Health were contracted to transport Sputum samples for GeneXpert testing, the Riders were also transporting blood samples for virology and CD4 tests, and dried blood spot (DBS) for early infant diagnosis (EID).

Much of the overall logistics and organization of facilities was beyond FACE-HIV manageable interests but District Nursing Officers and facility staff often remarked on FACE-HIV project staff willingness to help out and transport supplies to facilities and between facilities when needed. Indeed, a delivery of USAID-supplied condoms, male and female, was made to a nearby facility in Gutu by the FACE-HIV vehicle during the evaluation.

Some facilities had outpatient or pharmacy buildings provided by MSF, that benefited the FACE-HIV project, and two facilities visited had been provided with portacabins [converted containers] by I-Tech/CDC. I-Tech informed the evaluators that they don't have a current linkage with FACE-HIV although they do meet up with staff a technical working group meetings. FHI 360 works closely with some FACE-HIV supported facilities, tracking index cases in the community and conducting community HTS.

FHI did not respond to requests for a meeting to explore the nature of the linkages. Facility staff and some FACE-HIV District Managers reported that PEPFAR partners in the community sometimes report new cases identified in the community—when testing family of index cases or from testing campaigns—that are actually known to be living with HIV.

PSI provides services in the community that complement OPHID supported facility services, where PSI clients are referred for treatment. One of the district partners coordinates a monthly meeting in each of the districts (Mutare, Chipinge, Makoni, Mazowe, Gweru and Bulawayo). PSI coordinates the national level quarterly meetings for the same partners to monitor progress and to facilitate effective collaboration.

Many of the facilities visited have primary counselors provided by the Global Fund – these ancillary workers are key to the provision of good counseling for HIV testing and PMTCT where they are deployed. A number of NGOs provide services that complements facility HIV services. North Star, offered an HTS close to the Beitbridge border crossing with South Africa [although that service ended at the end of September 2016], CESHHAR mobilizes sex workers for HIV services in Rusape, and in Bulawayo the Sexual Rights Centre offers services for men. There were several reports of volunteers in the community—going by a number of acronyms—that were left over from previous nongovernmental organization (NGO) programs, including from MSF programs. The FACE-HIV supported services benefit from all of these. In Kwekwe, the Lions Club have support the adolescent ART clinic.

2. WHAT ARE THE MAJOR CHALLENGES FACED BY THE FACE-HIV ACTIVITY IN DELIVERING HIV SERVICES (HTS, ART, TB/HIV, EMTCT, CARE, SUPPORT, RETENTION, ADHERENCE) AND HOW CAN USAID ADDRESS THESE CHALLENGES?

Pertinent Evaluation Findings:

Congested Clinics

As noted in response to Question 1, above, some clinics visited during the evaluation are still very congested with long wait times for clients. However, many ART clinics have been decongested and clinical providers report that they no longer see long lines of very ill patients [mirrored by an emptying of the in-patient wards] since the wide availability of ART has virtually eliminated opportunistic infections. One facility visited had not opened for business until the evaluation team arrived at 10 am, thus starting the day with a long line of clients that was not reduced during the 2-hour period of the evaluation visit. However, most congested clinics did not result from late opening. At one facility where there were very few patients on the Saturday morning of the evaluation visits, the team was greeted by the in-charge who volunteered that the clinic is so congested that the congestion compromises client confidentiality. At a clinic in Beitbridge, a man and woman attending ANC together were observed to be in the congested facility, mainly waiting for services, for *more than 2 hours*. Later, two FGDs at Beitbridge General Hospital elicited that clinics are insisting that clients return in person bimonthly to pick-up prescription refills. The FGD were well informed about CARGs and wanted to group themselves to take it in turn to pick up refills, but even spouses attending with the client's documents were being refused refills without the client in person attended. This was an exceptional problem in Beitbridge where some spouses were working in South Africa and cannot return every two months for a routine prescription refill. It also contributed to the congestion in clinics.

More commonly, ANC and some family child health (FCH) clinics are very congested and long waits for clients are the norm. The couple who were observed to be in a clinic for more than 2 hours were each, separately, interviewed for a client exit survey. Neither client had any complaint about the long lines and wait: such waits are routine accepted by clients. [In contrast, clients at the facility that did not open its doors until 10am were vocal in criticizing that as a dereliction of duty by the facility staff.] None of the ANC clinics visited by the evaluation offered timed appointment systems – they did not even book some clients as afternoon visits and some as morning. All clients were expected to be present at 8am for "the health talk" and none of the service providers thought it was unreasonable to expect clients to wait for hours for services. While there may be logistic reasons—such as country bus schedules—for the time of arrival of some clients, urban clients and rural local clients who walk to the facility could be offered an afternoon appointment to reduce the congestion in ANC/FCH clinics. However, it appeared to the evaluators, that the health workers actually want a long line of clients, and consequential long wait times for clients, as evidence that the health workers are overworked. The evaluation found long lines and congestion in some facilities that had project deployed locum nurses and there seemed to be a perverse incentive for the clinics to continue the long lines, to ensure that they continue to be paid as locums on their days off.

User Fees

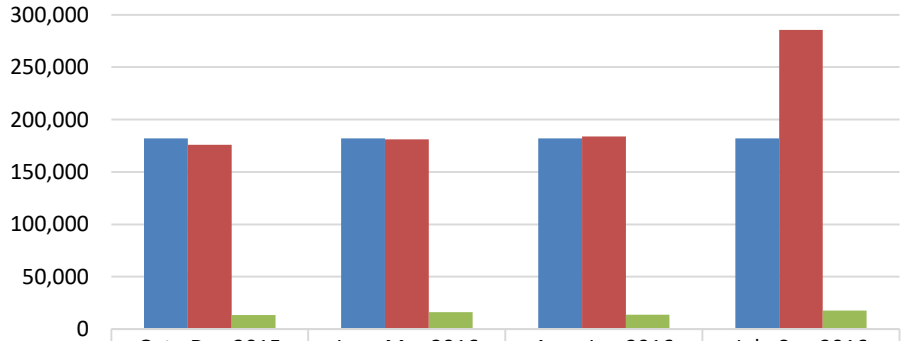
In general, the evaluation was not designed and unable to demonstrate whether user fees affect uptake of services. However, one FGD in a rural facility did elicit that some clients, who lived geographically near a municipal facility that had user charges, chose to walk and cross a river to attend the rural facility that did not have user charges.

Many of the facilities, including one mission hospital, visited provided services free of charge under Results Based Financing (funded by DFID/World Bank). The vast majority of facilities visited had prominent notices detailing the schedule of charges, exemptions, or that no fees are charged. There were no reports to the evaluators in client exit interviews or FGDs of informal or under the table payments being required by health workers to deliver services.

HIV Counselling and Testing

The FACE-HIV project quarterly and annual reports indicate that the project facilitated the revision of HIV testing and counseling guidelines for children in 2013-14. To increase the reach of HTS, 385 health care workers were trained in rapid HIV Testing and Counselling in select districts, while primary counsellors (PCs) were trained in extended adherence counseling and HCT for children. These trainings were complemented by on-site sensitization workshops in 2015-16 held for health care workers on provider initiated testing and counselling (PITC) in 330 priority facilities. FACE-HIV deployed locum nurses to support 132 high volume sites in 2016 to increase HTS (specifically in Bulawayo, Chitungwiza, Mutare, Bulilima, and Masvingo). [8] During the trainings and sensitization meetings, the concept of 90-90-90 was emphasized. FACE-HIV partners have provided transport for distribution of HIV test kit stock to refill supplies at site that had stock-outs from other sites in the district with a good stock, as well as provided on-site HTS, CD4 counts (with a roving point of care analyzer) and pre-ART counselling to clients in high volume priority sites.

Figure 3: Comparison of Achievement against COP15 Targets for individuals tested for HIV and received their test results



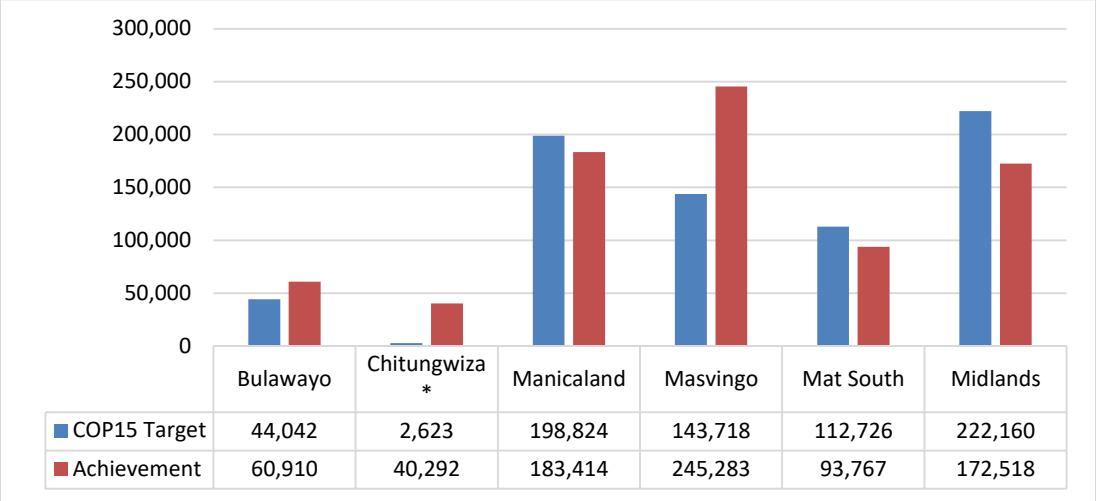
	Oct - Dec 2015	Jan - Mar 2016	Apr - Jun 2016	Jul - Sep 2016
Target COP15	182,023	182,023	182,023	182,024
# tested and received result	175,775	181,157	183,988	285,653
# HIV positive	13,556	16,323	13,651	17,818

This resulted in an increase in the number of people testing for HIV and receiving their results in 2015-16. Of the 826,573 people tested for HIV and received their results, the FACE HIV project surpassed their target for COP15 with a 113.5 percent achievement rate (see Figure 3 above). Of those tested, 61,348 were HIV positive giving a positivity rate of 7.4 percent.

Data for HIV testing by province for 2015-16 indicates that Bulawayo, Chitungwiza and Masvingo provinces surpassed COP15 targets (see Figure 4, below). Manicaland, Matabeleland South and the Midlands were below the target. For Manicaland province, Makoni and Mutasa districts are the two poorly performing districts in terms of yield. Further assessment on why the two districts had low yield indicates that HIV testing started early in these districts. As such most of the PLHIV know their status (possibly the first 90 has been reached) and many are already on treatment.

[8] OPHID Draft Quarterly Report. PY4 Quarter 4 2016

Figure 4: Comparison of Achievement against COP15 Targets among individuals tested for HIV and received their test results



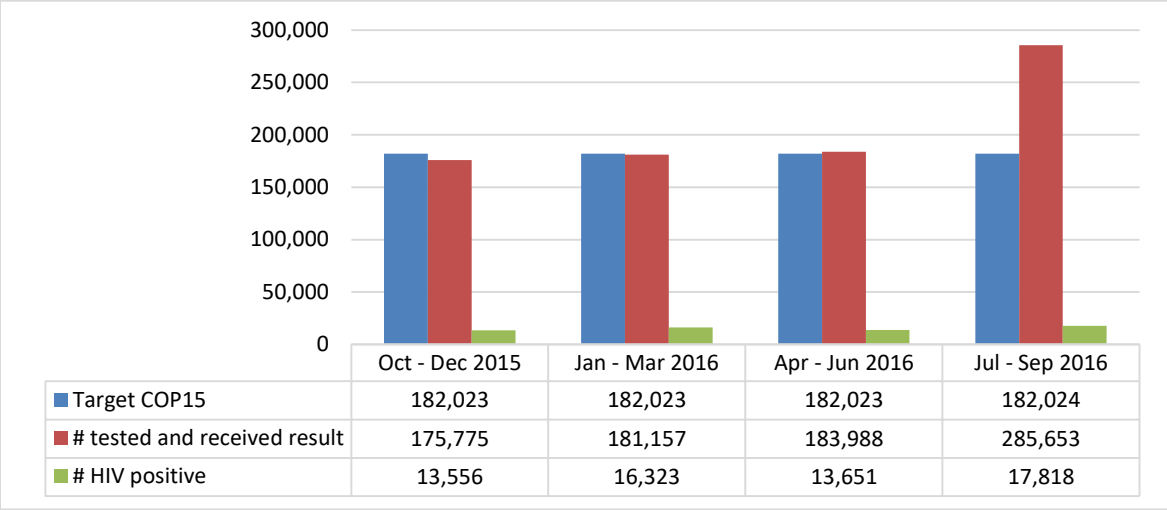
	Bulawayo	Chitungwiza *	Manicaland	Masvingo	Mat South	Midlands
COP15 Target	44,042	2,623	198,824	143,718	112,726	222,160
Achievement	60,910	40,292	183,414	245,283	93,767	172,518

The 2015 Zimbabwe Demographic and Health Survey (Zimbabwe DHS 2015) has indicated that HIV prevalence in Manicaland has decreased by about 25%, from 14.1 in 2010 to 10.5[9]. As survival has been improved by access to treatment, it is likely that new infections [incidence] is also greatly reduced in Manicaland. The field evaluation found that utilization of HIV services by apostolic faith followers is reduced—some apostolic women do utilize services for their children but will not accept PMTCT Option B+ when they are tested positive. There were reports of such pregnant women preferring to consult their prophet in Harare and later returning to the facility after delivering in an apostolic birthing center with an infant who was positive on EID testing. Health workers reported that apostolic men are even less likely to attend a health facility and utilize services than women. For the Zimbabwe DHS 2015, the majority of respondents were Christians with the highest proportion in the Apostolic Sect (42 percent of women and 32 percent of men). However, the DHS does not detail the geographic spread of the Apostolic faith.

The Zimbabwe DHS 2015 shows that 80% of women age 15-49 years have been tested for HIV and received the test results. In the 12 months preceding the survey, 49% of women were tested for HIV and received the results. Men reported lower levels of past HIV testing and receipt of their results (62%), with 36% tested for HIV in the past 12 months and received their test results.[10]

[9] Personal communication in advance of full publication of the 2015 results.
[10] Zimbabwe National Statistics Agency and ICF International. 2016. *Zimbabwe Demographic and Health Survey 2015: Key Indicators*. Rockville, Maryland, USA: Zimbabwe National Statistics Agency (ZIMSTAT) and ICF International.

Figure 5: Achievement against COP15 Targets for individuals tested for HIV and received their test results



	Oct - Dec 2015	Jan - Mar 2016	Apr - Jun 2016	Jul - Sep 2016
Target COP15	182,023	182,023	182,023	182,024
# tested and received result	175,775	181,157	183,988	285,653
# HIV positive	13,556	16,323	13,651	17,818

One concern all FACE-HIV staff reported is the low yield of positive clients that HTS is giving in project facilities. The most recent data show FACE-HIV is exceeding its targets for testing but yield is only around 7.5% positive for the period. [See Figure 5: Achievement against COP15 Targets for individuals tested for HIV and received their test results.] The field evaluation identified that health workers in all facilities were well informed on HIV testing and that there was a concerted effort to test everyone who presented to the facility whose status was not known or who had been tested more than three months earlier. One adverse effect for targets for testing is that there did not seem to be any ascertainment of risk—everyone was being tested if they presented to a facility. Other more serious testing issues that seem to be arising from the high PEPFAR targets, reported to the evaluation team include (1) partners in the community follow up "index cases" in the home and then report four or five positive members of the family. However, the health workers report that these are not new cases, they are known and some are even already on ART. (2) NGOs conduct community HTS campaigns, and give away a tee-shirt to everyone who tests. They get a high yield from their campaign but again, many of those who test positive during the campaign are already known and either on ART or registered in pre-ART.

The field evaluation also found evidence that when health workers are conducting the testing themselves, there is little counseling. HIV testing has become routine in ANC in the same way that syphilis testing is routine. Specific counseling and consent is not sought. As HIV infection is now treatable, and treat all is the policy in Zimbabwe, the loss of pretest counseling and consent is no longer the huge ethical issue it was previously.

ART Initiation

In 2014-15, the FACE-HIV project supported the MOHCC with the editing and printing of the Operational Service Delivery Manual which guides health care facilities to operationalize new ART guidelines. After the 'PEPFAR Pivot', the FACE-HIV project had an increased focus on HTS and initiating eligible positive clients on ART. In 2015-16, the project moved to '*treat all*': HIV testing is now offered as a routine and all positive clients are initiated on treatment, irrespective of their CD4 count. FACE-HIV piloted '*treat all*' in seven learning districts (Bulilima, Mangwe, Gwanda, Mutasa, Makoni, Mutare, Chipinge), and six sites in Chitungwiza were sensitized on *'treat all*'. Implementation of '*treat all*' throughout project sites began at the end September, 2016, and the evaluation team confirmed that facilities are testing and initiating treatment without waiting for CD4 count results. The yield from COP15 indicates that the people identified as HIV positive were in Matabeleland North, Matabeleland South, Bulawayo, Harare and the Midlands provinces, while Masvingo and Manicaland provinces recorded fewer cases. Figures 6,

below, shows project yield and achievements of 41.9 percent for ART initiation, and Figure 7, below, the number of adults and children newly initiated on ART against the COP15 target.

Figure 6: COP15 Yield per Quarter

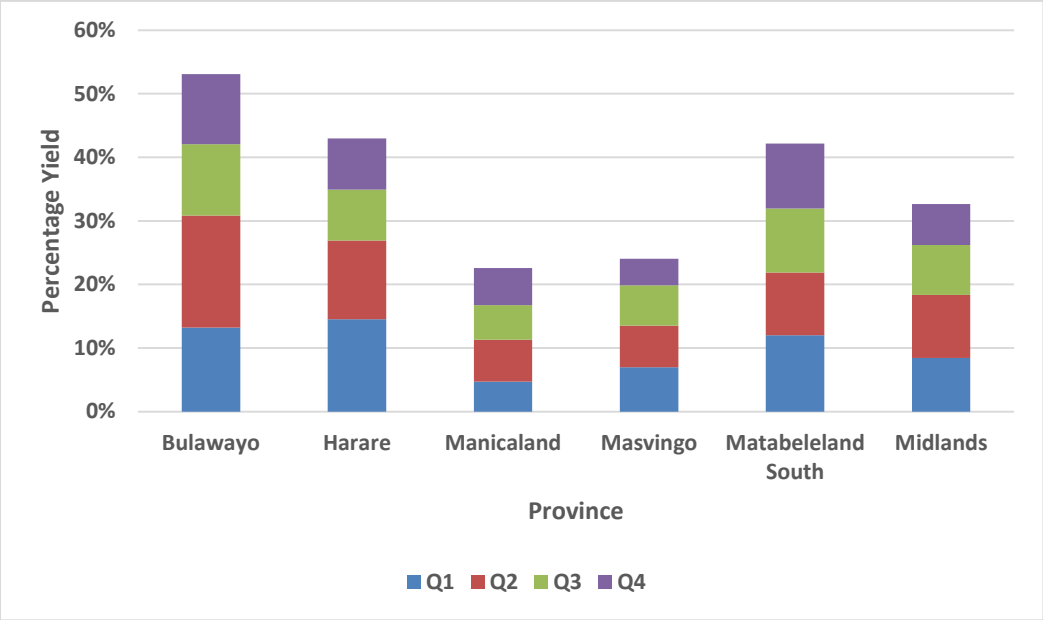
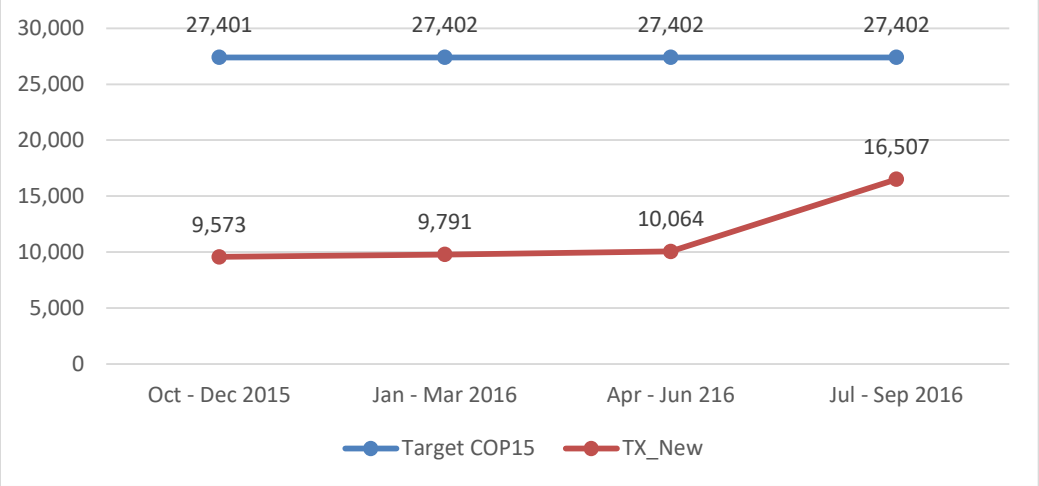


Figure 7: Number of adults and children newly initiated on ART



The FACE-HIV reports indicate that a limited number of facilities are providing EID and ART initiation for infants. The project has noted delays in DBS testing and turnaround time of results in its quarterly reports. It reports, some health care providers have low confidence and an attitude towards initiating infants on ART and hence the resulting in low numbers of infants initiated on ART. However, at the field evaluation facilities, the health workers interviewed were confident about initiating but reported very few posi-

tive dried blood spots (DBS) since they started Option B+. Indeed, in many clinics the health workers are highly engaged and know every one of the infants who have tested positive. They attribute the positive infants to mothers presenting after the birth in the community, or elsewhere, of their infant or mothers of apostolic faith rejecting Option B+. One positive infant's mother was known to be living with HIV but refuses HIV services. Nurses at Bulawayo Mpilo hospital are trained and ready to initiative pediatric ART but are to date being thwarted by the pediatricians in the teaching hospital who are insisting on seeing all positive infants for ART initiation.

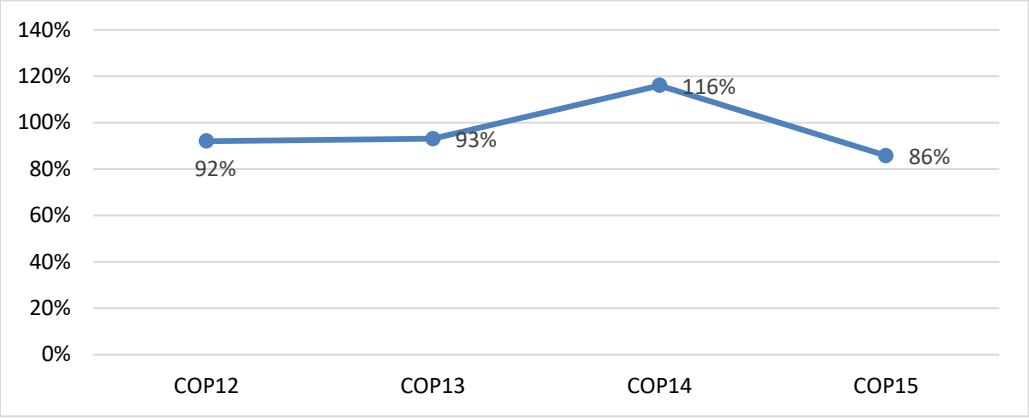
Elimination of Mother-to-child Transmission of HIV (eMTCT)

From its Year 1, the FACE-Ped HIV project has ensured the national PMTCT and Pediatric HIV Unit within the MOHCC HIV/TB Directorate was fully capacitated, by seconding technical staff to the Unit. These staff provide policy support and leadership to implementation of the national strategic plan. FACE-Ped HIV and FACE-HIV have further supported MOHCC leadership and coordination of the PMTCT program at provincial and district level through review meetings and routine site support and supervision visits in districts where the project is implemented.

In 2013, WHO introduced new ART guidelines. The FACE-HIV project supported national dialogue on Option B+ and contributed technical assistance for the adaptation of the WHO guidelines and planning to transition to Option B+ (Lifelong ART for HIV positive pregnant women). By the end of December 2014, all MNCH clinics were implementing Option B+. To raise awareness on PMTCT, a national consultation was undertaken with networks and support groups of PLHIV on the policy shift to lifelong ART for HIV positive pregnant women and lactating women (Option B+); platforms for dialogue were created and community campaigns were held. These activities aimed at reaching out to different subpopulation and have them recognize their role in advocacy and community-level support for adherence and retention in health services, and to encourage male involvement in ANC.

In-service training of health service providers continued, building their capacity in PMTCT, and in integrated management of adult and adolescent illness/integrated management of pediatric AIDS care (IMAI/IMPAC), HTS, and ART initiation, as well as pediatric ART.

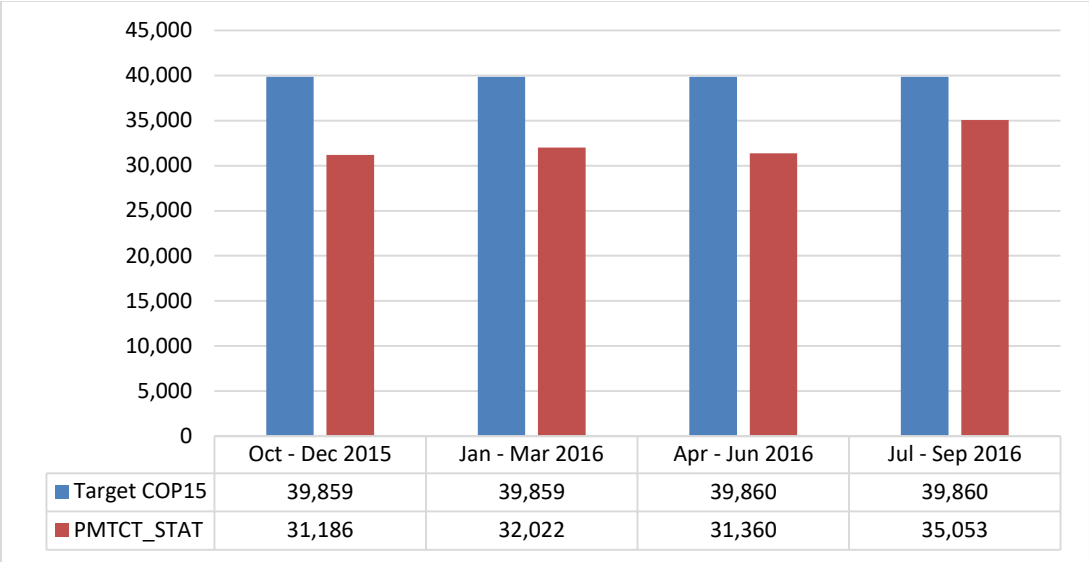
Figure 8: Percentage of HIV Positive Pregnant Women Initiated on ART



However, not all women identified as HIV positive are initiated on ART to prevent mother-to-child transmission of HIV. As shown in the trend analysis in Figure 8, the project has achieved 92% in 2012-13; 93% in 2013-14 and 86% in 2015-16. A percentage of 116% was reached in 2014/15 the year of transition to Option B+ and decentralization of the ART program. The FACE-Ped HIV achievements were significantly above the national percentages for the same period. The MOHCC reports that the proportion

of HIV positive pregnant women who receive ART to reduce MTCT was 85% in 2012, 82% in 2013, 79% in 2014 and 85% in 2015.[11] [No explanation given for the fall between 2012 and 2015.]

Figure 9: Comparison of Achievement against COP15 Target for Positive Pregnant Women Who Received ART to Reduce MTCT of HIV



	Oct - Dec 2015	Jan - Mar 2016	Apr - Jun 2016	Jul - Sep 2016
Target COP15	39,859	39,859	39,860	39,860
PMTCT_STAT	31,186	32,022	31,360	35,053

An analysis of quarterly achievements for the year 2015-16 indicates that overall, the project has not reached PEPFAR PMTCT targets (see Figure 9). The data shows that 129,621 pregnant women received ART to reduce MTCT of HIV against a COP15 target of 159,438, reaching an achievement rate of 81.3%.

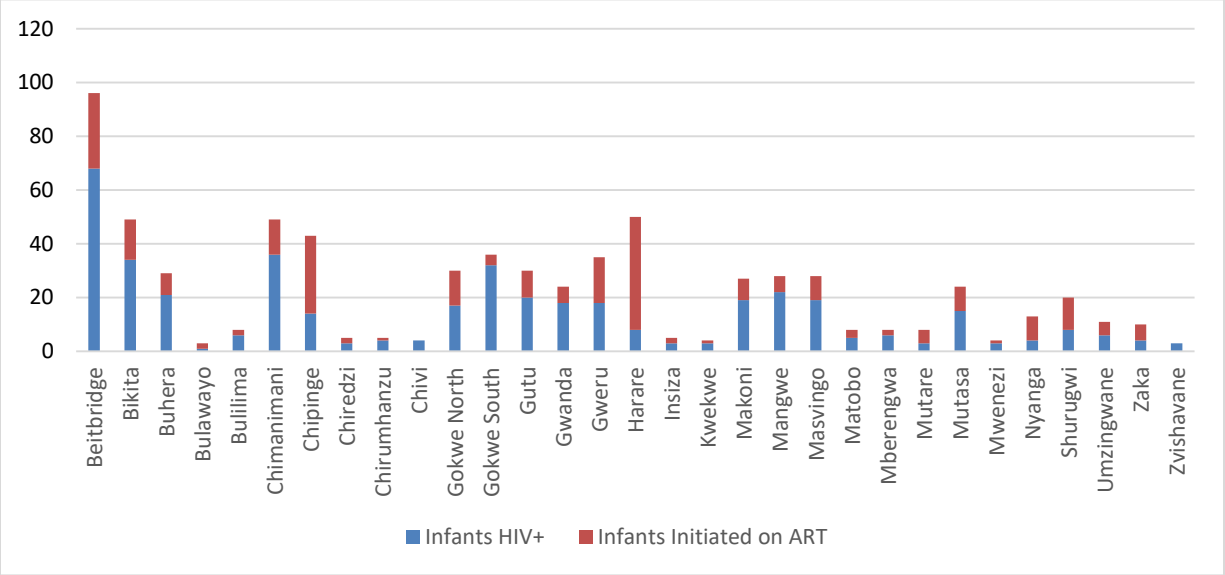
Many providers reported to the evaluators that 'treat all' is greatly welcomed as this removed a barrier to male support for PMTCT. Providers found it very difficult to offer ART for life for positive pregnant women under Option B+, but have to tell the women's positive male partners that they had to wait for a CD4 count result, and when the CD4 was more than 500 tell the partner he was not yet eligible for ART. One reason given for positive pregnant women not accepting option B+ was apostolic faith, although an apostolic follower was interviewed in an exit interview from a PMTCT clinic and she was accepting ART as, at age 19 years old, she already had one positive child.

Evaluation exit interviews also identified that where the health provider in ANC conducted counseling and testing rather than send the client to a primary counselor, the posttest PMTCT counseling was very limited. In contrast, clients who had been counseled by a primary counselor were very well informed on PMTCT and infant feeding.

[11] MOHCC, 2016. Global AIDS Progress Report 2016. Zimbabwe Country Report Jan 2015 to December 2015.

Early Infant Diagnosis

Figure 10: COP15 Infants less than One Year Tested Positive and Initiated on ART



The Figure 10 indicates the number of infants less than one year who were tested for HIV and found to be positive and those who were later initiated on ART. The numbers vary by district. Overall, 427 infants tested HIV positive, 270 of them (63.2%) were initiated on ART: showing a significant gap in the eMTCT postnatal cascade.

Nonetheless, the field evaluation found that providers in rural facilities believe that all the mothers who accept Option B+ bring their infants back for EID and follow up in FCH. The only losses to follow up acknowledged were in the Midlands where the providers reported that some positive mothers and their infants move when their miner husbands move. The evaluators acknowledge that these reports were from new facilities that are just about to come on board with FACE-HIV evaluation: providers in facilities that have received FACE-HIV support over time may be less willing to admit to loss to follow

TB/HIV

Tuberculosis is highly associated with HIV infection in Zimbabwe, and the most common opportunistic infection. The MOHCC estimates 80% of TB clients are co-infected with HIV.[12] TB services are a critical entry point for the promotion of HIV prevention, testing and treatment, as well as for adherence support and ARV drug resistance monitoring. Likewise, HIV services are also a critical entry point for TB care. As such, both HIV and TB care require an integrated service provision and a chronic disease management approach.

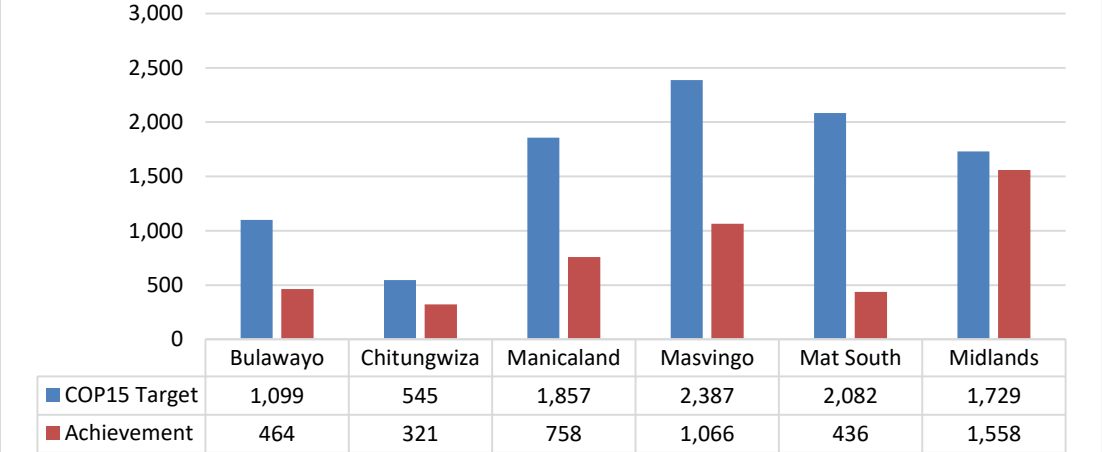
To ensure TB infection control, FACE-HIV reported to USAID that all the facilities have identified coughing zones away from waiting areas. The field evaluation confirmed this.

FACE-HIV reports that facilities practice triage to prevent infection to other clients visiting the facilities. The field evaluation found that many facilities bring TB patients in at 7am for directly observed treatment (DOTS) and many clinics have a separate clinic and waiting area for TB patients. A few facilities volunteered that they triage new patients and separate out those complaining of cough. There was general awareness of the need for good ventilation where TB clients are waiting and seen.

[12] MOHCC. National Guidelines for TB/HIV Co-Management.

One concerning finding in the field was that while there were no reports from clients of stigma and discrimination against PLHIV by health workers, there was evidence that TB, and in particular multiple drug resistant TB (MDRTB) is stigmatized. TB clients frequently reported that they felt discriminated against as a result of their infections as they were frequently required to remain outside in waiting sheds until they are called into see the health worker. Consultations were often in corridors or in rooms with the windows and door open—to improve ventilation—that reduce privacy during the consultation. During one client exit survey being conducted in a waiting shed, a health worker interrupted to warn the enumerator to take care as the client had MDRTB.

Figure 11: Comparison of Achievement against COP15 Target for HIV Positive TB clients on Treatment Initiated on ART



	Bulawayo	Chitungwiza	Manicaland	Masvingo	Mat South	Midlands
COP15 Target	1,099	545	1,857	2,387	2,082	1,729
Achievement	464	321	758	1,066	436	1,558

Since the "PEPFAR pivot", the FACE-HIV project has supported the provision of integrated TB/HIV services, although it attained only 47.5% of its COP 15 target, [please see figure 11.] The project provides on-site technical support and mentoring of all 330 priority sites, to ensure TB patients are screened for HIV and initiated on ART. The field evaluation elicited that all providers know that PLHIV must be screened for TB at every contact and that any PLHIV with productive cough should have sputum sent for GeneXpert testing. All the facilities visited had functioning transportation arrangements for sputum transportation to GeneXpert sites—mainly provided by Riders for Health, funded by USAID through ChallengeTB. Some sites in Makoni reported that sample transportation was provided by MSF, and one site visited in a district that users Riders for Health, had transportation provided by a female environmental health technician who has a government issued motorcycle.

The field evaluation also confirmed that there was a high awareness in TB clinics of the need to test TB clients for HIV. Providers were sometimes challenged initiating ART in TB/HIV coinfected patients after two weeks on DOTS. Some clients are reluctant to test and others who test positive are reluctant to accept ART, preferring to wait, as they are in denial that they have two infections. Some of those that initially refuse testing and or ART do accept ART at later clinic visits although that might be beyond the time for reporting. Hence, because of cohort reporting of TB clients and TB/HIV clients diagnosed in TB clinics, reporting of TB/HIV coinfection and ART for TB patients, might be lower than actuality.

One area of clinical practice not meeting minimum standards

An area of concern to the evaluators is in relation to use of disposable gloves when drawing blood. The nurses uniformly claim to wear gloves but only one nurse was observed to wear gloves when taking blood—from and infant for a DBS. The same nurse did not use gloves when taking blood from two adults for an HIV test. When one of the evaluation team had a rapid test for Malaria, the nurse did not wear

gloves while drawing blood. There were also very few used gloves discarded in the waste receptacles in the clinics and fewer in the medical waste burning pits. One nurse admitted that when the supply of gloves is running low, she saves them for use with infants. It seems very likely that many if not most nurses do not routinely wear gloves when drawing blood.

Reporting Quality

The evaluators conducted a quick quantitative data quality assessment (DQA) during the field evaluation. Data for six indicators was checked by comparing the monthly reports with the registers for five months, April to August 2016. One of the indicators—*Number of clients tested for HIV and receiving their results this month*—was problematic in some facilities where the reports included data from outreach and specific community campaigns, but the outreach registers were not available. Data was verifiable for the five other indicators in most facilities:

Number of clients testing positive for HIV this month

Number of clients started on ART this month

Number of pregnant women attending first ANC visit this month

Number of eligible pregnant women tested for HIV at the first ANC visit

Number of HIV exposed infants tested for HIV using DBS at 6-8 weeks and received results.

For higher volume facilities and indicators, an accuracy of +/- 5% was set as an acceptable standard

For Beitbridge General Hospital reporting on *Number of clients tested for HIV and receiving their results this month* and *Number of clients testing positive for HIV this month* were not verifiable because of inclusion of outreach data; **all other reports were accurate to within five percent**]

At Gweru Provincial Hospital for *Number of clients tested for HIV and receiving their results this month* **underreported by 14-25 percent** all months except July when it **over reported by 17 percent**. Gweru Provincial Hospital also **consistently underreported by 13-15 percent** *Number of clients testing positive for HIV this month*, and **underreported by 6-30 percent** *Number of clients started on ART this month* in four of the five months. Gweru also **underreported by 25 percent** the *Number of HIV exposed infants who tested for HIV using DBS at 6-8 weeks and received results* in June 2016. Other reports from Gweru Provincial were accurate to within 5 percent.

At Mpilo Hospital, while the overall reporting on *Number of clients tested for HIV and receiving their results this month* were not verifiable because of inclusion of outreach data, the reporting from the ANC department for clients tested and receiving their results could be verified against the register. The reports were **accurate to within five percent**. All other Mpilo reports **were accurate within 5 percent.**

A DQA could not be conducted at Kwe Kwe General Hospital

For lower volume facilities, a small error—for example under or over reporting by 1 client—could result in a 50 percent or 33 percent error, and so the discussion of the findings does not use the 5 percent standard for accuracy.

Silobela hospital reports included errors four out of five months for *Number of clients started on ART this month* and underreporting errors two months for *Number of HIV exposed infants tested for HIV using DBS at 6-8 weeks and received results.*

The findings for Zhombe Mission Hospital [New site] indicate that the reports from the Hospital were completed by a person or persons who did not understand the process. The reports included many very large over reports for *Number of clients testing positive for HIV this month* and many very large underreports for *Number of eligible pregnant women tested for HIV at the first ANC visit*. There was also a very large over report for *Number of clients started on ART this month* in June and a very large under report for *Number of HIV exposed infants tested for HIV using DBS at 6-8 weeks and received results* in April.

All of the clinics made errors of one to three in a third or more of their reports. The DBS reports were most problematic as most facilities frequently underreported by one to two. As the reports are all for small numbers, the widespread underreporting [and no over reporting] may have had a significant impact on the overall reporting against this indicator.

2.1 HOW SUCCESSFULLY HAS THE IMPLEMENTING PARTNER MANAGED CHANGES IN USAID REQUIREMENTS RELATED TO THE PEPFAR PIVOT? HAVE THE CHANGES AFFECTED PROJECT PERFORMANCE?

Pertinent Evaluation Findings:

The evaluation found that the changes that were imposed **after the "PEPFAR pivot" from December 2015**, whereby staff had to be moved from provinces that USAID was no longer supporting, and the focus of implementation expanded from prevention and treatment of pediatric HIV to comprehensive HIV/TB services were dramatic. The feeling expressed by many project staff was that the timescale for the change was unrealistic but the leadership and staff were committed and made it happen. Certainly, the changes demonstrated the flexibility of the project approach and management. Staff coped with transitioning from their native Shona speaking provinces to Ndebele speaking provinces; new staff from the new provinces were also recruited. Kapnek staff transitioning from Ndebele speaking provinces to the Midlands, where both Shona and Ndebele are spoken had an easier transition linguistically. The ability to respond successfully to the changes, particularly the greatly enlarged technical areas, demonstrate that the project approach—building the capacity of and enabling the MOHCC—is critical to achieving the intended results.

FACE-HIV staff report that managing the more geographically focused project is easier and more realistic than managing the national scope of FACE-Ped HIV. However, the move from provinces that were passed to CDC/I-Tech, and the change in FACE-HIV partners supporting some of the provinces required new working relationships and trust to be developed with provincial medical directorates and district health executives. Where USAID went the implementing partner to explain the PEPFAR pivot and the reasons for the programmatic changes, the provinces were more rapidly accepting of the changes in development partners. However, OPHID faced challenges to its wider operations as its other donor funded programs were leveraged on FACE in Mashonaland East and Central Provinces that were transferred.

The most difficult area to achieve buy in was as a result of the PEPFAR direction to priority districts and hotspot sites implying other districts are not a priority. The field evaluation was told by several District Nursing Officers that their work in districts not supported by FACE-HIV is now more difficult as they don't have the transport and other resources to provide the supportive supervision and other support that FACE-HIV provides to PEPFAR priority districts. One repeated suggestion is that FACE-HIV should be able to fund all the districts in a province to attend the review meetings as the districts not prioritized would have opportunity to learn from the experience of the FACE-HIV supported districts.

The technical shift from PMTCT to comprehensive HIV/TB services required capacity building for FACE-HIV program staff and recruitment of technical staff. That took some time and clearly there was a hiatus in field activities until the staff were trained and in position in their new provinces/districts and had built relations with the new provinces and districts. After the PEPFAR pivot, less level of effort was expended on eMTCT as staff had to also support the wider services and a dip in performance towards achieving PEPFAR targets. **Figure 8: Percentage of HIV Positive Pregnant Women Initiated on ART**, above, that demonstrates the fall in performance achieving COP15 targets, when there had been a trend for increasing performance prior to the "PEPFAR pivot" over COP 12, 13, 14.

eMTCT services as evident during the clinic site assessments were easily of the minimum necessary standard or better. HTS when conducted by primary counselors were also equal or better than minimum required standards. The evaluation found evidence that HTS when conducted by the health worker at the point of service did not always provide adequate counseling; in particular, PMTCT counseling and information on infant feeling was sometimes lacking. ART services assessed by the field evaluation [no pediatric ART services were seen] also met or exceeded minimum required standards. Adolescents in two fo-

cal group discussions in different provinces were satisfied with the quality of care that they received and appreciated being seen in their own clinics outside school hours.

While HTS and ART were technical areas that FACE-Ped HIV had experience in relation to positive pregnant women, TB/HIV services were essentially new in FACE-HIV. The field evaluation found that this area of service delivery is of adequate quality relative to professional norms, without any issues that would indicate underlying problems.

The evaluation field findings on quality of service delivery at facilities is broadly in line with USAID SIMS assessments for 2016. Although only 4 of the facilities in the evaluation are ones that have had SIMS assessments, overall the FACE HIV sites have scored well on SIMS and the great majority are dark green. Only 2 FACE-HIV supported sites failed the SIMS 25/50 rule.

Conclusions

1. HOW CAN THE FACE-HIV ACTIVITY DESIGN AND IMPLEMENTATION BE ENHANCED TO INCREASE EFFICIENCY AND EFFECTIVENESS IN CONTRIBUTING TO CURRENT PEPFAR PRIORITIES TO REACH THE UNAIDS FAST TRACK TARGETS GETS

The activity is pragmatically deploying locum nurses to government direct service delivery positions in PEPFAR priority districts and facilities. There are three models for selection of locum nurses, two of which involve hiring nurses on their time off. The third model rehires recently retired nurses. Hiring nurses on their time off is problematic as these nurses are not getting the full rest and recuperation between shifts/during the year and, despite the financial incentive, might lead to more rapid burnout. This model also demotivates health workers in facilities that "do not receive the benefit" of the additional financial incentives. Hiring nurses on their time off is thus undesirable and should be avoided. There are many unemployed nurses in Zimbabwe—including many newly qualified nurses who do not find employment for 3 or 4 years. Hiring these nurses, or rehiring recently retired nurses avoids the problems of hiring nurses on their time off but might also lead to challenges as project hires are paid regularly and on time each month. Currently, in the districts visited, health workers are being paid monthly but not necessarily on the scheduled payday. With the economic situation in Zimbabwe, the position for payment of government employees could change—many health workers are owed an arrears of 6 months' salary payments indicating that there have in the recent past been times when the government has not met its payroll.

The activity would be more effective if there was far greater deployment of volunteers living with HIV throughout. In line with experience in other PEPFAR countries, with training volunteers could offer task sharing for lower level tasks from the nursing staff, including reporting. They could provide in the facility and community more intense, consistent and comprehensive support for adherence and living positively, as well as for eMTCT throughout the cascade and involvement of men in eMTCT.

As linkages with the community—over the continuum of HIV/TB services from prevention to treatment adherence—are weak in the FACE-HIV project, and said to be stronger under FACE-PED, the activity design might be more effective and implementation better coordinated, if community partners were included in the consortium. This might better facilitate integrated service delivery over the continuum from the facility to the community, and the clients' homes, with unified leadership and responsibility for implementation throughout the continuum of care and service delivery.

FACE-HIV staffing at subnational level is relatively light by comparison with PEPFAR projects elsewhere, and might be more efficient with additional technical staff and management staff at provincial and district levels for oversight of the expanding personnel and more intensive programming for attaining project targets.

1.1 What design and implementation aspects of the FACE-HIV project are critical to achieving intended results? Why?

Secondment of technical staff to the MOHCC at National level is vital for effective activity implementation and for wider effectiveness of the Zimbabwean public health services as the MOHCC budget constrains its hiring for these directorate level positions.

'*Treat all*' is critical to achieving the second 90 of UNAIDS' fast track 90:90:90 targets as it reduces the loss of clients living with HIV after testing and before initiation on ART. It has also reduced challenges for staff delivering eMTCT services, as male partners living with HIV are now also initiated on ART without delays for CD4 counts.

1.2. What design and implementation aspects of the project are not achieving intended results?

FACE-HIV as currently being implemented is not demonstrating achievement of the third 90 of UNAIDS' fast track 90:90:90 targets. In part, the achievements are not being *verified* by low levels of virologic testing. In border areas where many are migrant workers to South Africa and Botswana, clients only return home annually and can only be tested annually. However, throughout Zimbabwe routine 6-monthly use of virologic monitoring of treatment is under-utilized and generally used only for clients showing clinical signs of poor viral suppression. FACE-HIV is supporting the MOHCC to scale up availability and use of virologic testing with training and job aids, as well as putting due emphasis on retaining persons known to be living with HIV in care and treatment. There are likely to be improvements in virological suppression rates in Year 5 resulting from 'treat all'.

1.3 What alternative approaches and strategies could achieve better results?

As noted in conclusion 1, above, greater deployment of volunteers living with HIV offering "expert client" and "mentor mother" services as in other PEPFAR countries would likely increase achievements of results from testing through to treatment and adherence.

1.4 What is the nature of the linkages and synergies with other USG and non-USG partners

The activity benefits from infrastructure and service provisions established by other development partners including the World Bank and DFID, and MSF. The field project links with FHI 360 and PSI in relation to HTS in the community where these IPs have programs. The linkages are fostered in review meetings.

2. WHAT ARE THE MAJOR CHALLENGES FACED BY THE FACE-HIV ACTIVITY IN DELIVERING HIV SERVICES (HTS, ART, TB/HIV, EMTCT, CARE, SUPPORT, RETENTION, ADHERENCE) AND HOW CAN USAID ADDRESS THESE CHALLENGES?

The major challenges to service delivery are congestion in clinics that might be reduced by strengthening local leadership and facility management. Introduction of timed appointment systems—initially morning and afternoon but potentially progressing to two-hour blocks—would potentially reduce congestion as would timely opening of facilities. Greater use of CARGs greatly reduces congestion in ART clinics.

Low yield of positive clients from HTS is another challenge. Higher yields might be obtained by better targeting of testing but high PEPFAR targets have encouraged testing all at facilities irrespective of risk. High PEPFAR testing targets may have also led to retesting of known PLHIV and reporting them as new clients. However, Apostolic faith living with HIV consult prophets who claim "cures". This also contributes to known PLHIV being retested and presenting as new clients.

Follow up of pre-ART clients has been a challenge but introduction of '*treat all*' has resolved this. Similarly, involving men in eMTCT has been problematic when partners living with HIV were not eligible for treatment. The introduction of '*treat all*' has also resolved this

There is under reporting of infants having DBS for EID and receiving their results in addition to the loss of exposed infants to follow up at facilities.

Reporting quality is an issue, particularly at lower volume sites where service providers are also doing the reporting. Beitbridge General Hospital and Mpilo Teaching Hospital reported within 5% accuracy. Apart from one new site where the reporting was clearly being undertaken by someone who did not understand the process, the reporting is probably near to as good as it can be. Given the environment of busy clinics and overworked service providers, missing one or two items from a report may well be the standard that can be realistically achieved *by health providers*.

USAID might address the challenges by inclusion of community partners and community activities in the FACE-HIV scope of work; and by negotiation with the Office of the Global AIDS coordinator on Testing targets. While high targets can be a stimulation to good performance, experience in family planning globally has demonstrated two important lessons: *setting very high targets* can lead to fraudulent or unethical actions and *provision of incentives* can also lead to fraudulent actions in false inflation of results.

2.1 How successfully has the implementing partner managed changes in USAID requirements related to the PEPFAR Pivot? Have the changes affected project performance?

The IP consortium has changed sub partners, programming has restructured geographically, staff have moved from provinces no longer supported by USAID, and two additional technical staff are hired to address the wider aspects of HIV/TB services supported by FACE-HIV. This happened rapidly from mid-December 2015, albeit with a dip in performance on PMTCT indicators at the beginning of 2016. The partners have well demonstrated their flexibility in accomplishing this upheaval and the relevance of the model of implementation to the wider aspects of HIV/TB services.

Recommendations

The evaluation findings and conclusions support the following key recommendations

(1) The IP should increase the project staffing at sub-national level to provide stronger technical management and oversight of both the proposed increase in deployment of locum nurses and the intensified programming required to achieve the required results. This is particularly necessary for achieving the third 90 of UNAIDS' fast track 90:90:90 targets.

(2) Use of volunteers living with HIV as expert clients and mentor mothers should be rapidly scaled up in FACE-HIV supported facilities and the community to increase achievement of results from testing through to adherence—across all three of UNAIDS' fast track 90:90:90 targets. There are PEPFAR partner models for use of volunteers in other southern African countries that could be adapted and implemented in Zimbabwe.

(3) USAID/Z future HIV/TB project designs might be more effective and implementation more efficiently managed if the activity design is integrated across the spectrum of services at the facility and in the community. Activities might include community partners and community activities within the manageable interest of the lead implementing partner for unified technical leadership and responsibility for delivering results across the spectrum of care and treatment services.

(4) FACE-HIV should include programming to strengthen local leadership and management of services to support timed appointment systems, initiating and utilizing CARGs, and greater involvement of volunteers living with HIV with task shifting to relieve health workers of lower level tasks including reporting.

(4.1) Emphasis on improving quality of reporting needs to continue, but should be part of this wider approach to strengthening local leadership, management and task shifting. Trained volunteers living with HIV might provide more accurate monthly reports than busy health workers.

U.S. Agency for International Development
1300 Pennsylvania Avenue, NW
Washington, DC 20523
Tel: (202) 712-0000
Fax: (202) 216-3524
www.usaid.gov