STOCKHOLM EVALUATION UNIT

ANNEXES TO

EVALUATION OF

THE ESHOWE HIV PROJECT

APRIL 2021

This publication was produced at the request of Médecins Sans Frontières, under the management of the Stockholm Evaluation Unit.

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DISCLAIMER
The author's views expressed in this publication do not necessarily reflect the views of Médecins sans Frontières and the Stockholm Evaluation Unit.

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ANNEX I. TERMS OF REFERENCE

Subject/Mission:	Eshowe HIV Project Evaluation
Starting Date:	February 2020
Period to evaluate:	2013-2018

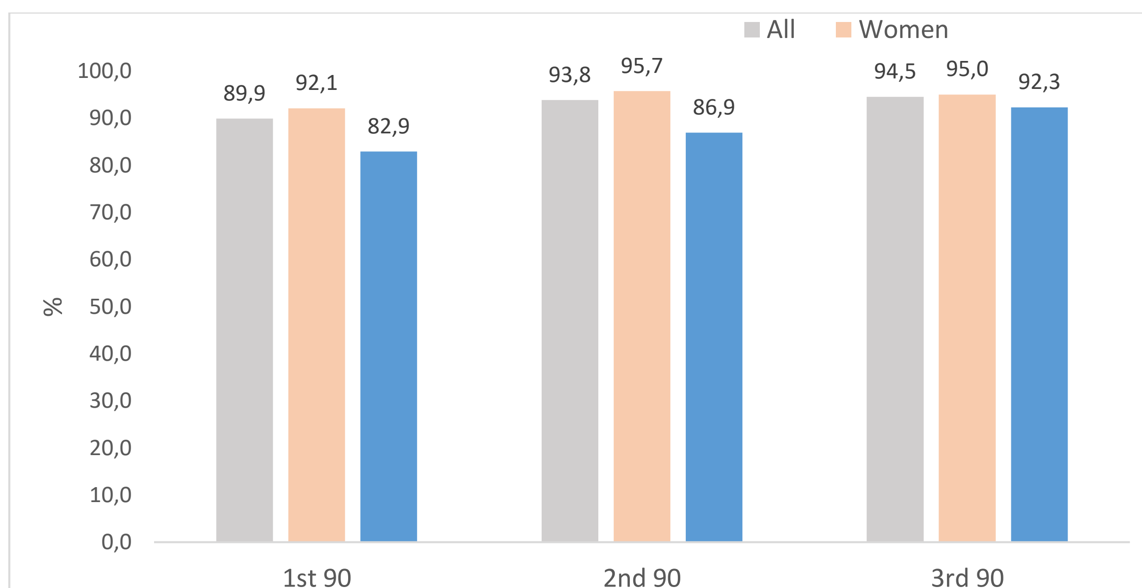
MEDICAL HUMANITARIAN CONTEXT

MSF in partnership with the KwaZulu-Natal Department of Health supports a HIV/TB project in the Mbongolwane and Eshowe areas (King Cetshwayo District). The Bending the Curves project was introduced in 2011 and aimed to reduce the incidence of HIV and TB, in addition to reducing HIV and TB related morbidity and mortality (bend the epidemic curves downwards) in line with the South Africa National Strategic Plan (2012-2016) aimed at fighting HIV, STIs and TB.

In 2013, Médecins Sans Frontières, Epicentre, and the Department of Health (DoH) implemented a population-based survey to assess parameters of the HIV epidemic in the sub-district of Eshowe/Mbongolwane, where MSF has been working since 2011. The findings of that survey helped MSF and the DOH to implement activities and adapt strategies in the sub-district. The SA department of health has introduced in 2016 a "Universal Test and Treat (UTT)" strategy and with this it was expected that there would be an identifiable improvement across the entire HIV prevention and treatment cascade i.e. HIV positive status awareness, ART coverage and viral load suppression. Subsequently, a second cross-sectional population survey was conducted in 2018.

The 2018 survey showed significant progress in combatting the scourge of HIV – with the overall 90-90-90 coverage target confirmed to have been achieved. That is, HIV positive status awareness increased to 90% in 2018 (up by 15% from 2013); ART coverage among those testing positive was 94% (up by 23% overall from 2013) while viral suppression among those on treatment, was up by 1% at 94% overall.

Results shown in the figure below.



The project included the following components:

1) *prevention:* through health promotion, community mobilization and awareness, condom distribution, medical male circumcision (MMC), prevention of mother to child transmission (PMTCT) and an HIV prevention package for students, all starting in 2012;

2) *HIV counselling and testing (HCT):* including expanded community testing at clinics, fixed community testing sites, through a mobile van at schools and at events, and door-to-door testing (through Community Health Agents Programme (CHAPS)), starting in 2012 until beginning of 2018 which was then replaced by Luyanda sites (that offer HIV testing and other medical services compatible with the 2018 scope of work of the Community Health Workers in South Africa);

3) *linkage to care and early ART initiation*: through follow up of people who tested positive at community and health facilities and lost to follow up tracing by CHAPS since 2012, conducting clinics in the Technical College in Eshowe and a mobile clinic focusing on the high risk populations at the farms, and a vertical male clinic Philandoda was established in the Eshowe Taxi Rank offering HCT, MMC, ART initiation and follow-up, STI screening and treatment of minor illnesses;

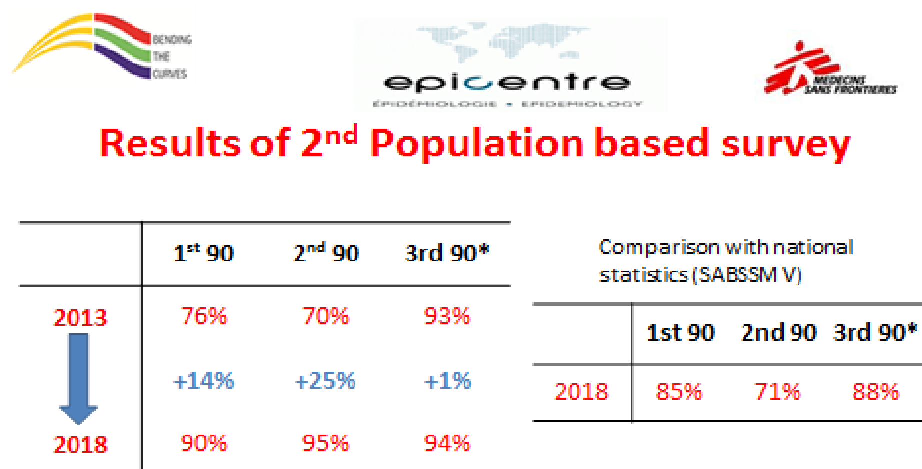
4) *retention in care and adherence for HIV-infected people*: through HIV initiation and adherence counselling conducted by lay counsellors, differentiated models of care (community and facility clubs, community ART support groups (CAGs), fast lane or community pick up points (PuP)) and mentoring on implementation of the national adherence guidelines.

This evaluation will cover these four components, with a strong focus on activities related to linkage to care component (completion of a first medical clinic visit within 30 days after an HIV diagnosis) and community interventions. It includes community based activities: CHAPs[1], Fixed Sites, M1SS[2] (schools, farms, industrial area, testing, comm events, churches, sports events), MMC[3], Community PR (Imbizos, War Rooms, liaison traditional leaders, traditional leaders feedback meetings, training THPs[4], CAB[5] etc.), Mobilization, CHW[6] Linkage, Adolescent Groups, Child Support Groups, Youth camps and community health volunteers including patient supporters.

REASON FOR EVALUATION / RATIONALE

The results released from this year's survey have generated an overwhelmingly enthusiastic response from policymakers, civil society, partner organizations and donors across the world, as well as UNAIDS, which launched its 2019 report in Eshowe, specifically inspired by the achievements of MSF's work with the South African NDOH.

Policymakers have focused on the specific relevance – if any – that the results have for SA's nationwide efforts to tackle the disease. A comparison of national level data, obtained through the fifth South Africa Social and Behavioural and the Eshowe results explains why.



	1st 90	2nd 90	3rd 90*
2013	76%	70%	93%
	+14%	+25%	+1%
2018	90%	95%	94%

Comparison with national statistics (SABSSM V)

	1st 90	2nd 90	3rd 90*
2018	85%	71%	88%

[1] Community Health Agents Program
[2] M1SS: mobile one-stop shop
[3] MMC: Male medical circumcision
[4] THP: Traditional health practitioners
[5] CAB: Community Advisory Board
[6] CHW: community health worker

It seems that Eshowe achieved higher figures for all these three indicators, and especially for treatment initiation, than the average results across South Africa. However, these results should be interpreted with care due to differences in methods and population samples. Of specific importance from a policy perspective is therefore, what Eshowe did differently to achieve a level of linkage that is on average 24% higher than that achieved by South Africa overall. To put these results into perspective, this means that in Eshowe, 80% of people living with HIV had an undetectable viral load, compared to 53% in the national survey. Given that Undetectable = Untransmissible (U=U) this means the potential for new infections is much lower in Eshowe compared to nationally. The very low incidence results in Eshowe is in line with this hypothesis. This is the basis for the request for this evaluation of the Eshowe project.

OVERALL OBJECTIVE and INTENDED USE

OVERALL OBJECTIVE. To assess the effectiveness and replicability of MSF's Eshowe intervention, and to identify those elements[7] within the project which have played a key role (overall and related to linkage to care).

INTENDED USE. This evaluation is aimed primarily at informing MSF-OCB in their conversations with SA's DoH on the national HIV program, with the aim to advise on how to better to implement (or scale back) activities in order to improve the performance of the HIV cascade with focus into linkage to ART services. It may also be used by MSF in their conversations with other regional and international actors.

SPECIFIC OBJECTIVES

What were the most effective elements[8] of the MSF intervention in Eshowe?

- To what extent have the agreed objectives been achieved?
- What were the main barriers and enabling factors for achievement or non-achievement of objectives?
- What are the specific elements of the MSF Eshowe intervention that have played the most significant role in project effectiveness? (overall and especially on linkage to care and enrollment into ART).
- To what extent did the intervention optimally approach population at higher risk of HIV? (ie; young men and women, sex workers, men who have sex with men).
- What could have been done to make the intervention more effective?

What elements of the intervention can be replicated elsewhere?

- How does the MSF intervention in Eshowe compare with SA National Plan? What did MSF do in Eshowe that was identifiably different?
- What are the elements of the MSF intervention in Eshowe, that are scalable and could be incorporated into SA's national HIV program?
- What are the lessons learned from MSF's Eshowe intervention to facilitate HIV management (with special attention to linkage to care) in South Africa's or other MSF HIV projects in similar contexts?

EXPECTED DELIVERABLES

- Inception Report

  As per SEU standards, after conducting initial document review and preliminary interviews.

  It will include a detailed evaluation proposal, including methodology.

- Draft Evaluation Report

  As per SEU standards. It will answer to the evaluation questions and will include conclusions, lessons learned and recommendations.

- Working Session

  With the attendance of commissioner and consultation group members.

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[7] Intervention elements refer to a range of project components (such as strategy, objectives, activities)

[8] As mentioned in the note before, intervention elements refer to a range of project components (such as strategy, objectives, activities)

As part of the report writing process, the evaluator will present the findings, collect attendances´ feedbacks and will facilitate discussion on lessons learned.

- Final Evaluation Report

  After addressing feedbacks received during the working session and written inputs.

- Other dissemination deliverables

  As defined in the attached dissemination plan.

TOOLS AND METHODOLOGY PROPOSED

In addition to the initial evaluation proposal submitted as a part of the application (see requirement chapter), a detailed evaluation protocol should be prepared by the evaluators during the inception phase. It will include a detailed explanation of proposed methods and its justification based on validated theory/ies. It will be reviewed and validated as a part of the startup phase in coordination with SEU.

RECOMMENDED DOCUMENTATION:

- Project documents (project proposals, logframes, sitreps, annual reports, field visit reports)
- MSF project-related documents (operational research, publications)
- Eshowe SEU evaluation (conducted by Richard Bedel in 2016 regarding the first 90)
- Eshowe epicenters surveys (2013 and 2018)
- National and regional (SA HIV national policies, SA reports)
- External literature and documentation of similar experiences

ANNEX II. LIST OF INTERVIEWEES

Name	Function
Jessie Kurnurkar	Former PCS Manager 2013-2015 (Former MSF)
Jen Furin	MSF Consultant for the Project
Miriam Aragao	Former Medical Activity Manager (Former MSF)
Sindisiwe Mabaso	M&E Coordinator (KZN DOH)
Emily D'Aubrey	Farmers Association of Eshowe
Jacqui Ngozo	HAST Coordinator (KZN DOH)
Rina Uenishi	Former PCS Manager (Former MSF)
Nokulunga Zondo	Former CNP (Former MSF)
Rugerro Giuliani	Former Project Medical Referent (Former MSF)
Linda Dlamini	HAST Reference (KZN DOH)
Busi Ndlovu	CHAP Coordinator (Former MSF)
Dr Nana Dube	Nursing Manager (DoH Sub District – Eshowe)
Matthew Reid	Former Project Coordinator (Former MSF)
Amir Shroufi	Former Medical Coordinator (Former MSF)
Mariana Garcia	SAMU Patient & Community Support Advisor (MSF)
Nozipho Mthembo	Former Director (SHINE)
Lwazi Fihlela	Director (Child Care South Africa)
Jabu	School Counsellor (MSF)
Nkosinathi	School Counsellor (MSF)
Feroza Clouts	Responsible – Schools Programme (MSF)
Ntombi Gcwensa	PCS Manager (MSF)
Bheki Xulu	Former CHAP Coordinator (MSF)
Sthembile Sibiya	Deputy Chairperson (Umlalazi Coalition)
Sthandwa Buthelezi	HIV Ambassador
Lisbeth Ohler	Eshowe Medical Responsible (MSF)
Celiwe Dlamini-Ndlovu	PRO Officer/Former Counsellor Supervisor (MSF)
George Mapiye	Deputy Field Coordinator (MSF)
Andrius Slavuckis	Logistics Manager (MSF)
Mr Mayise	HIV Ambassador
Makhosi Ngema	Traditional Healer
Lindiwe Dlamini	High Transmission Areas Coordinator (MSF)
Mduduzi Mbatha	Deputy Director (DOH - King Cetshway District)
Nokukhanya Hlophe	Director (DOH - King Cetshwayo District)
Dludla Nokwethembo	Life Skills HIV/AIDS Coordinator (DOE - King Cetshwayo District)

Sister Zwane	Head of Youth Adherence Club at Siyalulama Clinic (DOH - Mbongolwane Sub District)
Sister Nomvula Nzuza	HAST OM Siyalulama Clinic (DOH - Mbongolwane Sub District)
Youth (x6)	Youth Adherence Club (Mbongolwane)
Farm Workers (x10)	Farm (Mbongolwane)
Sister Winnielove Ntamane	Head Nurse at King Dinizulu Clinic (DOH Eshowe Sub District)
Sister P.L. Bhengu	HAST Coordinator/OM Sinethemba (DOH - Eshowe Sub District)
Nozipho	Counsellor (DOH)
Youth (x6)	Youth Adherence Club (Eshowe)
Mrs Khosa	Ntumeni Clinic (DOH - Mbongolwane Sub District)
Zikhethile	CHA
Inkosi Dube	Traditional Leader
Mr Sangweni	CEO Eshowe Hospital
Farm Workers (x11)	Farm (Eshowe)
Jonathan	Farm Owner
Ntuli Cabangile	HAST Coordinator (DOH – King Cetshwayo District)
Pheli Mbuyazi	Training Coordinator (DOH – King Cetshwayo District)
Stone	Head of Drivers (MSF)
Gugu	Community Health Worker
Mrs Mthabela	Former PHC Manager (DOH - Eshowe Sub District)
Sister Mlambo	Eshowe Gateway Clinic (DOH - Eshowe Sub District)
Youth (x1)	Youth Adherence Club
Adults (x2)	Youth Adherence Club
Nompumelelo	LSA (Ntabantuzuma High School)
Learner (x1)	Schools Programme (Ntabantuzuma High School)
Beneficiaries (x6)	CHAPs beneficiaries in Vuma (Mbongolwane)
Rosie Stewart	Study Coordinator (MSF)
Beneficiaries (x6)	CHAPs beneficiaries in Eziqwaqweni
Nomthandazo Buthelezi	CHA in Eziqwaqweni
Beneficiaries (x6)	CHAPs beneficiaries in Thintumkhaba
Nonhlanhla Ntombela	CHA in Thintumkhaba
Inkosi Zulu	Traditional Leader
Henry Mpanza	TVET Learner Supporter
Craig Hanbury-King	Farmer
Gavin Wiseman	Farmer
Beneficiaries (x7)	CHAPs Clinic beneficiaries in Mbongolwane (Ngudwini)
Zandile Ngcobo	CHA in Mbongolwane (Ngudwini)
Mrs Mkhwanazi	CEO Mongolwane Hospital
Mduduzi Dlamini	TVET College Lay Counsellor (MSF)
Learners Grp 1 (x7)	(Bambiswano High School)

Learners Grp 2 (X6)	(Bambiswano High School)
Mrs Nkulu	LO Teacher (Bambiswano High School)
Wanda Blose	LSA (Bambiswano High School)
Beneficiaries (x9)	MMC (Umlalazi)
Learners (x10)	Schools Programme (Mbongolwane High School)
Laura Trivino-Duran	South Africa Medical Coordinator (MSF)
Vinayak Bhardwaj	South Africa Deputy Head of Mission (MSF)
Ellie FordKamara	Former Project Coordinator (Former MSF)
Bongiwe Thwala	Sub-District Manager (Broadreach)
Gilles Van Cutsem	SAMU HIV/TB Advisor (MSF)
Daniela Garone	Commissioner: Medical Deputy Coordinator (MSF)
Sibonelo Mantame	MMC Manager (DOH Mbongolwane Sub-District)
Musa Ndlovu	Former Deputy Project Coordinator (MSF)
Dr Carter	Technical Advisor (CHAI)

ANNEX III. INTERVIEW & DISCUSSION GUIDES

KEY INFORMANT INTERVIEW (KII) GUIDE

KEY INFORMANT INTERVIEW (KII) GUIDE	
NAME OF INTERVIEWEE:	
ORGANISATION:	
POSITION:	
PLACE:	
DATE:	
TIME:	
INTERVIEWER:	
NOTE TAKER:	

Interview Brief (Key Stakeholders/Respondents):

Good day/Good morning. My name is Aidan/Josianne, and I/we am part of Indigo Innovation. We are not MSF staff, but have been commissioned by MSF to conduct an independent evaluation of the HIV Eshowe Project. In particular, we would like to discuss certain aspects of the project as they relate to effectiveness and replicability. That is, we are seeking to understand how effective the project was in delivering on its objectives, and how might some of the successful activities or lessons be used elsewhere. We will also seek information on the projects' four components: a) prevention; b) HCT; c) linkage to care and ART initiation; and d) retention in care and adherence.

The interview should take approximately 40 minutes.

Verbal and Written Consent/Assent:

Before we begin, I would just like to inform you of the process. Firstly, the purpose of this interview is to talk to you due to your specific role and experiences of the project, and therefore, as I have some specific questions, this will be more like a conversation.

Secondly, I would like, with your permission, to record the interview. The evaluation team will only use the recording for analysis purposes and your name will not be used in the report, or any report, but only what you may have said. In fact, no names will be used at all in any reports for this work.

Is this OK with you? Do you have any questions? May we proceed with the Interview? If yes, PRESS RECORD.

INTRODUCTION **Introductory questions: All respondents (except beneficiaries)**
Q1. Can you please provide me with your name, your title, organisation, and where you work (location – name of facility)?
Q2. Can you please briefly outline your roles and responsibilities within or related to the project (in the delivery of HIV-related services where MSF was involved)?
Q3. What are the thematic/technical areas you cover/ed? **(a) Prevention; b) HCT; c) Linkage to care and ART initiation; and d) Retention in care and adherence)**
Q4. When did you join or link to the project, and for how long?
EFFECTIVENESS
Key Evaluation Questions: ALL respondents (except beneficiaries)
We know that the project has been successful in attaining the UNAIDS 90-90-90 targets. In this regard: **Q1. What factors do you think contributed towards project success, and in reaching the targets?** **Note 1**: After the response, ask specifically on each of the following separately: What role do you think the involvement of Community-based structures and community engagement played? Local and Traditional Leadership; Government Support and the work of Operation Sukuma Sakhe (OSS); Lay Counsellors; Types of services; Place of services, or other? **Note 2**: More specifically, what factors do you think contributed towards project success in terms of the following: a) Prevention; b) HCT; c) Linkage to care and ART initiation; and d) Retention in care and adherence **NB**: Allow the respondent to answer for EACH of the above components. Be aware that the respondent may not have much information on those components that they did not deal with directly.
MSF (and ex-staff), Government (provincial/district), OSS personnel, and partners (SHINE and others).
Q1a. In terms of strategy and planning, what would you say have been the main contributors towards project success, if any?
Q1b. What was your involvement, if any, in planning for the project? What did planning entail, do you know? Can you briefly outline any processes which you are familiar with?
Q1c. In your experience, what would you say might have been better planned for, within the project, if anything?

PROBE: How much of stakeholder engagement and community engagement was involved and at which levels? Who were the stakeholders and their roles? (NOTE: we want to understand community level involvement (communities at the centre!) and what planning and engagements or sessions, looked like. **PROBE**: Have you planned or participated in any Traditional Authority Imbizios or other community outreach activities? If yes, what did these entail? Was this a formal process? If no, can you share anything from your work on these engagements, more generally?
Q1d. What effect did centralisation/decentralisation of services play in the project area, if any?
Q1e. What roles did Government, especially at the district level, participate in, and how effective were these? NOTE: If respondent is with Government, then ask specifically about their department (Health/Education)
Q1f. What were the implications on the intervention with the introduction of the Universal Test and Treat guidelines?
Q2 for ALL respondents (except beneficiaries)
Q2. When thinking about project delivery, in all its forms (e.g. mobile and fixed sites, self-testing etc.), what do you think were the main barriers or challenges in project delivery (in the delivery of HIV-related services where MSF was involved)? **NOTE:** It is important to go through the list and types of sites, especially for those practitioners who deliver these services. Also, it is important to ask about the Prevention and Awareness services such as communications and advocacy as they relate to MMC and Condom use. And important to ask for barriers not related to intervention (distance to service, financial situation, health condition of patient, stigma).
Q2a. Conversely, what do you think were the main enabling factors in project delivery? **PROBE**: Depending on the role of the respondent, follow up probe can mention strategy, planning, protocols, engagements, service delivery modality etc.
Q3 and Q4 for (ALL respondents)
Q3. What are the specific elements of the MSF Eshowe intervention that played the most significant role in project effectiveness overall? **NOTE**: Allow the respondent to list these first, and then seek evidence through additional probing by asking, how, where, can you provide an example etc.
Q3a. With regards to linking to care and ART initiation, what did this component contribute in terms of project effectiveness, if any?

Q4. How did the project approach or reach higher-risk and key populations (i.e. adolescent girls and young women, young boys and migrant workers, MSM and sex workers)? To what extent were these approaches successful? (Particularly for MSF personnel - strategy). **PROBE**: What were the considerations for inclusion/exclusion and ways for access/to reach, these populations? Were different considerations and approaches used in these instances? If yes, please explain through examples.
Q5. Have you seen any changes in attitudes among people in the community towards getting tested? If yes, what are these? Why do you think these attitudes changed?
REPLICABILITY
Q1. In your opinion, what are the elements from the Eshowe intervention that you feel are scalable and perhaps could be incorporated into SA's national HIV program? (PROBE for reasons, and what needs to be adapted -if anything- to make the mentioned element scalable). And what is definitely not scalable or cannot be incorporated? (probe for reasons)
Q2. In terms of carrying some of these lessons that you've noted above, have you any ideas as to how the MSF intervention in Eshowe compares with SA National Plan? (If the respondent is aware of the details in the plan)
Q3. What are the lessons learned from MSF's Eshowe intervention to facilitate HIV management (with special attention to linkage to care) in South Africa's or other MSF HIV projects in similar contexts?
Q4. What specific roles did government play in this project, and could these efforts be reasonably replicated?
Q5. With regards to collaborations and partnerships, what elements do you feel worked well and what did not work well? PROBE for reasons, examples. **PROBE: What was collaborative about the DoH/MSF programme? DoH and other NGOs? (For DOH/DOE)**
Q5a. What are the main lessons that should be considered when working with local partners, in particular working with NGOs and CBOs?
Q5b. What are the main lessons for working with government structures? (For MSF only) **PROBE: MOU - what worked well and what did not work well**
Q5c. What are the main lessons for working with international donors or international organisations in this type of intervention? (For Government and CBOs only!). How is MSF different from other international organisations?

PROBE: MOU - what worked well and what did not work well
Q6. What are the implications of Human Resources for Health (HRH) on scaling a project of this nature?
Q7. What are the implications of donor assistance (e.g. PEPFAR) on such interventions, and what are those implications for replicability?
Q7a. How could donor assistance or sources be used better (leveraged) that would be most effective for scale-up?
Q8. Were there overlaps or duplications in effort between DoH and MSF? **PROBE: For example, in 2010, the Government conducted a HIV counselling and testing (HCT) campaign - was there any sort of government campaigns such as prevention, HCT in the period 2011-2018?**
Q9. What other implications might be considered for scalability or replicability?

FOCUS GROUP DISCUSSION (FGD) GUIDE (SCHOOLS PROGRAMME)

FOCUS GROUP DISCUSSION GUIDE (SCHOOLS PROGRAMME)		
NAME OF INTERVIEWEE GROUP/SERVICE ACCESS LOCATION:	Youth - Schools	
PLACE OF INTERVIEW:	Eshowe	
	Mbongolwane	
DATE:		
TIME:		
INTERVIEWER:		
NOTE TAKER:		

Interview Brief (Key Stakeholders/Respondents):

Good day/Good morning. My name is Aidan/Josianne, and I/we am part of Indigo Innovation. We are not MSF staff, but have been commissioned/asked by MSF to conduct an independent evaluation of the HIV Eshowe Project. In particular, we would like to discuss certain aspects of the project as they relate to effectiveness and replicability. That is, we are seeking to understand how effective the project was in delivering on its objectives, and how might some of the successful activities or lessons be used elsewhere. We will also seek information on the projects' four components: a) prevention; b) HCT; c) linkage to care and ART initiation; and d) retention in care and adherence.

We would like to hear from you, as a participant in the project. We would like to hear your opinions and experiences of the project. There are no right or wrong answers in this interviews. Also, let us all note that what is discussed here remains between us. It is your experiences and interactions we would like to hear about.

The interview should take approximately 45-60 minutes.

Verbal and Written Consent/Assent:

Before we begin, I would just like to inform you of the process. The purpose of this interview is to talk to you due to your specific role and experiences of the project, and therefore, as I have some specific questions, this will be more like a conversation.

Before we start, we would like your permission to record the interview, we will only use the recording for analysis purposes and your name will not be used in the report, or any report, but only what you may have said. In fact, no names will be used at all in any reports for this work.

IS THIS OK WITH YOU? Do you have any questions? May we proceed with the Interview? If yes, **PRESS RECORD.**

Now that we are recording, please can you give us your consent to proceed with the interview?

INTRODUCTION
Q1. Can you please confirm that you took part in the Schools Programme? What is the name of your school and in what Grade are you in?
Q2. Please tell us how the MSF Schools Programme was run in your school/class. Tell us about what you did or what they did with you? Can some of you explain some of the issues/topics you discussed?
Q3. Tell us what you liked the most about the Schools Programme?
Q4. Tell us what you didn't like about the Schools Programme? **Q4a. What can you suggest to make it better or more fun?**
Q5. Can you explain your interactions with the MSF Schools Counsellor?

Q5a. How was the Counsellor you met in your classroom? (on time, professional, enough information, etc.). PROBE: If they said they were good/great, ask why – ask for examples.
EFFECTIVENESS
Q6. Can you please explain what you know, and your experiences of, if any, of the following: **A. Prevention: (campaigns, condom distribution, loud hailing, tents, events, etc.)** - What worked well, and what did not work well? **B. HIV Counselling and Testing: MSF had tents outside your school, good idea/convenient** - What worked well, and what did not work well?
Q7. What can be done to make these components work better, in your opinion? PROBE: What can government (local services) do better in the delivery of these services?
Q8. Have you seen any changes in attitudes among people in your school or community towards getting tested? If yes, what are these? Why do you think these attitudes changed? Where did you see that?
REPLICABILITY
Q9. What lessons should be though about for taking this project to other schools or communities?
Q10. Any additional final thoughts on the project delivered by MSF and partners?

FOCUS GROUP DISCUSSION (FGD) GUIDE (OTHER GROUPS)

FOCUS GROUP DISCUSSION (FGD) GUIDE (OTHER GROUPS)		
NAME OF INTERVIEWEE GROUP/SERVICE ACCESS LOCATION:	Youth - Youth Adherence Clubs	
	Farm Workers – Farms	
	Beneficiaries – Clinics	
	Beneficiaries - CHAPs	
	Beneficiaries - MMC	
PLACE OF INTERVIEW:	Eshowe	
	Mbongolwane	
DATE:		
TIME:		
INTERVIEWER:		

NOTE TAKER:		

Interview Brief (Key Stakeholders/Respondents):

Good day/Good morning. My name is Aidan/Josianne, and I/we am part of Indigo Innovation. We are not MSF staff, but have been commissioned/asked by MSF to conduct an independent evaluation of the HIV Eshowe Project. In particular, we would like to discuss certain aspects of the project as they relate to effectiveness and replicability. That is, we are seeking to understand how effective the project was in delivering on its objectives, and how might some of the successful activities or lessons be used elsewhere. We will also seek information on the projects' four components: a) prevention; b) HCT; c) linkage to care and ART initiation; and d) retention in care and adherence.

We would like to hear from you, as a participant in the project. We would like to hear your opinions and experiences of the project. Please note, there is no right or wrong answers in this interview. Also, what is discussed here today, remains between us. It is your experiences and interactions we would like to hear about.

The interview should take approximately 45-60 minutes.

Verbal and Written Consent/Assent:

Before we begin, I would just like to inform you of the process. The purpose of this interview is to talk to you due to your specific role and experiences of the project, and therefore, as I have some specific questions, this will be more like a conversation.

Before we start, we would like your permission to record the interview, we will only use the recording for analysis purposes and your name will not be used in the report, or any report, but only what you may have said. In fact, no names will be used at all in any reports for this work.

IS THIS OK WITH YOU? Do you have any questions? May we proceed with the Interview? If yes, **PRESS RECORD.**

Now that we are recording, please can you give us your consent to proceed with the interview?

INTRODUCTION
Q1. Can you please provide me with the name of your group (youth adherence club, farm, clinic, CHAPs or MMC) or what type of programme (or services) you accessed from MSF? (They may not have a name!)
Q2. Can you please explain where you accessed services from, and about the process from the beginning?

PROBE – how often do you meet with them? How did the groups work? How often, how many people, who facilitated them, how were topics chosen (we need to understand how the groups were formed (mixed or separated, external facilitator etc.)
Q3. Can you explain the interactions with MSF/SHINE/CHAPs personnel? Can some of you explain some of the issues/topics you discussed. **Q3a. Also, how were the personnel you met? (on time, professional, enough information, etc.)**
Q4. Can you tell us about some of the positive aspects of accessing the services (at farm/clinic/your home/MMC) where did you go or were you part of the group (youth adherence club) (MSF project)**?**
Q5. Can you tell us about some of the negative aspects of accessing the services (at farm/clinic/your home/MMC) or being part of the group (youth adherence club) (MSF project)**?**
EFFECTIVENESS
Q6. Can you please explain what you know, and your experiences of, if any, of the following: **C. Prevention: (campaigns, condom distribution, loudhailing, tents, events, etc.)** - What worked well, and what did not work well? **D. HIV Counselling and Testing: (at clinics, at home, in tents, etc.)** - What worked well, and what did not work well? **E. Linkage to care and ART initiation:** - What worked well, and what did not work well? **F. Retention in care and adherence:** - What worked well, and what did not work well?
Q7. What can be done to make these components work better, in your opinion? PROBE: What can government (local services) do better in the delivery of these services?
Q8. Have you seen any changes in attitudes among people in the community towards getting tested? If yes, what are these? Why do you think these attitudes changed? Where did you see that?
REPLICABILITY
Q9. What lessons should be though about for taking this project to other communities or districts?
Q10. Any additional final thoughts on the project delivered by MSF and partners?

ANNEX IV. INFORMATION SOURCES

In preparing the Inception Report, a desktop review of several key project documents took place, which helped the evaluation team garner a clear understanding of the project's objectives, and assisted in informing on specific areas to include in the data collection instruments, these documents are listed in the Table below. Any additional sources referenced after the submission of the Inception Report are mentioned directly in the report as footnotes.

Documents Reviewed

Key Documents
Project documents (project narratives and annual reports; project background reports; project proposals; Logical Framework; Theory of Change plans; Performance Management Framework/Plan and field visit reports)
MSF project-related documents (operational research, publications, including studies not in the public domain)[9] - Optimizing HIV, TB & NCD Treatment in Five Sub-Saharan Africa Countries. Evaluation of DGD-Funded Projects: Guinea, Kenya, Mozambique, South Africa and Zimbabwe (2014-2016). - Hu et al. The impact of lay counselors on HIV testing rates: Quasi-experimental evidence from lay counselor redeployment in KwaZulu-Natal, South Africa. AIDS 2018, 32:2067-2073. - Shigaeva A. et al. ADVANCED HIV DISEASE IN KWAZULU NATAL, - SOUTH AFRICA, 2008 – 2018. SAAIDS Poster. - Shigaeva A. et al. Retention in care among patients in differentiated models of HIV care in KwaZulu-Natal, South Africa. Poster AIDS2020. - Getting to 90-90-90: what will it take? Perspectives and realities from the field. - Cost of community-based testing and characteristics of those tested. - Bedell R. Evaluation of community HIV testing modalities. SEU, February 2016. - Duvivier H. Uptake of differentiated models of antiretroviral therapy delivery in uThungulu district, KwaZulu Natal, South Africa. IAS 2016, poster. - Steele SJ et al. Measuring linkage to care after HIV testing in the community: preliminary analyses, challenges and next steps. KZN Research Day Poster, 2017. - Steele SJ et al. Linkage to care after HIV testing in the community in a high HIV prevalence setting. CROI poster, 2018. - Faniyan O et al. Factors associated with linkage to facility care among newly diagnosed HIV positive clients from a community HCT programme in KwaZulu-Natal. ICASA poster, 2013.
Eshowe SEU evaluation (conducted in 2016 regarding the first 90)
Eshowe Epicentre surveys (2013 and 2018)
National and regional (SA HIV national policies, SA reports) - South Africa's National Strategic Plan for HIV, TB and STIs 2017 – 2022 (NSP) - Universal Test and Treat Strategy - Primary Health Care (PHC) re-engineering strategy

[9] Documents received by Gilles Van Cutsem will be reviewed during the desk review process

UNAIDS reports

- UNAIDS. (2019). Communities at the Centre – Global AIDS Update 2019.

External literature and documentation of similar experiences:

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Sites Visited during the field visit (5-15 October 2020)

Name	Location		
	Eshowe	Mbongolwane	Other
DoH King Cetshwayo District Office (Empangeni)			X
Mbongolwane Hospital		X	
Ntumeni Clinic		X	
Siyalulama Clinic		X	
Eshowe Hospital	X		
King Dinizulu Clinic	X		
Eshowe Gateway Clinic	X		

Farm - Rocky Ridge		X	
Farm – Chase	X		
Farm – Kwamahlela	X		
Ntabantuzuma High School	X		
Bambiswano High School	X		
Mavumengwane High School		X	
TVET College	X		

Stockholm Evaluation Unit
http://evaluation.msf.org/
Médecins Sans Frontières

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