Report of the

Strategic Information Assessment In Swaziland

January 2006

Report of the

Strategic Information Assessment in Swaziland

Mbabane, Swaziland
January 2006

In support of evidence-based decisions making.

This report is intended for use by the M&E community, governmental and non-governmental organizations engaged in the provision of AIDS care and treatment services, and development partners operating in Swaziland.

A Joint Project of:

MEASURE Evaluation

United States Agency for International Development Regional HIV/AIDS Program

The Centers for Disease Control and Prevention

National Emergency Response Council on HIV/AIDS – Swaziland

Swaziland National AIDS Program/Ministry of Health and Social Welfare

Government of Swaziland

Report Prepared by:
V Kemerer, MPH
Project Manager
MEASURE Evaluation
Tulane School of Public Health
Department of International Health and Human Development
1440 Canal Street, suite 2200
New Orleans, LA 70112 USA
+504-988-3650
vkemerer@tulane.edu

This report was made possible by support from the U.S. Agency for International Development (USAID) under terms of Cooperative Agreement GPO-A-00-03-000003-00. The author's views expressed in this publication do not necessarily reflect the views of USAID or the United States Government

.

Acknowledgements

The Strategic Information Assessment in Swaziland represents a collaborative effort of HIV and AIDS M&E stakeholders. The National Emergency Response Council on HIV and AIDS (NERCHA) was instrumental in identifying and initially coordinating the assessment through a series of meetings with development partners - the Untied States Agency for International Development (USAID), the Centers for Disease Control and Prevention (CDC), the Joint United Nations Programme on HIV/AIDS (UNAIDS), and MEASURE Evaluation at Tulane School of Public Health. The Global AIDS Monitoring and Evaluation Team (GAMET) opened the process of the developing M&E Road Map to the effort, harmonizing the assessment with tasks requested and required by HIV and AIDS M&E stakeholders in Swaziland. The Ministry of Health and Social Welfare fully supported the effort through their newly formed M&E Unit and the Swaziland National AIDS Programme (SNAP) also provided support and valuable input into the effort.

The following individuals and organizations provided their time, knowledge, and guidance to shape the focus of the assessment and this report: Sibongile Maseko (Epidemiologist - M&E Unit, MOHSW) and technical staff: Nomsa Mulima and Thulani Dlamini; Marjorie Mavuso (NERCHA - M&E Coordinator) and technical staff: Thabo Hlope, Vilakati, Mboni, and Themba Ginindza; Marelize Gorgens (GAMET); Beatrice Dlamini and Rejoice Nkambile (SNAP); and Nunbulelo Dlamini (Health Planning and Statistics Unit, MOHSW).

Additionally, this effort was a collaboration and effort to pilot new tools and special recognition must be given to Shannon Salentine (Senior Research Officer, The Futures Group, MEASURE Evaluation) and Alan Johnston (Senior Data Demand and Information Use Specialist, The Futures Group, MEASURE Evaluation).

Table of Contents

List of Tables

List of Figures

List of Acronyms

AMICAALL	The Alliance of Mayors Initiative for Community Action on AIDS at the Local Level
ANC	Ante-natal clinic
ART	Antiretroviral Therapy
ARV	Anti-retrovirals
BCHA	Business Coalition Against HIV and AIDS
BMS	Bristol Myers Squibb
CANGO	Coordinating Assembly of Non-Governmental Organizations
CBO	Community-Based Organization
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control and Prevention
CMTC	Crisis Management and Technical Committee
CRIS	Country Response Information System
DFID	United Kingdom Department for International Development
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
FBO	Faith-Based Organization
GAMET	Global HIV/AIDS M&E Support Team
GFATM	Global Fund to fight AIDS, Tuberculosis, and Malaria
GOS	Government of Swaziland
HCP	Health Care Provider
HMIS	Health Management Information System
HPSU	Health Planning and Statistics Unit
IT	Information Technology
M&E	Monitoring and Evaluation
MOHSW	Ministry of Health and Social Welfare
NERCHA	National Emergency Response Council on HIV and AIDS
NGO	Non-Governmental Organization
NRC	National Research Council
NSP	National Strategic Planning Process
OI	Opportunistic Infection
OPD	Outpatient
OVC	Orphans and Vulnerable Children
PEP	Post Exposure Prophylaxis
PLWHA	Persons Living with HIV/AIDS
PMTCT	Prevention of Mother To Child Transmission of HIV
PSHACC	Public Sector HIV/AIDS Coordinating Committee
PSI	Population Services International
SHAPMoS	Swaziland HIV/AIDS Programme Monitoring System
SINAN	Swaziland Infant Nutrition Action Network
SIPAA	Support to International Partnerships against AIDS in Africa
SMO	Senior Medical Officer
SNAP	Swaziland National AIDS Programme
STI	Sexually Transmitted Infection
SWANNEPHA	Swaziland National Network of People Living With HIV and AIDS
TB	Tuberculosis
UNIADS	The Joint United Nations Programme on HIV/AIDS
UNISWA	University of Swaziland
USAID-RHAP	United States Agency for International Development-Regional HIV/AIDS Program
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

Executive Summary

Purpose of the Assessment

Strategic information – or high quality and timely information to monitor and evaluate programmes and to guide policies – is fundamental to the success of Swaziland's national HIV/AIDS program expansion. During May 2005, MEASURE Evaluation, under direction from USAID-RHAP, visited Swaziland to discuss the feasibility of an assessment to establish a baseline from which to track strategic information (SI) system development and an accountability framework for the national monitoring and evaluation (M&E) work plan. During a second visit in June 2005, key activities were defined in the National HIV/AIDS M&E Road Map through a participatory process with the Global AIDS Monitoring and Evaluation Team (GAMET), UNAIDS and Nercha that would guide the assessment.

The specific objectives of the assessment are to define data flow of national level output indicators; outline data collection, management, reduction, use, and dissemination challenges; assess the Ministry of Health and Social Welfare (MOHSW) M&E structures and institutional capacity to provide the necessary HIV/AIDS program data on a routine basis; develop a list of stakeholder groups and stakeholders by programmatic area; and develop a directory of HIV researchers, HIV research organizations, and HIV research to use as a reference resource for future partnership in conducting targeted evaluation.

Methods

The assessment utilized a variety of methods and instruments, including desk reviews and documentation, questionnaire-based interviews, and exploratory interviews.

Key Findings

1. The MOHSW has exhibited a nascent capacity for M&E of the national response to HIV/AIDS.
2. The amount of data collected versus the amount of data required for program strengthening and reporting purposes remains out of sync – a lot of unused data are collected while reports are often incomplete due to a lack of available data.
3. Data flow patterns are limited, flowing from facilities to national-level agencies that report to development partners. This results in limited use of data collected at the facility level from being used in those same facilities.

The Health Care Delivery System and Facility-based HIV/AIDS Data

The health care delivery system is operating in all four regions of the country and is divided into three levels and four facility types. The system consists of public, mission, and private health centers. A functional health management information system that consistently and reliably produces strategic information is crucial to the functioning of a health system.

To assess data collection, management, use, and reporting, health facility assessments were undertaken. These assessments targeted services provided in the health facilities, including Prevention of Mother-to-Child Transmission of HIV (PMTCT), Voluntary Counseling and Testing (VCT), Anti-retroviral Therapy (ART), Tuberculosis (TB), Sexually Transmitted Infections (STI), and Malaria. Ten facilities (of N sampled facilities) agreed to participate in the assessment.

PMTCT: Of the ten sites assessed, three clinics and two regional hospitals provide PMTCT services. Three sites record PMTCT data: two sites utilize PMTCT registers and one uses electronic patient records, which captures patient data electronically.

VCT: VCT was initiated in public facilities in 2001 and National Guidelines for VCT were developed by MOHSW in 2002. By 2005, there were 24 functioning VCT centers. The services provided in VCT centers are comprehensive and include pre-test counseling, rapid testing, post-test counseling, and referral and, when need arises, ongoing counseling. Seven of the ten assessed sites provide VCT services: two private and one government clinic and the four regional hospitals. Each site uses patient records, a general register, a dedicated register, or some combination of records and registers, to record data, indicating a lack of harmonization of data collection efforts.

ART: Since beginning in 2001, the scale-up of ART has been rapid. Six of the ten assessed sites provide ART services: two private clinics and the four regional hospitals. The sites record ART data using dedicated registers, individual patient records, and general registers. One private clinic and one government hospital record data electronically. Five sites attempt follow-up activities, which require active program monitoring and patient management.

TB: TB is a leading cause of morbidity (prevalence is estimated at 700 cases/100,000/year; case detection rate <50%) and accounted for 20% of adult institutional deaths in 1999. The prevalence of HIV among individuals presenting with TB is greater than 70%. Five of the ten assessed sites provide TB services.

STI: HIV prevalence among patients with STIs rose from 11.1% in 1992 to 47.6% in 1998. Five of the assessed sites provide STI management services: one government clinic, two government hospitals, and two private clinics. The participating sites record STI data using general registers, a dedicated STI form, and individual patient records. The two private clinics record individual patient records electronically.

Malaria: Four of the assessed sites provide malaria services. The participating sites record malaria data using an electronic individual patient record database, the OPD Register, a dedicated malaria register, and individual patient records

Data Collection & Quality

Data are collected for reporting purposes almost exclusively using facility registers. Currently the National Emergency Response Council on HIV and AIDS (NERCHA) only collects data from health facilities. NERHCA's regional offices and umbrella organizations do not have operational data collection systems in place.

Twenty-two sites participated in the reporting module, compiling a mean of 3 registers (Range: 0 – 5) per day. Five types of staff personnel are responsible for data collection: ART Educators, Counselors, Data Collectors, Laboratory Technicians, Nurses, and Receptionists. The majority completed registers on a daily basis (60%), with the remainder completing registers more frequently.

There is a long lag time between deadlines for data submission and date of data receipt. Data arrive incomplete, particularly diagnoses fields. The M&E Unit of the Swaziland National AIDS Program (SNAP) has not yet developed a data quality assessment plan. The Sexual and Reproductive Health Unit (SRHU) does not have a written protocol for data quality. After data are compiled it reviews the data, but does not actually do anything if a problem is identified during the review.

Data Analysis

Data analysis is limited to data reduction and summarization for reporting purposes to the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM). No data analysis activities or data analysis plans, outside of compilation and reduction of counts for the purposes of reporting, were identified during this assessment.

Reporting

Seventeen of the assessed sites (77%) produce a mean of 3 reports (Range: 0 – 9) per month. Registers used in the health facilities are compiled into monthly summary sheets which are reported to either to senior administration at the facility (hospitals) or are taken to monthly meetings with representatives from MOHSW and international development partners where they are hand delivered.

Data Flow, Reporting, and Management

Currently the primary goal of the M&E Unit (SNAP) is to establish a routine HIV/AIDS HMIS that would collect data to monitor the health sector response. HIV/AIDS data are collected vertically and are linked to the national HMIS through the use of a standardized OPD Register.

The data flow mapping exercise is focused on mapping existing data flows and not planned data flows. By only mapping documented, routinely collected and reported data elements to output level indicators identified in the National Multi-Sectoral Response to HIV/AIDS M&E Framework, the assessment provides the necessary information to conduct a type of data collection gap analysis. Such an analysis would allow NERCHA and SNAP/MOHSW to focus their attention on developing

registers and methods to collect routine data to feed into the identified national output level indicators.

SNAP receives VCT, PMTCT, ART, CHBC, and STI data. These data are not yet integrated into the same routine data collection system in use by other health sector data. Data are not yet flowing into the M&E Unit (SNAP) from the facilities (with the exception of last quarter's ART data), the HPSU, SNAP, nor NERCHA. Data flow from facilities towards predetermined indicators using MOHSW-produced registers and facility-produced registers. Data collected from facilities for GFATM reporting pass through NERCHA and then to SNAP and GFATM. Since NERCHA is the GFATM principal recipient, most of NERCHA's reporting is to GFATM, and therefore relies on health-sector data sources.

Guidelines

Half (11/22) of the sites assessed reported that their facility did not have a written policy on confidentiality and one site reported that it was not certain whether or not there was such a policy.

Confidentiality guidelines (except for that which has been articulated for the purposes of VCT) and data security guidelines were not identified by this assessment.

Research Directory

There are efforts to establish a mechanism to coordinate and widely disseminate HIV/AIDS research in Swaziland. Although operations research is conducted, few programs disseminate findings of this research to stakeholders. National research priorities need to be identified. Currently, there is no research inventory of the studies that have been conducted, of research institutions, or researchers conducting research in Swaziland.

Next Steps

The first step to address the above issues is to develop a research directory of HIV/AIDS research organizations, HIV/AIDS researchers, and HIV/AIDS research conducted in Swaziland. To this end, MEASURE Evaluation has partnered with NERCHA and the University of Swaziland to develop this research directory.

1. SWAZILAND – OVERVIEW

The 2004 Swazi population was estimated to be approximately 1.1 million; 46% of the population are between the ages 15-49 years; 55% are female; and roughly two-thirds live below the poverty line (MOHSW, UNDP, NERCHA, HAPAC, World Bank, UNFPA, et al., 2005). Swaziland ranks 137 on The Human Development Report 2004, despite being classified as a lower middle-income developing country (MOHSW, UNDP, NERCHA, HAPAC, World Bank, UNFPA, et al., 2005; HDA, Draft). Swaziland is bilingual, with siSwati and English as official languages. Swaziland has an area of 17,364 km^2 and is divided into four regions (Hhohho, Lubombo, Manzini, and Shiselweni) and 55 Tinkhundla, headed by an Indvuna appointed by His Majesty the King. Each Nkhundla is comprised of several chiefdoms, formed by clusters of homesteads (MOHSW, UNDP, NERCHA, HAPAC, World Bank, UNFPA, et al., 2005).

2. HIV/AIDS IN SWAZILAND

The first diagnosis of HIV in the Kingdom of Swaziland was reported in 1986 (MOHSW, UNDP, NERCHA, HAPAC, World Bank, UNFPA, et al., 2005). The first case of AIDS was reported in 1987 (MOHSW, 2001), and HIV/AIDS was declared a national disaster in Swaziland in 1999 (Kelly & Magongo, 2004).

A sentinel surveillance system to monitor the proportion of pregnant women attending ante-natal care (ANC) clinics who are infected with HIV has been instituted since 1992 (MOHSW, 2001). More than 90% of pregnant women are reported to make contact with ANC services at least once during pregnancy (MOHSW, UNDP, NERCHA, HAPAC, World Bank, UNFPA, et al., 2005; SHRU & UNFPA, n.d.). ANC-based HIV sero-prevalence has risen from between 3.0% (MOHSW and WHO, 2003) and 3.9% (MOHSW, 2001; MOHSW, UNDP, NERCHA, HAPAC, World Bank, UNFPA, et al., 2005) in 1992 to 42.6% in 2004 (MOHSW, UNDP, NERCHA, HAPAC, World Bank, UNFPA, et al., 2005), making it the country with the highest prevalence rate among pregnant women seeking services at an ANC clinic in the world (HDA, Draft; USAID & CDC, 2004).

All of Swaziland's four regions have similarly severe epidemics (MOHSW, UNDP, NERCHA, HAPAC, World Bank, UNFPA, et al., 2005; HDA, Draft). The HIV/AIDS epidemic affects the most productive part of the population, those between 15 to 49 years of age, while teenage girls (15-19 years old) and women (20-29 years old) are the most impacted members of the population (47.38% for young women and 18.27% for young men) (MOHSW, 2001; MOHSW, UNDP, NERCHA, HAPAC, World Bank, UNFPA, et al., 2005; USAID, 2004b).

As the epidemic matures, the impact is becoming visible through an increasing number of patients coping with opportunistic infections (OIs), an increase in mortality rates, and a rapidly growing population of orphans and vulnerable children (OVC) and persons living with HIV and/or AIDS (PLWHA) (MOHSW, UNDP, NERCHA, HAPAC, World Bank, UNFPA, et al., 2005). The most common OIs include tuberculosis, *Pneumocystis carinii* pneumonia, cryptococcal meningitis, and candidiasis (MOHSW and WHO, 2003).

About 40,000 women deliver annually in Swaziland, resulting in an estimated 6,000 babies infected with HIV annually (MOHSW, 2005). Roughly 35,000 children have been orphaned by the pandemic; 60% of hospital patients are suffering from AIDS related diseases; and AIDS attributable mortality could reach over 21,000 in 2015. It is estimated that the population will be 41% lower in 2015 than it would have been in the absence of HIV/AIDS (USAID, 2004b).

The main factors driving the epidemic in Swaziland include multiple, concurrent sexual partnerships and the young age of sexual debut, especially among women (MOHSW and WHO, 2003; MOHSW, FHI, USAID, and FLAS, n.d.; USAID & CDC, 2004). Halting the epidemic is stymied by conservative religious and traditional beliefs against condom use alongside social acceptance of multiple partners in both monogamous and traditional polygamous relationships. Poverty, unemployment and continued economic decline are present (USAID, 2004a).

3. PURPOSE OF THE ASSESSMENT

Strategic information – or high quality and timely information to monitor and evaluate programs and to guide policies – is fundamental to the success of Swaziland's national HIV/AIDS program expansion.

The need for a national strategic information systems assessment was initially discussed during a meeting in Pretoria, South Africa, in March 2005 with NERCHA, MOHSW, The Joint United Nations Program on HIV/AIDS (UNAIDS), Centers for Disease Control and Prevention (CDC), and MEASURE Evaluation. During May 2005, MEASURE Evaluation, under direction from USAID-RHAP, visited Swaziland to discuss the feasibility of an assessment, and during a second visit in June 2005 identified key activities defined in the National HIV/AIDS M&E Road Map that would guide the assessment.

The National HIV/AIDS M&E Road Map is a national, integrated action plan to operationalize Swaziland's HIV/AIDS M&E strategy. It was developed in June 2005, and approved by the national Monitoring and Evaluation Technical Working Group at a meeting on 22 June 2005. The National HIV/AIDS Road Map allows NERCHA's M&E Unit, MOHSW, development partners providing M&E support and technical assistance, other public sector institutions, private sector companies, non-governmental organizations, community-based organizations, and faith-based organizations to align their M&E processes, and to collectively develop a synchronized, integrated, and comprehensive national HIV/AIDS M&E System.

The specific activities of the assessment were also activities the national HIV/AIDS M&E Road Map had identified as necessary. Therefore, the assessment is considered indispensable and a valuable contribution to the national HIV/AIDS M&E system.

The specific objectives of the assessment were to:

1. Define data flow of national level output indicators from HIV implementers, coordination structures (regional HIV/AIDS structures and umbrella organizations), Government of Swaziland (GOS), and international development partners.
2. Outline data collection, management, reduction, use, and dissemination challenges from implementers to umbrella organizations to development partners and NERCHA.
3. Assess the MOHSW M&E structures' mandate and institutional capacity of health facilities to provide the necessary HIV/AIDS program data on a routine basis.
4. Identify all MOHSW partners (including NERCHA), the indicators required for reporting purposes, and map those indicators to MOHSW and its funders.

5. Develop a list of stakeholder groups[1] and stakeholders[2] by programmatic area (see Table 2: Programmatic Areas Identified in the National M&E Framework) and identify the most appropriate dissemination channel by stakeholder for each data source[3] and each M&E information product[4] that were defined in the national HIV/AIDS M&E Strategy.

6. Develop a directory of HIV researchers, HIV research organizations, and HIV research to use as a reference resource for future partnership in conducting targeted evaluation (outcomes research/essential research) activities and to assist Swaziland in developing a coherent research agenda.

The assessment was intended to establish a baseline from which to track strategic information system development and an accountability framework for the national M&E work plan: the "M&E of M&E". In this way, a coordinated "one M&E" approach to building capacity for production and use of information products is greatly facilitated.

Methods

The assessment utilized a variety of methods and instruments, including desk reviews and documentation, questionnaire-based interviews, and exploratory interviews. Participants were selected based upon their involvement in data collection, use, management, and/or reporting. (See Appendix 7: Methods and Appendix 8: MOHSW/SNAP Data Flow Facility Assessments Questionnaire.)

[1] Stakeholder groups: Coordinating bodies, regional structures
[2] Stakeholders: HIV implementers
[3] A **data source** is defined as any data set that has been collected through a survey or a standardised data collection process and that would provide indicator values at specific points in time. The national HIV/AIDS M&E strategy defines the following data sources: biological surveillance, population-based (non-biological) surveillance, national workplace survey, health facility survey, national HIV/AIDS Programme Monitoring System (HAPMoS), MOHSW HIV/AIDS monitoring system, school-level data collection system for life skills education, and the monitoring systems of HIV/AIDS implementers.
[4] An **M&E information product** is defined as a regular, routine, and standard report that the NERCHA produces at predefined intervals and in which it provides information about the progress made with the national HIV response by presenting the latest indicator data, and by interpreting such indicator data for use by HIV implementers, intervention planners and decision makers, such as: Quarterly HIV/AIDS service coverage report, annual HIV/AIDS M&E report, and biennial UNGASS report

4. KEY FINDINGS AND RECOMMENDATIONS

Key findings were identified prior to the assessment's validation workshop. Participants were divided into three groups to discuss whether or not they agreed with the findings and why, to revise and finalize the findings, and then to form recommendations to address those findings.

Below are key findings finalized during the workshop. These findings are presented with the groups' consensus for agreement or disagreement, and recommendations.

1. MOHSW Capacity for M&E of the national response to HIV/AIDS:
    - ❒ In the face of inadequate fiscal and human resources, MOHSW has successfully adhered to its mandate.
    - ❒ MOHSW is further operating under a health sector plan, is reviewing it, and is developing a road map before the health sector plan expires. MOHSW is also developing an M&E framework.
    - ❒ MOHSW needs to link its HIV/AIDS data to the HMIS in order to support its entire mandate and not simply develop vertical systems for interlocking programmatic areas.
        - ❒ Group consensus: Information has been disseminated and all programs being introduced are set to begin operations or are functioning. The framework must act as a guideline for the sake of uniformly collecting, managing, and reporting data. It is difficult for facilities to obtain information directly from MOHSW.
        - ❒ Recommendations:
            A. MOHSW needs to establish clear communication channels to contact matrons and senior medical officers (SMOs) on patient/nursing issues
            B. Data clerks are necessary to ease the burden of nurses who are responsible for data collection, management, and reporting.
            C. Coordinating opportunities for facilitating data collection, management, and reporting.
            D. MOHSW needs to provide more information, resources, and training about M&E for all health care providers (HCPs).
            E. Develop a common database that is accessible and is for use by all health care facilities.
            F. Train all HCPs to use computers and relevant database software, such as Microsoft Excel and Access.
2. The amount of data collected versus the amount of data required for program strengthening and reporting purposes:

- ❒ Amount of data currently identified to be collected via registers and forms versus the amount of data needed for patient and program monitoring and reporting purposes
- ❒ The assessment identified 27 registers for collecting data relevant to HIV/AIDS, with a median of 3 (range 0 – 5) registers completed per day per site.
- ❒ There are a large number of core output-level indicators for which data are not being currently collected. Similarly, there are a large number of data elements that do not feed into the core national output-level indicators.
    - ❒ Group Consensus: Reporting demands and duplication of information generates a surplus of data elements, which results in limited data capture and analyses. Further, core data elements are obscured and difficult to identify. Registers need to be reviewed and revised so that each data element either feeds directly into a core national indicator or is used directly for on-going monitoring and program management purposes. A national health sector M&E coordinating unit needs to be responsible for reconciling data currently collected and data needed with the data that is required for reporting and program management purposes.
    - ❒ Recommendations:
        A. Develop a national health sector M&E framework – with a specific unit mandated to coordinate it – based on the following information:
            i. Programs operating in Swaziland
            ii. Indicators into which each program would feed data
            iii. Human capacity
            iv. Financial information
        B. Utilize information from this assessment to establish a Program Management Unit in the MOHSW that has its own budget and authority

3. Data flow patterns:
    - ❒ Data are collected and often reported, but do not feed into their appropriate indicators.
    - ❒ Data are perhaps not reaching their intended target due to the fact that the data flow channels are not clearly defined.
    - ❒ Data flow only in one direction.
        - ❒ Group Consensus: These findings reflect a need for education, advocacy, and supervision among those expected to collect and process data on the utility and importance of strategic information to inform decisions. This is not a once-off event, but rather an on-going process to introduce and develop systematic data flow step-by-step. Additionally, data use needs to occur at the clinic level.

- ❒ Recommendations:
    A. Hire data entry clerks at the clinic level who would be responsible for data entry, compilation, and descriptive analysis.
    B. Develop an electronic HMIS that stores data at the regional and national level
    C. Develop data dissemination and auditing guidelines
    D. Define individual roles and responsibilities relevant to data collection and use and actively train and supervise those individuals.
    E. Identify data needs.

5. HEALTH FACILITY DATA – COLLECTION, MANAGEMENT, USE, AND REPORTING

5.1. The Health Care System

The health care delivery system is operating in all four regions of the country and is divided into three levels and four facility types. (See Appendix 3: Institutional Inventory Lists)

The health care system consists of public, mission, and private health centers. (See Appendix 5: Health Care Delivery System) The system is highly accessible with 80% of the population residing within eight kilometers of a health care unit and over 60% able to access a health care unit within one hour. Additionally, the private health care sector is a major stakeholder: physicians in private practice or industry account for almost 50% of all physicians; there are two privately run hospitals; and just over 100 care services points run by private, NGO, or industry clinics (MOHSW, UNDP, NERCHA, HAPAC, World Bank, UNFPA, et al., 2005; HDA, Draft).

5.2. Routine Health Facility-based HIV/AIDS Service Statistics

A functional health management information system (HMIS) that consistently and reliably produces strategic information is crucial to the functioning of a health system. Health service information reflects the coverage, quality, and efficiency of health services and includes general health service data, vertical program data, and administrative data. Health service data are gathered routinely. Data flow from the health care unit level (clinic, health center or public health unit, hospital) to the regional office and onto the Health Planning & Statistics Unit (HPSU) in the MOHSW (MOHSW, UNDP, NERCHA, HAPAC, World Bank, UNFPA, et al., 2005; World Bank, 2004). Although HIV/AIDS data are captured at the health care unit level, and some of these data flow to the regional level, there is not an HIV/AIDS HMIS in place.

The role of the HPSU in the HMIS is not yet formalized. Data capturers at the regional level are responsible for collecting outpatient and some inpatient data. Data at the health care unit level are collected by facility staff, including both nursing and clerical staff, and are then sent to the regional level (World Bank, 2004).

5.3. Health Facility Assessments

Of the sixteen facilities sampled, ten facilities (62.5% of sampled facilities) agreed to participate in the assessment. Four regional hospitals participated: two government hospitals, one government-mission partnership hospital, and one mission hospital. Twenty different sections of service provision were assessed in these four hospitals through 17 separate interviews. Four clinics (two

government and two private) and one mission-run palliative care site also participated. This resulted in 22 separate assessments.

5.3.A. Prevention of Mother-To-Child-Transmission of HIV

Mother-to-child transmission accounts for 10% of total transmissions in developing countries and is now largely preventable. The Swazi PMTCT program was officially launched in March 2003 and was integrated in the SNAP and is operating under SRHU. MOHSW is promoting PMTCT-Plus to ensure a comprehensive baby-parents care package (MOHSW and WHO, 2003; HDA, draft). The current PMTCT sites include:

- 17 Nazarene clinics supported by UNICEF
- 4 Hospitals
  - Good Shepherd Hospital
  - Mankayane Government Hospital
  - Mbabane Government Hospital
  - Raleigh Fitkin Memorial Hospital
- 3 Government clinics

At Mbabane Government Hospital the community component of PMTCT has started, with community educators used for door-to-door visits. This is part of a pilot operational research and community program in PMTCT-Plus supported by Bristol Myers Squibb's "Secure the Future" program (MOHSW, 2005).

Coverage remains very limited and many health sector staff have limited knowledge about PMTCT, and its roll-out strategy (HDA, Draft), and they have expressed confusion about whether or not PMTCT is currently operational.

Of the ten sites assessed, three clinics and two regional hospitals provide PMTCT services. Three sites record PMTCT data: two sites utilize PMTCT registers and one uses electronic patient records. Only the electronic patient records capture data electronically.

Table 1: Methods of Recording PMTCT Data

Data Element	PMTCT Registers	Individual Patient-Held Record
HIV pre-test counseling information	√	√
HIV testing information	√	√
HIV status of the mother	√	√
TB status of the mother		√
Post-test counseling information	√	√
ARV prophylaxis for the mother		√
HIV infant testing		√
ARV prophylaxis for infant		√
Mother infant feeding intention		√
Breast Feeding Counseling		√

PMTCT reports flow from hospital-based facilities to the project coordinator at Elizabeth Glazer Pediatric AIDS Foundation (EGPAF) or at Swaziland Infant Nutrition Action Network (SINAN) or to the hospital senior medical officer, who then reports to SRHU at SNAP and also to NERCHA. Government clinics report to the senior matron at the regional public health center, which reports to SNAP.

5.3.B. Voluntary Counseling and Testing

VCT was initiated in public facilities in 2001 and National Guidelines for VCT were developed by MOHSW in 2002 (MOHSW and WHO, 2003; USAID & CDC, 2004). The MOHSW VCT roll out and expansion strategy targets establishment of VCT and care-integrated centers in all inpatient facilities, free-standing VCT centers with outreach to rural communities, and integrated VCT services (MOHSW and WHO, 2003).

By 2005, there were 24 functioning VCT centers, including 18 centers integrated within health services, five free-standing VCT centers and one permanent mobile unit established in partnership with the private sector. All VCT centers provide outreach VCT services. Regionally, VCT centers are well distributed: seven centers in Manzini, five in Hhohho, six in Lubombo, and three in Shiselweni (HDA, Draft; MOHSW, 2005).

The services provided in VCT centers are comprehensive and include pre-test counseling, rapid testing, post-test counseling, and referral and, when need arises, ongoing counseling. The number of clients has increased by 122 percent from 2003 to 2004. All personnel working in VCT centers have been trained. In every VCT centre, there are at least two trained counselors and one receptionist (MOHSW, 2005).

Seven of the assessed sites provide VCT services: two private and one government clinic and the four regional hospitals. Each site uses patient records, a general register, a dedicated register, or some combination of records and registers, to record data.

On a quarterly basis VCT reports are sent from the hospital:

- ❒ Directly to SNAP and NERCHA
- ❒ Through the SMO to SNAP
- ❒ Through the Regional AIDS Office to the HIV/AIDS Prevention and Care Program (HAPAC)
- ❒ Through the hospital's senior matron to SNAP

Government clinics report to the senior matron at the regional public health center, who then reports to SNAP on a quarterly basis. Private clinics report directly to SNAP and to the World Health Organization (WHO) on a quarterly basis. Additionally, reports are sent directly from Population Services International (PSI)-funded facilities to PSI-Swaziland.

Table 2: Number of Sites Collecting Data Elements for VCT

Data Elements	Number of sites collecting (n = 7)
Received pre-test counseling	6
HIV/AIDS test performed	5
HIV/AIDS status recorded	6
Received post-test counseling	5
TB status	5

5.3.C. Anti-Retroviral Therapy

Since beginning in 2001, the scale-up of ART has been rapid. Within each ART center, patient numbers have increased dramatically. All six centers reported having to increase operating times and dates in order to service the increased demand. ART first started at the HIV/AIDS referral clinic in Mbabane General Hospital in late 2001 but it was not until November 2003 that ART was offered free of charge to the public. All seven hospitals have reportedly started ART. No national reports on ART uptake were available and there is a need to introduce cohort analysis into a national reporting system (USAID & CDC, 2004).

At present, and with financial support from the Swazi Government and GFATM, ART is provided freely in six public and mission hospitals in the country (Mbabane Government Hospital and Piggs Peak Government Hospitals in Hhohho region, Raleigh Fitkin Memorial Hospital and Mankayane Government hospitals in Manzini region, Good Shepherd in Lubombo region and in Hlatikulu Government Hospital in Shiselweni region) (MOHSW, 2005).

Technical guidelines on the use of anti-retrovirals (ARVs) have been developed and a training program on ARV use was initiated in 2002 (MOHSW and WHO, 2003). Anti-retroviral therapy M&E has been included in the National Multi-sectoral HIV/AIDS Response M&E Framework. However, record-keeping tools still need to be put in place and reporting forms developed. The strategy for monitoring drug resistance has not yet been initiated (MOHSW, 2005).

Swaziland initiated its ART program in January 2004. The national target as defined by the Swazi Government was 13,000 HIV/AIDS patients on ART by the end of 2005. To date Mbabane Government Hospital has registered approximately 6,000 HIV-positive patients and approximately 3,000 have been started on ART (these numbers could not be confirmed). More that 50 percent of all HIV/AIDS patients who have been enrolled in ART program are accessing treatment at the Mbabane Government Hospital (MOHSW, 2005).

In addition to the establishment of a multi-sectoral Technical Working Group on ART, the Ministry of Health and Social Welfare developed a plan to roll out ART in the country consisting of three phases:

1. Establishment of ART centers in major hospitals in the country
2. Expansion of ART service delivery to all health centers and to some private company clinics
3. Continuation of coverage of private clinics as well as public clinics (MOHSW, 2005).

Six of the ten assessed sites provide ART services: two private clinics and the four regional hospitals. The sites record ART data in the following manner:

- ❒ One mission hospital uses dedicated register
- ❒ Two private clinics use individual patient records
- ❒ Three government hospitals use individual patient records, general register, and dedicated register.

One private clinic and one government hospital record data electronically.

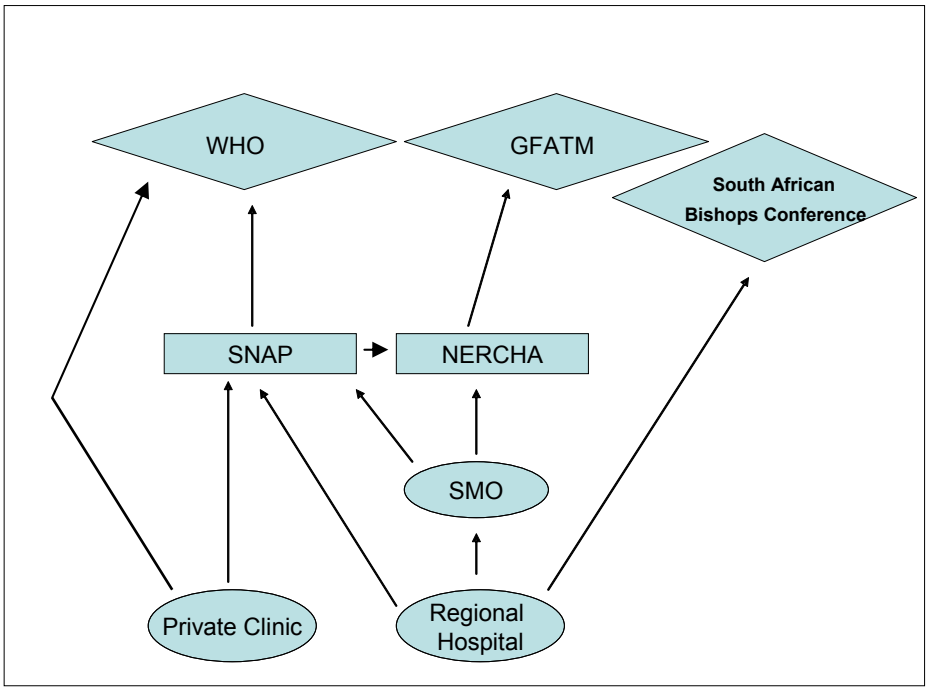
Table 3: Number of Sites Collecting Data Elements for ART

Data Elements	Number of sites collecting (n = 6)
HIV status	4
CD4 count	5
Viral Load	1
Opportunistic infections diagnosed and/or treated	5
TB status	4
ARV medications taken	5
Adverse reactions to medications	5
Clinical staging	5
AIDS related mortality	3
Patient follow-up information	5

Five sites attempt follow-up activities, which require active program monitoring and patient management, using the following methods:

- ❒ Health education prior to initiation
- ❒ On-going visitations
- ❒ Patients telephoned
- ❒ Education of family caregivers to ensure that they know when to refill ARVs
- ❒ Daily attendance register that is used to identify those who miss appointments; the patient is then visited by hospital personnel
- ❒ Adherence counseling for clients taking ARVs provided every time client returns for refills.

Figure 1: Reporting Flow of Client ART Data



5.3.D. Post-Exposure Prophylaxis

Four of the ten assessed sites provide post-exposure prophylaxis (PEP) services: two government hospitals and two private clinics. The sites record PEP data in the following manner:

- ❒ Two private clinics use individual patient records
- ❒ Two government hospitals use individual patient records and general registers

One private clinic uses its electronic patient record-keeping database to record data electronically. Data include HIV status, laboratory tests conducted, and patient follow-up.

The assessment failed to identify any reporting for PEP.

5.3.E. Tuberculosis

Tuberculosis is a leading cause of morbidity (prevalence estimated at 700 cases/100,000/year; case detection rate <50%) and accounted for 20% of adult institutional deaths in 1999. The prevalence of HIV among individuals presenting with tuberculosis is greater than 70% (MOHSW and WHO, 2003).

Five of the ten assessed sites provide tuberculosis services: one private clinic, three government hospital tuberculosis wards, and one government-based outpatient clinic. However, the outpatient clinic declined to participate. The participating sites record tuberculosis data in the following manner:

- ❒ Outpatient register
- ❒ MOHSW National Tuberculosis Program Tuberculosis Register

Hospitals and outpatient clinics report tuberculosis information. From hospitals, the reports flow to the National Tuberculosis Program. From the Outpatient clinics, reports move to the regional health office, the MOHSW HPSU, and then to SNAP.

5.3.F. Orphans and Vulnerable Children

Two of the four assessed hospitals – one mission and the other a government-mission partnership – provide care for inpatient orphans. Neither hospital collects OVC-specific data.

The assessment failed to identify any reporting for OVCs. The United Nations Children's Fund (UNICEF) held a week-long workshop in September 2005 to develop monitoring and evaluation systems for OVCs.

5.3.G. Sexually Transmitted Infections Care

HIV prevalence among patients with STIs rose from 11.1% in 1992 to 47.6% in 1998. Young people between 15–24 years of age are the group most affected by STIs (MOHSW and WHO, 2003). Prevalence of syphilis among women attending ANC sites declined from 11.6% in 1992 to 4.2% in 2002 and then roughly doubled to 8.1% in 2004 (MOHSW, UNDP, NERCHA, HAPAC, World Bank, UNFPA, et al., 2005).

Five of the ten assessed sites provide STI management services: one government clinic, two government hospitals, and two private clinics. However, the outpatient clinic, which provides STI management in one of the government hospitals, declined to participate. The participating sites record STI data in the following manner:

- One government clinic and two government hospitals use general registers
- One government clinic uses a dedicated STI form
- Two private clinics use individual patient records.

The two private clinics record individual patient records electronically.

Table 4: Number of Sites Collecting Data elements for STI Care

Data Elements	Number of sites collecting (n = 5)
Laboratory diagnosis	0
Syndromic diagnosis	3
STI laboratory tests performed	0
Names of STI laboratory tests performed	0
Sufficient availability of appropriate medicines	0

STI reports are submitted to the regional health office, which then reports to the MOHSW Statistics Unit. Government clinics report to the senior matron at the regional public health center, which then reports to SNAP. Private clinics report directly to SNAP and to WHO on a quarterly basis.

5.3.H. Laboratory Services

Six of the ten assessed sites provide laboratory services: three hospitals – two government, and one government-mission partnership – each having general and VCT-specific laboratory services, and one private clinic. The participating sites record laboratory service data in the following manner:

- The government and the government-mission partnership hospitals' VCT laboratories uses a dedicated register
- One government hospital laboratory uses a dedicated register and the other uses both a general and dedicated register
- The government-mission partnership hospital laboratory uses individual patient records, a general register, and a dedicated register
- The private clinic uses electronically-based individual patient records

Table 5: Number of Sites Collecting Data Elements for Laboratory Services

Data Elements	Number of sites collecting (n = 6)
HIV testing done on site	6
CD4 count done on site	2
Viral load done on site	1
Lymphocyte test done on site	3
TB Sputum smear done on site	4
Syphilis testing done on site	4
Gonorrhea culture done on site	4
Gonorrhea slide done on site	4
Chlamydia testing done on site	1

Hospital-based laboratories either submit reports directly to the Central Laboratory or the hospital statistics office, which submits to the SMO who then reports to SNAP and NERCHA.

5.3.I. Community Home-Based Care

The high level of HIV infection means that a large number of people require treatment, care, and support services which can no longer be offered solely in health facilities. Community and home based care (CHBC) is defined as care given to the sick and those affected in their communities and homes, and care extended from the hospital or health facility to the homes through family participation and community involvement. Community and home-based care guidelines have been developed by the MOHSW to guide, harmonize, and strengthen coordination of these efforts, (MOHSW and WHO, 2003; HDA, Draft; MOHSW, 2005), but a number of delivery models are being implemented, including use of rural health motivators (RHMs) and hospital outreach utilizing health care providers who provide community outreach and limited palliative care services (HDA, Draft).

CHBC guidelines, developed in November 2002 by the MOHSW, include clear guidance on the purpose, implementation and monitoring of CHBC (USAID & CDC, 2004). Core elements of CHBC in Swaziland include:

- ❒ Palliative care (treatment to relieve pain and other distressing symptoms in people suffering from incurable and terminal illness)
- ❒ Basic physical care
- ❒ Treatment of common health conditions
- ❒ Health and environmental education
- ❒ Psychosocial and spiritual support
- ❒ Material support including basic medicines and other supplies
- ❒ Infection control
- ❒ Discharge planning
- ❒ Referral (SNAP, 2004).

The first national palliative care strategy (implemented in 2000) was drafted by SNAP under the leadership of the clinical coordinator of the national HIV referral center in Mbabane and is expected to be reviewed in 2006. There are currently no national standards or protocols for palliative care, training guidelines or systematic palliative care training for pre- and in-service professional health care workers (including pharmacists) or for informal community health workers (USAID & CDC, 2004).

Four of the ten assessed sites provide community home-based care: two government clinics, one mission hospital, and one government hospital. The participating sites record CHBC data in the following manner:

- ❒ One government clinic uses a dedicated register
- ❒ One mission hospital uses individual patient records and a dedicated register
- ❒ One government hospital uses individual patient records, a dedicated register, and a general register

None of the sites records CHBC data electronically.

CHBC reports flow from the hospital, to the regional CHBC coordinator, who submits it to HAPAC and SNAP, which shares the information with NERCHA. CHBC reports also flow from the hospital to the SMO in the hospital. The SMO then submits the reports to SNAP, which shares the reports with NERCHA. Government clinics report to the Senior matron at the regional Public Health Centre who then reports to SNAP, and the reports are shared with NERCHA.

One of the sites assessed provides palliative care in a quasi home-based setting. Individual patient records tracks pain medications and prophylaxis for opportunistic infections taken by patients. The site uses both a paper-based system and Access database for patient management and reporting.

The palliative care site reports to Caritas International, the South African Bishops Conference, and to the Catholic Church Diocesan Administration, Swaziland.

5.3.J. Nutrition

Nutrition education gives PLWHA the opportunity to develop healthy eating habits and to take action to improve food security (cultivation, storage, and cooking) in the home. The national guidelines on nutrition and HIV/AIDS were developed by the National Nutrition Council in 2003 (MOHSW and WHO, 2003).

Four of the ten assessed sites provide nutrition services: one government clinic, two private clinics, and one mission hospital. The government clinic abandoned the World Vision register when food delivery became irregular. The two private clinics record data in individual patient records. The mission hospital uses individual patient records and a dedicated register.

The assessment failed to identify any reporting for nutrition services.

5.3.K. Rehabilitation

Of the ten sites sampled, only one private clinic and one government hospital provide rehabilitation services. The government hospital uses individual patient records and a general register to record the following data elements:

- ❒ Age
- ❒ Gender
- ❒ Location
- ❒ Diagnosis
- ❒ Inpatient or outpatient

The private clinic assessed only records data in an electronic individual patient record database.

The assessment failed to identify any reporting for rehabilitation services.

5.3.L. Blood safety

Blood screening for HIV was initiated in 1987. Efforts to improve the availability of safe blood include the renovation of the blood bank, establishment of a Red Cross partnership, and the move towards giving the program a semi-autonomous status (MOHSW and WHO, 2003).

Only one private clinic engages in a blood safety program. No data are collected.

5.3.M. Malaria

Four of the ten assessed sites provide malaria services: two government clinics and two private clinics. The participating sites record malaria data in the following manner:

- ❒ The two private clinics use an electronic individual patient record database
- ❒ One government clinic uses the outpatient register

- One government clinic uses the outpatient register, a dedicated malaria register, and individual patient records.

Table 6: Number of Sites Collecting Data Elements for Malaria Services

Data Elements	Number of sites collecting (n = 4)
Malaria – severe anemia	2
Malaria – uncomplicated	2
Malaria cases per week	1
Malaria treatment available per week	1
Referrals for malaria	1
Number of deaths attributable to malaria per week	1
Complications	1

Government clinics report to the senior matron at the regional public health center, who is then expected to report to SNAP. Malaria data also come from the field to the MOHSW Malaria Program manager. NERCHA extracts data from the Malaria Program Manager to report to GFATM.

5.4. Data Collection

Data are collected for reporting purposes almost exclusively using facility registers. The data from these registers are compiled onto monthly summary sheets which are then reported. (See: Appendix 2: Health Sector Registers Collecting HIV/AIDS Data) Depending on whether the monthly summary sheets are submitted to the regional health office or HPSU determines at which level (regional or national) the data are entered into an Access database. Currently, HPSU travels to collect the monthly summary sheets, but the M&E Unit (SNAP) M&E officers may assume this responsibility. (See: Section 5.4.C. Reporting)

Currently NERCHA only collects data from health facilities. NERCHA's regional offices and umbrella organizations do not have operational data collection systems in place.

NERCHA is attempting to implement an impact mitigation national HIV/AIDS MIS using two databases – District Health Information Software System (DHIS), which is Access based, and the Country Response Information System (CRIS). Part of the process includes opening NERCHA regional offices. Implementers, especially those not receiving funding through NERCHA, are reluctant to report. Currently, NERCHA is also collecting health-sector response data to report to GFATM and maintaining it in the DHIS.

A Swaziland national HIV/AIDS program Monitoring System (SHAPMoS) was created to ensure that NERCHA collects all necessary non-health sector output level data for the national HIV/AIDS M&E system (GAMET, 2005).

The SRHU manages reporting on four different PMTCT registers and/or reporting forms: EGPAF; UNICEF; Good Shepherd Hospital, and the SNAP PMTCT Monthly Summary Forms, which is used exclusively by the Red Cross. Data from these different registers are compiled manually at SHRU and then entered into a MS Word table. The last table completed by SHRU was in October 2004. These data are supposed to be delivered to the M&E Unit (SNAP). Prior to the M&E Unit (SNAP)'s formation, these data were reported to NERCHA, WHO, and the MOHSW upon request.

In the future, the M&E Unit (SNAP) expects that reports will be submitted first to their unit and then the data will be submitted to HSU.

SNAP was able to identify some of the monthly reports due to its program coordinators:

Table 7: Number of Monthly Reports Due to SNAP

Programmatic Area	Number of reports/month
ART	16
CHBC	***
PEP	11
STI	***
VCT	30

HPSU, the M&E Unit (SNAP), and SHRU were not able to identify the number of monthly reports due to HPSU nor the number actually received.

Twenty-two sites participated in the reporting module, compiling a mean of 2.4 registers (Range: 0 – 5) per day. Six types of staff personnel are responsible for data collection: ART educators, counselors, data collectors, laboratory technicians, nurses, and receptionists. The majority completed registers on a daily basis (60%), with the remainder completing registers more frequently than on a daily basis.

Most sites (60%) responded that instructions were available and were easy to understand. Only three sites reported ever having run out of registers and that replacements were available between one and two weeks. All staff responsible for maintaining the registers and compiling them into monthly summary sheets responded that they were responsible for analyzing the data.

Eight sites (36%) reported that they receive feedback on the quality of their data collection from clinic supervisors, National TB Program, project managers, regional sisters (nurses working at the regional level), and WHO. Frequency of this feedback ranges from rarely, weekly, whenever there are problems, monthly, quarterly, to annually.

Three sites (14%), one of which is the SMO who compiles data, use a computer for data entry. The two non-SMO sites use Access for data management.

Only one site had specific data entry staff, but this staff also had other responsibilities, including coordination of patients' movement through the facility. Twenty sites (96%) reported that staff responsible for data collection and data entry had had no formal data collection, entry, or management training.

5.4.A. Data Quality

The HPSU reports that there is a long lag time between deadlines for data submission and date of data receipt. The estimated data submission delay ranges from 3 to 6 months. It is difficult to quantify the exact delay as there are no processes in place to register data as they are received. The 2001-2002 report is available but has not been published and the 2003 report has not been produced due to flawed data entry for the Shiselweni region. Data are available through April 2004 (Mthethwa, Z. & Kasheeka, E.B., 2004).

Further, data arrive incomplete, particularly diagnoses fields, resulting in the probability that AIDS cases are under-reported. Most HIV/AIDS hospital admissions and deaths are listed as a co-morbidity, such as diarrhea, pneumonia, or TB (Mthethwa, Z. & Kasheeka, E.B., 2004).

The M&E Unit (SNAP) has not yet developed a data quality assessment plan.

SHRU does not have a written protocol for data quality. After data are compiled it reviews the data, but does not actually do anything if a problem is identified during the review.

Most of the data coming from the facilities lack quantification and are therefore not useful. Many facilities simply do not report, and there is a lack of retrievable data storage at the facility level, so if something goes missing, it is lost forever. There are very limited skills and incentives for data collection resulting in incomplete and unreliable data sets (GAMET, 2005).

5.4.B. Data Analysis

Data analysis is limited to data reduction and summarization for reporting purposes to GFATM. No data analysis activities or data analysis plans, outside of compilation and reduction of counts for the purposes of reporting, were identified during this assessment.

5.4.C. Reporting

Twenty-two sites participated in the reporting module. Seventeen of the assessed sites (77%) produce a mean of 2.7 reports (Range: 0 – 9) per month. Staff responsible for reporting varied by site.

Table 8: Staff Responsible for Reporting, by Number of Sites

Job Title	Number of Sites (n = 22)
Social worker	1
VCT Nurses	1
Counselors	2
Laboratory technicians	1
Senior Administrative Staff	4
Done collectively	2
Data collectors	1
TB Staff	1
Occupational Therapist	1

Registers (See: Data Collection) are compiled into monthly summary sheets which are then reported to senior administration at the facility or taken to monthly meetings where they are hand delivered.

Staff members at six of these sites (27%) have received some kind of training in report production. Nine sites (41%) were able to produce all of their required reports on time and only three (14%) stated that they had had some data missing in their last reports. Fifteen sites (68%) produced their reports exclusively manually. Except for private clinics, all sites report on a monthly basis. These monthly reports are then usually compiled into quarterly reports, which, in turn, are compiled into annual reports. Reports are typically physically transferred from the facility to SNAP, NERCHA, WHO,

or another NGO umbrella organization by either taking the reports to monthly meetings or waiting for an M&E officer from NERCHA or a representative from WHO to collect the reports.

5.4.D. Indicators

During this assessment, core national indicators were being finalized through a consensus process that involved M&E officers from the M&E Unit (SNAP). The M&E officers expressed concern that the indicators identified do not reflect data currently collected through the registers. In short, there is no set of identified health sector response indicators from which SNAP, MOHSW, nor the newly formed M&E Unit (SNAP) are working. There is also concern that there has not been time to correlate the data collection forms to the newly identified core national indicators.

NERCHA completed its national strategic planning (NSP) process on 09 September 2005 and now has a set of core indicators for the national multi-sectoral response to HIV/AIDS (NERCHA, 2005).

5.4.E. Data Flow, Reporting, and Management

The M&E Unit (SNAP)'s primary goal is to establish a routine HIV/AIDS HMIS that would collect data to feed into both GFATM and the core national indicators.

Currently, HIV/AIDS data is collected vertically and is tenuously linked to the national HMIS through the use of a standardized outpatient register. This register captures AIDS Presumptive, Pulmonary TB, and Syndromic diagnoses and treatment of STIs, which provides a tenuous link between HIV/AIDS data and the national HMIS.

SNAP receives VCT, PMTCT, ART, and STI data. These data are not yet integrated into the same routine data collection system used by other health sector data. Further, it appears that the routine data being collected is too vague for the purposes of managing the national health sector response. At the same time, there are no defined data flows from the facility to SNAP. Data trickles into SNAP on an ad hoc basis.

Data are not yet flowing into the M&E Unit (SNAP) from the facilities (with the exception of last quarter's ART data), the HPSU, SNAP, nor NERCHA. The proposed (or at least understood) plan is for data to be exchanged between SNAP and HPSU on a quarterly basis during quarterly meetings. Most data are flowing from the facilities either directly to the MOHSW Statistics Unit or through regional health offices to HPSU. The relationship between HPSU and M&E Unit (SNAP) has not been defined, nor has the flows of data between the two units.

Data flow from facilities towards predetermined indicators using MOHSW-produced registers and facility-produced registers. Tally sheets are produced by the facility. NERCHA receives quarterly reports on its Periodic Activity Reporting Form, which is physically collected from an average of 60 sites per quarter by the M&E officers.

5.4.F. Data Use and Reporting

Data collected from facilities for GFATM reporting pass through NERCHA and then to SNAP and GFATM.

The assessment was not able to identify compliance with reporting requirements, but did identify a pressing need for the development of a matrix for report tracking.

The NERCHA M&E Unit shares data with NERCHA coordinators on a quarterly, semi-annual, and annual basis. There are no reporting templates. NERCHA is to have an annual report and different offices maintain databases of partners, which are not coordinated and use Excel, Access, and MS Word.

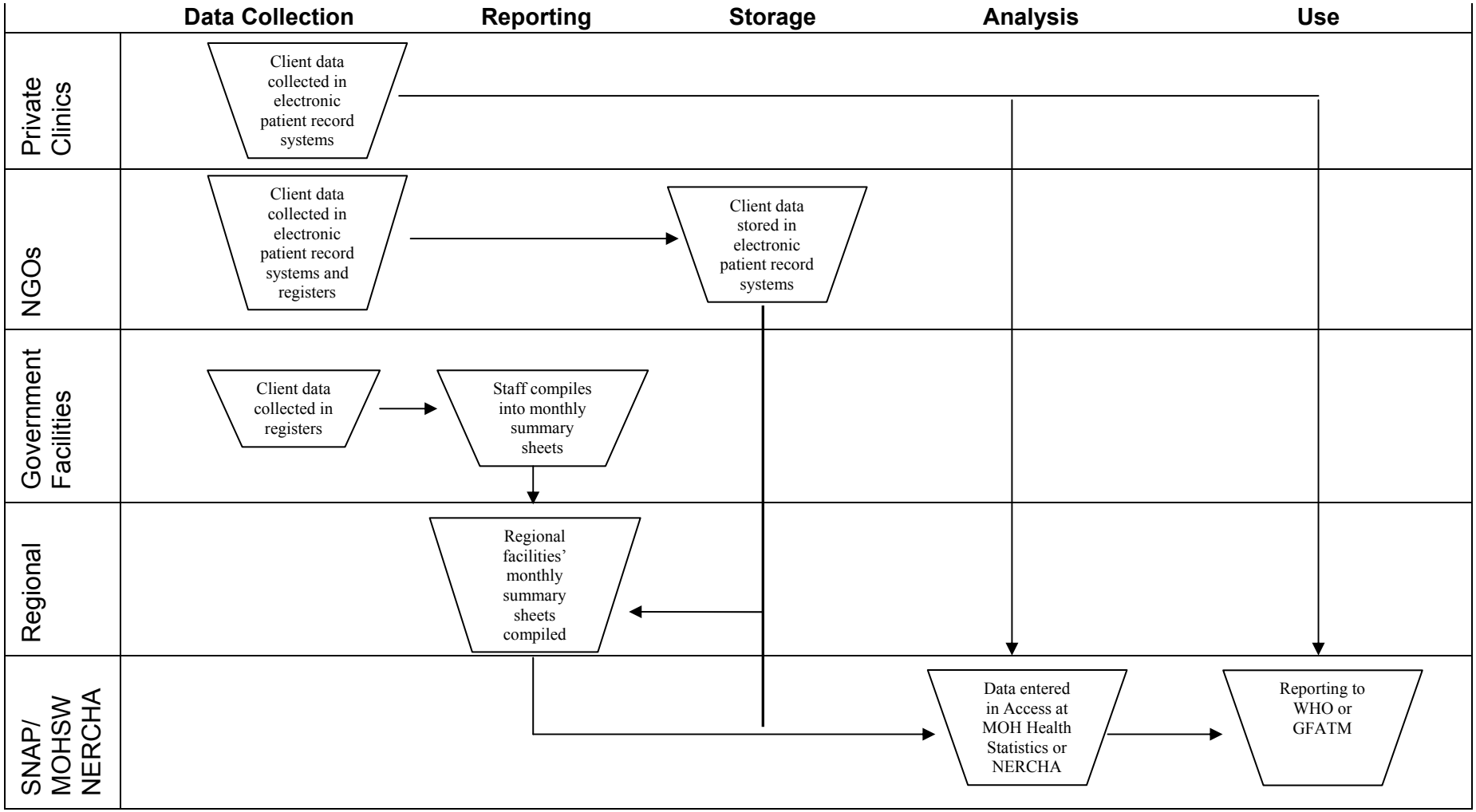
Since NERCHA is the GFATM Principal Recipient, most of NERCHA's reporting is to GFATM, and therefore relies on health-sector data sources.

Data that are reported up from the facility level are not processed and translated into information that is useable in the facilities. Currently, NERCHA has proposed a plan to disseminate key information products, which are to be based upon reported data, back to the facilities. (See Appendix 4: Dissemination Channels)

5.4.G. Data Flow Mapping

The data flow mapping exercise is focused on mapping existing data flows and not planned data flows. By only mapping documented, routinely collected and reported data elements to output level indicators identified in the National Multi-Sectoral Response to HIV/AIDS M&E Framework, the assessment provides the necessary information in order to conduct a type of data collection gap analysis. Such an analysis would allow NERCHA and SNAP/MOHSW to focus attention on developing registers and methods to collect routine data to feed into the identified national output level indicators. However, if data elements *are* being collected they will be mapped to the appropriate indicator, whether or not they are currently feeding into said indicator. (See Appendix 1 – Data Flow Maps for Core National-Level Output Indicators)

Figure 2: Overview of Information Flow for Swaziland's HIV/AIDS Program at the National Level



5.4.H. Reporting Feedback

Nineteen sites responded to questions on feedback of reported information. Thirteen sites (68%) do not receive visits from their supervisory offices regarding submitted data. Of the six sites (32%) receiving visits, one reports regular, quarterly visits, two report visits due to data quality issues, and one reported a workshop conducted for them by the regional health team. Nine sites (47%) receive STI/HIV/AIDS information from GoS. This information includes:

- ❒ Common STIs and their treatments
- ❒ Surveillance reports
- ❒ Management of HIV staging
- ❒ Information to distribute to patients.

This information is typically distributed to the senior matrons, chief medical officers, or other senior administrator, who, in turn, is expected to distribute it to the appropriate staff. MOHSW and NERCHA also hold workshops, but it is not clear how a staff member is selected to attend a specific workshop. Five sites (26%) reported receiving reports from GoS that were relevant to their specific program. However, no site was able to list a single relevant report.

Nine sites (47%) reported that there were no channels available for them to communicate with MOHSW about STI/HIV/AIDS information; three (16%) communicate through their facility administrative structure; two (11%) communicate via the regional health office; and the remaining four (22%) have established direct communication with either the AIDS Coordinator or Program Coordinator at SNAP.

Ten sites (53%) reported that they would see receiving STI/HIV/AIDS information from MOHSW or NERCHA as helpful.

Table 9: Types of MOHSW-Produced STI/HIV/AIDS Information That Would Be Considered Useful, If Available

Information Use/Product	Frequency
Patient care/best practices	4
Advocacy	2
Administration/resource allocation	2
Working with the community	1
Sentinel Surveillance Report	1

Ten sites (53%) also reported that they would see receiving information from the MOHSW based on their reporting as useful, but were unclear how it would be useful:

- ❒ Basic demographic information (morbidity/mortality rates)
- ❒ General information on HIV/AIDS, STIs, and TB
- ❒ Sentinel surveillance report
- ❒ Targets for number of patients to be initiated onto ART
- ❒ HIV/AIDS reports from foreign countries.

Sites identified how MOHSW and NERCHA could best provide them with information that is useable for program planning and resource allocation:

- ❒ Manual and guidelines
- ❒ Seminars and workshops
- ❒ Reports and graphs

5.4.I. Facility Use of Reported Information

The majority of sites reported using the information they report, with the exception of one government hospital. One private clinic states that it does not report information. Information use by facility is listed below:

Table 10: Facility Use of Reported Information

	1 Government Hospitals (7 sites)	1 Mission Hospital (3 sites)	1 Gov't-mission hospital (7 sites)	2 Government Clinics	1 Private Clinic	1 Palliative Care Facility
Health Planning	5	2	2	1	Yes	Yes
Activity planning	7	2	3	2	Yes	Yes
Procure drugs/vaccines	6	2	3	2	Yes	No
Personnel management	6	1	2	2	Yes	Yes
Budget	1	1	3	2	Yes	Yes
Supervision	6	1	3	1	Yes	Yes
Evaluation	6	1	3	2	Yes	Yes
Epidemiological Surveillance	0	2	2	2	No	Yes
Implementation of Priority Health Programs	6	1	3	1	No	Yes

Seven sites report displaying information that has been collected in their facility or office:

Table 11: Methods to Display Reported Information

Method of Information Display	Number of sites using method (n = 13)
Catchment Area Map	4
Graphs or Charts	7
Data Tables	2

5.4.J. Information Storage

No formalized data storage system was identified during the process of this assessment. Eight sites store individual patient records. No site mentioned a system to facilitate easy retrieval of data. Data storage is not organized and may or may not be kept in locked cabinets or drawers. The M&E Unit (SNAP) has indicated that once it begins receiving data it will store it electronically. However, there is no plan to store the paper-based summary sheets used to submit data.

Table 12: Information Storage

Method of Storage	P/T records (n = 8)	Registers (n = 19)	Reports (n = 12)
Unlocked cabinets	0	7	3
On bookshelves	2	4	1
Locked cabinets/offices	4	4	4
Wherever space can be found	1	3	2
Electronically	1	1	2

5.4.K. Confidentiality

Half (11/22) of the sites assessed reported that their facility did not have a written policy on confidentiality; one site reported that it was not certain whether or not there was such a policy. Of the sites reporting a policy on confidentiality, 70% provided VCT and/or ART services. Eighteen sites provide test results and all provide results only to the individual tested. Specific guidance regarding confidentiality was quite common. However, some positions were not provided the appropriate guidance:

- Counselors at one private clinic
- Medical and laboratory staff at one government hospital
- Ancillary staff at all four regional hospitals

Ten of the sites (46%) reported that individual patient records do contain HIV/AIDS information. These records are the MOHSW Appointment Booklet (*Ngiyayinakekela Imphilo Yami*), which are kept by the patients. Ten of the sites (46%) also reported that clinic registers contain HIV/AIDS information. Twelve sites (55%) reported keeping registers containing HIV/AIDS information in a locked cabinet or room as well as having a secure system to handle this information. When asked to describe the system, three of the twelve sites (25%) were unable to describe their system, three sites (25%) reported that only codes and no names were used, five sites (42%) described the system of maintaining confidentiality when disclosing results to a patient, and the remaining one site (8%) stated these data are in a locked room. Three sites (25%) reported having a system to protect electronic information: one used password protection; one stated that there was no Internet connection; and one was unable to describe its system.

However, it is important to note that Public Health Act Number Five of 1969, the Public Health Bill of 1999 (which is a working document and is meant to repeal the aforementioned Public Health Act), and general medical ethics are assumed to guide confidentiality practices in Swaziland.

5.4.L. Availability of Guidelines, Procedures, and Manuals

Confidentiality guidelines (except for that which has been articulated for the purposes of VCT) and data security guidelines were not identified by this assessment.

All 22 sites were queried about the availability of guidelines, procedures and manuals. Only the two government hospitals identified the MOHSW Monthly Summary Sheet and General Register as guidelines for data collection and data handling and use.

5.4.M. Equipment

None of the sites reported having a satellite link and only one private clinic reported having a mobile telephone (purchased in 2000), although most staff interviewed had access to their own personal mobile telephone. One government hospital site reported purchasing computer equipment in 2003 but only began to learn to use and use it during August 2005.

Table 13: Working Equipment at Facilities

	Working Equipment								
	PC	Data Back-up Unit[1]	Printer	UPS	Generator	Telephone	Internet Access	Calculator	Offsite Storage
2 Government Hospitals (12 sites)	17 (2005)	6 (2005)	3 (2005)	9 (2003)	0	13	1	0	0
1 Mission Hospital (3 sites)	2 (2004)	1	1	0	1	2	0	3 (2004)	0
1 Gov't-mission hospital (7 sites)	5 (2004)	0	3 (2004)	0	1	3	0	2 (2004)	0
1 Palliative Care Facility	1 (2004)	0	1 (2005)	0	0	1	0	1	0
2 Government Clinics	0	0	0	0	1	2	0	2	0
2 Private Clinics	5 (2004)	0	1 (2002)	0	1	3 (1998)	4	5 (1998)	1
Totals:	*29*	*7*	*9*	*9*	*4*	*24*	*5*	*13*	*1*

5.4.N. Utilities

Each of the ten facilities reported having experienced interruptions in electricity. The frequency of outages ranged from "rarely" to two-to-three times per week.

Table 14: Frequency of Power Outages

Frequency of Outages	Frequency of reply
Rarely or occasionally	7
Common in Summer/in bad weather	6
Frequently	2
1-2 times/month	4
1 time every 2 months	2
At least once per week	2

Of the respondents, the loss of electricity has minimal impact on work involving data and data use, while greatly impacting laboratory functioning and clinical care. The minimal impact on data and data use reflects the ubiquitous pen and paper approach to data management and use in the health sector.

[1] Data Back-up units included floppy diskettes, CDs, or zip

Table 15: Impact of Power Outages on Work

Impact on Work	Frequency of reply
None	8
Computer Use	1
Loss of Data	1
Laboratory functions and computer use	5
Patient Care	6

Only six sites reported having air-conditioning. All sites reported having running water, although one site noted that the water was not potable.

5.5. National Capacity and Coordination

5.5.A. Policy

In 2001 MOHSW produced a policy document on HIV/AIDS and STIs. The document outlines policies addressing coordination, information and education communication, HIV testing, blood safety, ethically conducted research, and condom promotion and availability. However, this document was not vetted through the Public Policy Control Unit, which is under the Office of the Prime Minister and reviews and endorses public policy (MOHSW, 2001).

5.5.B. National Response

The national response is based on a two-prong approach – the health sector and impact mitigation responses. The national response is heavily funded by GFATM and other international development partners and is to be implemented based on the NSP.

NERCHA was chosen as the secretariat of the Country Coordinating Mechanism (CCM). The CCM is responsible for coordinating the GFATM activities in Swaziland. It consists of representatives of government, NGOs and civil society. The GFATM has committed more than USD 100 million over five years through two separate grants to Swaziland. Major areas of focus for GFATM funds include ART, STI treatment, VCT expansion, home-based care, behavior change among youth, support to the education sector and monitoring and evaluation of HIV/AIDS programs. To date, NERCHA has also been the Secretariat and Principal Recipient for the GFATM grant in Swaziland (MOHSW and WHO, 2003; MOHSW, UNDP, NERCHA, HAPAC, World Bank, UNFPA, et al., 2005; USAID & CDC, 2004; Kelly & Mangongo, 2004).

Other major donors include the European Union, DFID/British High Commission (capacity development), the World Bank (support for M&E), and the Italian Cooperation (WHO and laboratory/research support). Bristol Myers Squibb is also supporting a small ART site in Mbabane offering family-centered services. Funding for the national response also comes from the Government of Swaziland (GoS), multi- and bilateral donor support, and the private sector (MOHSW and WHO, 2003; MOHSW, UNDP, NERCHA, HAPAC, World Bank, UNFPA, et al., 2005; USAID & CDC, 2004; Kelly & Mangongo, 2004).

In 2000, Swaziland developed a five year (2000-2005) National Multi-Sectoral HIV/AIDS Strategic Plan. In November 2004 the NSP was reviewed and the main priorities for the next strategic plan

were identified. During the process of this assessment, the NSP resulted in the finalization of a set of core national indicators for the multi-sectoral response to HIV/AIDS (MOHSW and WHO, 2003; MOHSW, UNDP, NERCHA, HAPAC, World Bank, UNFPA, et al., 2005; HDA, Draft).

5.5.C. Health Sector Response

SNAP is mandated to manage the health sector response to HIV/AIDS. The goal of the health sector response is to contribute to the reduction of the incidence of HIV and mitigation of the impact of AIDS through the provision of health and social welfare services for prevention and care. Efforts to reach this goal include:

- Strengthening the BCC interventions within the health sector
- Condom promotion among young people
- Strengthening adolescent sexual and reproductive health through the establishment of youth-friendly corners in health facilities is a high priority and
- Strengthening laboratory services, which are under enormous pressure due to the introduction and rapid increases in demand for VCT and clinical care (MOHSW and WHO, 2003; MOHSW, UNDP, NERCHA, HAPAC, World Bank, UNFPA, et al., 2005; MOHSW, FHI, USAID, and FLAS, n.d.; HDA, Draft).

In 1987, MOHSW, in collaboration with WHO Global Program on AIDS, initiated the national response through the establishment of the Swaziland National AIDS Program (SNAP) to develop and coordinate a national response to the AIDS epidemic. The national response covers seven intervention areas:

- Development of effective prevention and control infrastructure
- Setting up advisory bodies
- Screening of all donated blood
- Development of technical guidelines
- Public awareness
- Establishment of surveillance activities, including laboratory services
- Training health care providers (MOHSW and WHO, 2003; MOHSW, UNDP, NERCHA, HAPAC, World Bank, UNFPA, et al., 2005).

Coordination of HIV/AIDS programs within the MOHSW is dependent on SNAP. SNAP is expected to:

- Implement and monitor the Health Sector Response Plan
- Generate HIV/AIDS strategic information
- Provide technical support to other sectors
- Facilitate operational research
- Facilitate linkages between MOHSW and other HIV/AIDS organizations and programs

- ❒ Provide, regularly update, and orient health care providers on technical guidelines for prevention, care, and support (MOHSW and WHO, 2003)

SNAP is also charged with implementing HIV/AIDS services including condom distribution, STI treatment, VCT, PMTCT, HBC, and ART. The MOHSW remains directly responsible for TB and OI treatment (HDA, Draft).

5.5.D. Impact Mitigation Response

NERCHA is mandated to coordinate and facilitate the national multi-sectoral response to HIV and AIDS by:

- ❒ Initiating national HIV/AIDS policy development, periodic review, and monitor its implementation
- ❒ Facilitating development and periodic review of the HIV/AIDS national strategic plan
- ❒ Facilitating joint planning by stakeholders
- ❒ Conducting advocacy for HIV/AIDS interventions
- ❒ Mobilizing resources and funding for HIV and AIDS programs
- ❒ Documenting and disseminating best practices on the national response
- ❒ Monitoring and evaluating the national response to HIV/AIDS (GAMET, Draft; Kelly & Magongo, 2004)

Lateral coordination will occur through strengthening various umbrella bodies that bring together stakeholders with common interest. NERCHA has identified nine umbrella bodies, including itself and MOHSW. Others include:

- ❒ The Alliance of Mayors Initiative for Community Action on AIDS at the Local Level (AMICAALL) – Mandated to coordinate the response to HIV and AIDS in the urban area. AMICAALL works in close collaboration with the Ministry of Housing and Urban Development and the city or town councils or boards. AMICAALL will be supported to coordinate the urban based response (GAMET, Draft).
- ❒ Business Coalition Against HIV and AIDS (BCHA) – Swazi employers are fighting back by setting up a Business Coalition against HIV and AIDS, with a comprehensive mitigation plan (IRIN, 2005).
- ❒ Coordinating Assembly of Non-Governmental Organizations (CANGO) – The coordinating body of NGOs sets standards for registration and working of NGOs, CBOs and FBOs in the country; creates a conducive environment for NGOs to deliver services and undertake capacity building; represents NGOs in meetings of other coordinating bodies; conducts advocacy for NGOs among stakeholders; conducts capacity building for NGOs; monitors and evaluates the work of NGOs; and submits reports to NERCHA and other partners (GAMET, Draft).
- ❒ Church Forum – The Church Forum is part of a coordinated response to the HIV/AIDS pandemic and operates to link churches, Christian organizations and networks to

enhance their HIV/AIDS response by sharing resource, ideas, skills, experiences, and stimulating strategic partnerships (Nexus (Pty) Ltd, 2003).

- Expanded UN Theme Group on HIV/AIDS –A structure responsible for coordinating the UN support to the national HIV and AIDS program. Also responsible for coordinating donor support to the country (GAMET, Draft).
- Public Sector HIV/AIDS Coordinating Committee (PSHACC) – Responsible for coordinating government ministries' and departments' roles in the fight against HIV/AIDS, which represents both the GoS and development partners' response. The workplace program is also to be coordinated in its entirety by PSHACC (GAMET, Draft).
- Swaziland National Network of People Living With HIV and AIDS (SWANNEPHA) – An NGO coordinated under CANGO, but since it coordinates programs for PLWHA its role is the same as that of CANGO, only focused on PLWHA (GAMET, Draft).

These umbrella bodies are to be supported to:

- Establish minimum standards, guidelines and regulations for service delivery
- Produce comprehensive annual work plans with budgets for the sector; support NGO involvement
- Coordinate service delivery
- Produce reports on the sector and disseminate to stakeholders, including NERCHA
- Disseminate information on HIV/AIDS interventions to stakeholders and
- Monitor and evaluate the sector response (GAMET, Draft).

It is necessary that NERCHA maintains contact with various ministries to stimulate and facilitate an increased national response as well as to foster joint sector programming by the different ministries and other stakeholders(GAMET, Draft).

The Regional M&E Coordinator for HIV and AIDS Programs has been designated to:

- Facilitate, coordinate, and strengthen M&E of regional HIV/AIDS programs and capacity for effective monitoring and evaluation of the regional response
- Collect M&E data, produce periodic reports and prepare descriptive and analytical reports on a quarterly and annual basis and whenever the need arises and
- Assist in program planning and implementation to conduct project appraisals (GAMET, Draft).

In 2000 the national strategic planning process was undertaken and it formed the basis for the health sector response; the Crisis Management and Technical Committee (CMTC) was created under the Office of the Deputy Prime Minister. The CMTC developed the National Strategic Plan (NSP) for HIV/AIDS in 2000, to cover 2000-2005 (MOHSW and WHO, 2003; USAID, 2004a; Kelly & Magongo, 2004).

NERCHA was established under the Prime Minister's Office and replaced the CMTC in 2001. The mandate of NERCHA is to coordinate the response to the epidemic, to foster the wider multi-sectoral involvement of all stakeholders and to mobilize and disburse resources. This requires that

the MOHSW mandate be realigned to focus on the following areas: (1) Provision of technical guidance/support on health sector-related interventions; (2) provision of clinical and public health services through the health systems; and (3) documentation of best practices through regular M&E (MOHSW and WHO, 2003; MOHSW, UNDP, NERCHA, HAPAC, World Bank, UNFPA, et al., 2005; HDA, draft; NERCHA, draft; Kelly & Magongo, 2004).

The NERCHA Directorate coordinates the implementation of the national AIDS program and the funds managed by NERCHA. It comprises national coordinators from prevention, care and support, and impact mitigation. Regional HIV/AIDS Offices are in the process of being established. Local representatives of the government and civil society will be responsible for the coordination of regional-level HIV/AIDS activities from the regional offices. Implementing partners are the entities receiving funds from NERCHA to implement HIV/AIDS activities in the country according the National Strategic Plan for HIV/AIDS. Implementing partners include entities from all sectors of society, government and civil (NERCHA, draft).

In 2003 the Global HIV/AIDS M&E Support Team (GAMET) began to provide technical assistance for M&E. The idea behind the establishment of this system was to coordinate and manage data demands from multiple development partners. The system being developed is dependent on the establishment of the Swaziland HIV/AIDS Program Monitoring System (SHAPMoS) to collect and feed data into output-level indicators (NERCHA, 2005). The core set of national indicators does not include all of the 22 output level GFATM indicators and it is not clear how this M&E system can be rapidly integrated and made functional so that it can be easily expanded as new data demands arise. At the same time, a parallel system for GFATM reporting is operating and it is not certain the benefit of either incorporating it into the national system or keeping it a separate, parallel system.

The Project Support Unit of the NERCHA ensures disbursement of funds for GFATM and has a supervisory role.

5.6. Health Sector Response Monitoring and Evaluation Structures and Capacity

5.6.A. Mandate

SNAP, including SRHU, is mandated to contribute to the reduction of the incidence of HIV and mitigation of the impact of AIDS through the provision of health and social welfare services for prevention and care (MOHSW and WHO, 2003). Specifically, MOHSW implements health-sector based interventions coordinated through SNAP, which SNAP is to monitor and evaluate.

HSU manages the national HMIS, ensuring that data is collected from health facilities and is analyzed to produce reports (Mthethwa, Z. & Kasheeka, E.B., 2004).

In an effort to meet GFATM reporting requirements, MOHSW entered discussions with NERCHA, which resulted in the establishment of the M&E Unit (SNAP). A clearly defined mandate has yet to be identified. One perceived mandate is that HPSU is to monitor the epidemic to strengthen the health sector response through data collection, analysis, and reporting. This is interpreted to mean that the M&E Unit (SNAP) is supposed to:

- ❒ Collect and analyze data, and write reports that will be directly reported to MOHSW
- ❒ Act as an information resource for all programmatic areas
- ❒ Provide SNAP/MOHSW input into the planning processes of all NGOs, CBOs, and FBOs operating HIV/AIDS programs in Swaziland.

Presently, the M&E Unit (SNAP) answers to the Principal Secretary in MOHSW. The MOHSW organogram proposes that the M&E Unit (SNAP) report to the Deputy Director in the Director's Office and to work closely with the SNAP Program Manager.

5.6.B. Structure

Currently, the M&E Unit (SNAP) is operating without a workplan or guidance from SNAP to identify its vision, goals, and objectives. The M&E Unit (SNAP) does not have its own budget and is dependent on GFATM for support.

5.6.C. Capacity

5.6.C.1. Structural Capacity

Information Technology (IT) support is supposed to come from the GoS-wide Computer Department. However, there is not a focal person in the department for MOHSW IT needs, which forms a significant barrier to effectively accomplish M&E activities.

There is neither a national programmatic database nor a national indicator database.

5.6.C.2. General MOHSW/SNAP Capacity

HSU has two computers, printers, telephone line, and access to transportation, which they use to travel to facilities to collect data. HPSU described itself as having limited exposure to health education and limited health sector experience.

SRHU has extremely limited computer skills. The only software application in use is MS Word. Epi-Info has been provided to SRHU, but is not in use because no one in HPSU has been trained to use it.

5.6.C.3. M&E Unit (SNAP) Capacity

The M&E Unit (SNAP) has five recently purchased, working computers (2 laptops and 3 desktops); one printer; Internet connection; photocopier; telephone line; and access to FAX capabilities. Staff are relatively new (all hired during July 2005) and consist of two M&E officers and one administrative assistant, in addition to the national epidemiologist, who heads HPSU.

It is expected that the M&E Officers in the M&E Unit (SNAP) will be responsible for writing reports, data entry, and data analyses. At the time of this assessment, these activities had yet to commence.

The two M&E officers in the M&E Unit (SNAP) who are expected to assume the bulk of the health sector response M&E activities have had the following training:

Table 16: M&E Unit (SNAP) M&E Officers' Training and Experience

Training	Number of staff trained
Highest level of education	2 B.A.s (Statistics & Demography)
Introduction to computer use	2
HMIS specific applications	0
Spreadsheets	2
Typing	2
Presentation	1
Word-processing	1
Database use	1
Database programming	0
Statistical analysis	2
IT Troubleshooting	1

Only one M&E officer reported conducting data analysis and none of the staff reported either experience or training to perform the following functions:

- ❒ Supervision of the quality of data collected in facilities
- ❒ Logistical management of printed supplies
- ❒ Report registration
- ❒ Data cleaning, quality control, and processing

M&E Unit (SNAP) staff lack a workplan, an orientation to the health sector (neither have any health education nor health sector experience, other than their current positions), and available channels to communicate with program coordinators at SNAP.

5.6.D.4. Databases

HSU uses an Access database for data entry and storage of data collected on inpatient and outpatient registers. HIV/AIDS data in this database is limited to presumptive AIDS diagnosis and syndromic diagnosis and management of STIs.

The M&E Unit (SNAP) lacks the establishment of databases for the data that it will eventually be collecting.

5.7. Impact Mitigation Monitoring and Evaluation Structures and Capacity

5.7.A. Mandate

According to the law, NERCHA is to coordinate projects or programs receiving funding through NERCHA. However, the M&E coordinator and the GAMET consultant view coordination of all projects or programs providing HIV/AIDS service in Swaziland as a high priority. Additionally, the M&E Unit's time is consumed by monitoring activities for GFATM, leaving little resources for operationalizing the national HIV M&E system (GAMET, 2005).

5.7.B. Structure

NERCHA's organizational structure is in the process of coalescing. There has been discussion as to whether NERCHA is to be responsible for coordinating the implementers or the umbrella bodies. If NERCHA coordinates the umbrella bodies, then the umbrella bodies would coordinate the implementers.

The NERCHA M&E Unit does not have a workplan based on program coordinator work plans, making the task of on-going monitoring difficult and contributing to HPSU's focus on GFATM at the expense of the national multi-sectoral response. This lack of work plans leaves The M&E Unit uncertain about what it is to monitor and reflects on the disconnect between program planning and M&E at the national level. In theory, an overarching NERCHA workplan would contain the M&E Unit workplan which would intersect with each of the program coordinators' work plans and would be based upon the national core indicators.

5.7.C. Capacity

NERCHA, as an agency, is young. The technical assistance that has come has yet to focus on the internal systems and workings of NERCHA. A system needs to be immediately identified to coordinate project managers, financial managers, and the M&E Unit in order to streamline the process to meet reporting requirements so that resources can be freed to focus on the overall goal of M&E, which is program strengthening. Part of this system must include manuals, guidelines, and functional, appropriate databases.

NERCHA's internal communication flow is disjointed and staff in different units of the organization tend to be unaware of what is happening in the organization as a whole.

The NERCHA M&E Unit has established a multi-sectoral M&E Technical Work Group with Terms of Reference and a work plan. The M&E Unit has also advocated for, and has facilitated, extensive M&E advocacy through "M&E 101" trainings. However, there has been a significant lag time between these trainings and skills development to make M&E functional in Swaziland.

Not all key stakeholders supporting different M&E systems are represented on the committee. The TWG has achieved the following key deliverables since its inception:

- Capacity assessment for M&E which led to training
- Development of an M&E framework
- Coordination of the Joint Program Review
- Supervising the development of terms of reference,
- Preparation process for Joint program Review
- NERCHA's M&E Unit plays a coordinating role in the M&E TWG
- Reviewing research related proposals. (Mthethwa, Z. & Kasheeka, E.B., 2004)

5.7.D. Databases

There currently is no functional programmatic or indicator database in operation in NERCHA.

The DHIS database was not explored as an option for capturing and analyzing facility-based service data. However, NERCHA has begun institutionalizing the DHIS to use for key GFATM indicators and the SHAPMoS system.

CRIS for Swaziland was elected as a data management solution to a number of problems with the existing data system, namely data redundancy; inability of existing data capture systems to grow to accommodate increases in project data; the need for the development of standard data transmission formats; and the need to enhance collaboration among decision makers and program planners, researchers, research institutions and funding organizations. The goal of implementing CRIS in Swaziland was to provide an information management tool, supported by an integrated database for indicators, research studies and project/resource data (NERCHA, n.d.).

CRIS is a user friendly information system which enables a systematic collection, storage, analysis, retrieval and dissemination of information on a country's national response to HIV. CRIS was developed by UNAIDS to assist countries to easily monitor and evaluate projects and programs in a more centralized and collective manner (CANGO, 2004).

CRIS is limited in that projects and indicators are only linked if data for a specific indicator has been entered. It is not possible to use CRIS for a linked indicator and programmatic database without the budget to conduct extensive customization and assistance from other applications. Further, attempts to reformat CRIS for Swaziland's purposes is a go-it-alone task as there are not many examples of other countries who have agreed to CRIS and have reconfigured it to meet their specific needs.

There is a lack of an integrated database for indicators, programs, project data, and research studies.

Data redundancy limits the ability to track project activities. There is a lack of standard data transmission formats.

6. RESEARCH DIRECTORY

There are efforts to establish a national repository of information on HIV and AIDS in the country. With the support of ActionAid-Support to International Partnerships against AIDS in Africa (SIPAA), NERCHA has established a national HIV and AIDS Information and Documentation (Resource) Centre. There is no structured mechanism to coordinate and widely disseminate HIV/AIDS research in Swaziland. Although operations research is conducted, few programs disseminate findings of this research to stakeholders. National research priorities desperately need to be identified. The research community has not been mobilised to identify national priorities in HIV and AIDS research, develop a coordinated national research agenda, and agree on appropriate dissemination channels. Currently, there is no research inventory on the studies that have been conducted, research institutions, or researchers conducting research in Swaziland (Mthethwa, Z. & Kasheeka, E.B., 2004; NERCHA, draft 2).

Research priorities have been identified, but not vetted:

- Basic facts about the epidemiological, demographic, and behavioral profile and context
- Monitoring of program coverage and activities
- Assuring the quality of program implementation
- Information to design and improve programs and activities
- Evaluation of the impact of programs and activities and the understanding of the combination of programs and activities that matter most. (Women Together, SASO, & SWAPOL, 2004)

The first step to address the above issues is to develop a research directory of HIV/AIDS research organizations, HIV/AIDS researchers, and HIV/AIDS researches conducted. To this end, MEASURE Evaluation, through the Tulane School of Public Health, has partnered with NERCHA and the University of Swaziland (UNISWA) to develop this research directory. The goal of the directory is to institutionalize in Swaziland research that has been undertaken in Swaziland. This would require building a database, based on the directory, of what research have been undertaken, Swazi researchers, and Swazi research organizations operating in Swaziland, as well as peer-reviewed articles and ethical reviews.

A workshop was conducted on 14 November 2005 to review the work undertaken by UNISWA to date and to map a way forward. During the workshop, it was agreed that there is a pressing need for a functional national research council (NRC). UNISWA has been in the process of finalizing policies and guidelines on research ethics. Initially, the NRC was founded in 1972 and housed in the Ministry of Economic Development and Planning. The NRC secretariat was then placed in UNISWA, but was not funded. A document before Parliament proposes moving the NRC to the Prime Minister's Office, because the Prime Minister has the authority to direct all other ministries. However, there was strong debate and deep ethical concerns about placing the NRC in a political office, and that document has been tabled.

Additionally, it was agreed that an over-arching, national research agenda over-simplifies HIV/AIDS research by focusing on research relevant to M&E and excluding clinical and experimental HIV/AIDS research.

REFERENCES

Coordinating Assembly of Non-Governmental Organizations (2004). Report on the Monitoring and Evaluation Training Workshop for Civil Society Organizations Implementing HIV/AIDS Interventions in Swaziland Held in Matsapha: Esibayeni Lodge

Global AIDS Monitoring and Evaluation Support Team (2005). Monitoring and Evaluation Mission to Swaziland: End of Mission Debriefing Report.

Global AIDS Monitoring and Evaluation Support Team (draft). Guidelines for Strengthening Decentralized Coordination of the National Multi Sectoral Response to HIV and AIDS in Swaziland.

Health and Development Africa (Pty) Ltd (Draft). Draft Report: Study of the Health Service Burden of HIV/AIDS and Impact of HIV/AIDS on the Health Sector in Swaziland

Kelly, K. & Magongo, B. (2004). Report on Assessment of the Monitoring and Evaluation Capacity of HIV/AIDS of Organizations in Swaziland. NERCHA: Swaziland.

Ministry of Health and Social Welfare (2005).Scaling up Anti-retrovial Treatment as Part of the Global Emergency Response to HIV/AIDS: 3 by 5 plan of Action for 2005

Ministry of Health and Social Welfare (2001). Policy Document on HIV/AIDS and STD Prevention and Control.

Ministry of Health and Social Welfare, Family Health International, United States Agency for International Development-Regional HIV/AIDS Program, Family Life Association of Swaziland (n.d.). Swaziland Behavioural Surveillance Survey

Ministry of Health and Social Welfare-Sexual and Reproductive Health Unit [SHRU], United Nations Population Fund (n.d.). Report for Swaziland Community Health Survey.

Ministry of Health and Social Welfare, United Nations Development Program [UNDP], National Emergency Response Council on HIV/AIDS, The HIV/AIDS Prevention and Care Program [HAPAC], World Bank, United Nations Population Fund [UNFPA], Swaziland National AIDS Program, Joint United Nations Program on HIV/AIDS, Coooperazione Italiana, and The World Health Organization (2005). Ninth Round of National HIV Sero-surveillance among Women Attending Antenatal Care Services at Health Facilities in Swaziland, 2004.

Ministry of Health and Social Welfare and The World Health Organization (2003). The Health Sector Response to HIV/AIDS Plan in Swaziland, 2003-2005.

Mthethwa, Z. and Kasheeka, E. B. (2004). Joint Review of National Response to HIV and AIDS – Report of the M&E Thematic Area.

National Emergency Response Council on HIV/AIDS (2005). National Multi-sectoral HIV/AIDS Response Monitoring and Evaluation Framework.

National Emergency Response Council on HIV/AIDS (draft). Monitoring and evaluation operational manual.

National Emergency Response Council on HIV/AIDS (draft 2). Evaluation Strategy for Operational or Essential Research in Swaziland.

National Emergency Response Council on HIV/AIDS (n.d.). Implementing and populating the Country Response Information System (CRIS)

Nexus (Pty) Ltd (2003). Situation analysis of Swaziland churches response to HIV/AIDS.

Swaziland National AIDS Program (2004). Rapid assessment report of situation analysis for organizations providing home based care in the Manzini region.

United States Agency for International Development (Bureau for Global Health) (2004a). Swaziland: Country Profile HIV/AIDS.

United States Agency for International Development (Regional HIV/AIDS Program) (2004b). US Ambassadors Initiative: Swaziland.

United States Agency for International Development and The Centers for Disease Control and Prevention (2004). US Government Rapid Appraisal for HIV/AIDS Program Expansion: Swaziland.

Women Together, Swaziland AIDS Support Organization, and Swaziland Positive Living (2004). Rapid Assessment/Profiling of Groups/Associations/Organizations of People Living with HIV/AIDS in Swaziland.

World Bank Health Information System Program (2004). HISP: Project Report - A Situational Analysis for the Health Information System in Swaziland

APPENDIX 1: Data Flow Maps for Core National Output-Level Indicators

NOTE: In the following diagrams, solid arrows indicate that the displayed data elements are to feed directly into the indicator(s). Dashed arrows indicate that the data elements are being collected, but do will not feed into the indicator. The core national indicators displayed in the data flow maps were just identified at the time of the assessment. Because of this, arrows were not used to show data flowing into the indicators, but a dot to show that potentially those data elements that are relevant to an indicator could potentially flow into that indicator.

Figure 3: Behavior Change Communication Mapping

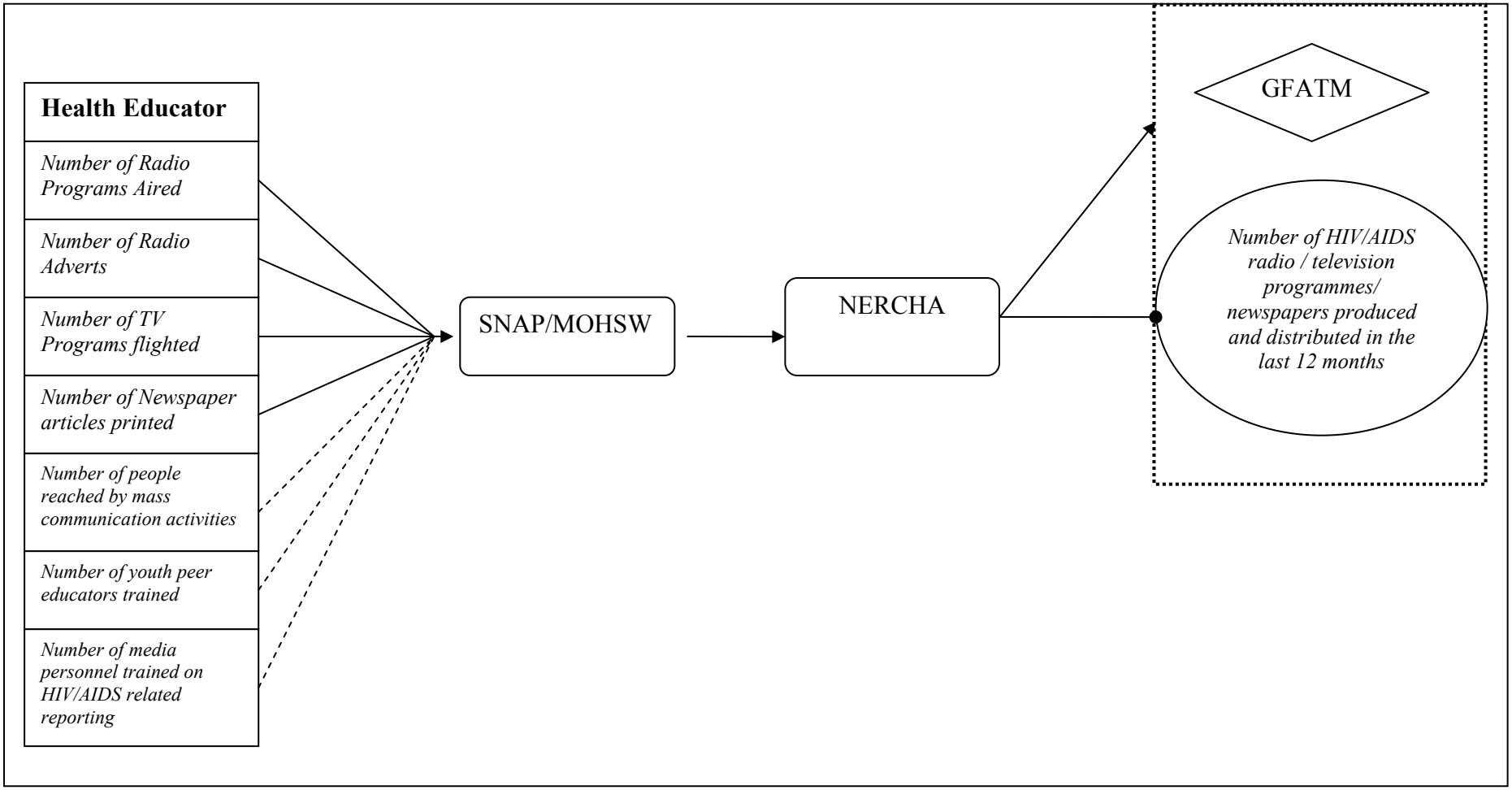


Figure 4: Blood Safety

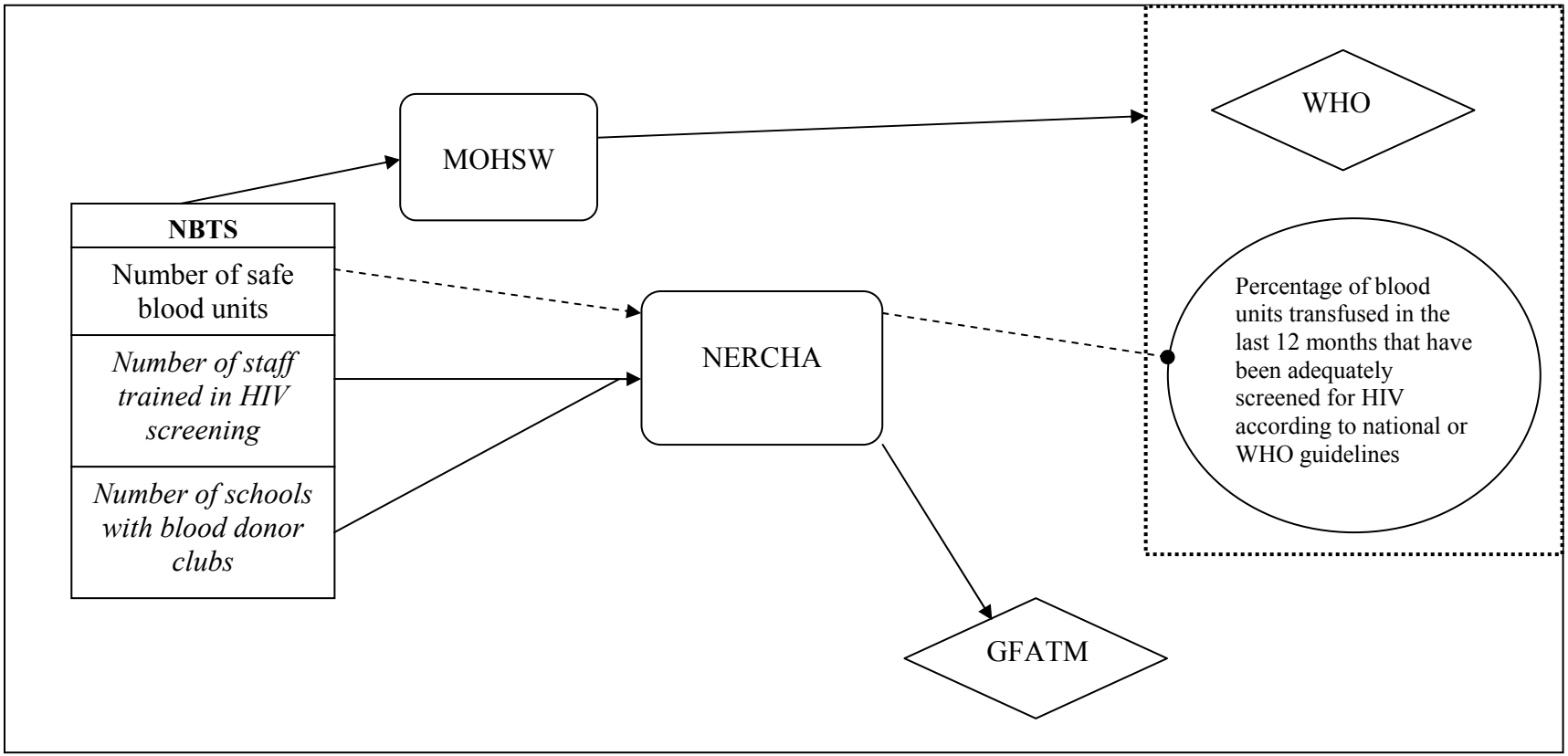


Figure 5: Condom Promotion and Management

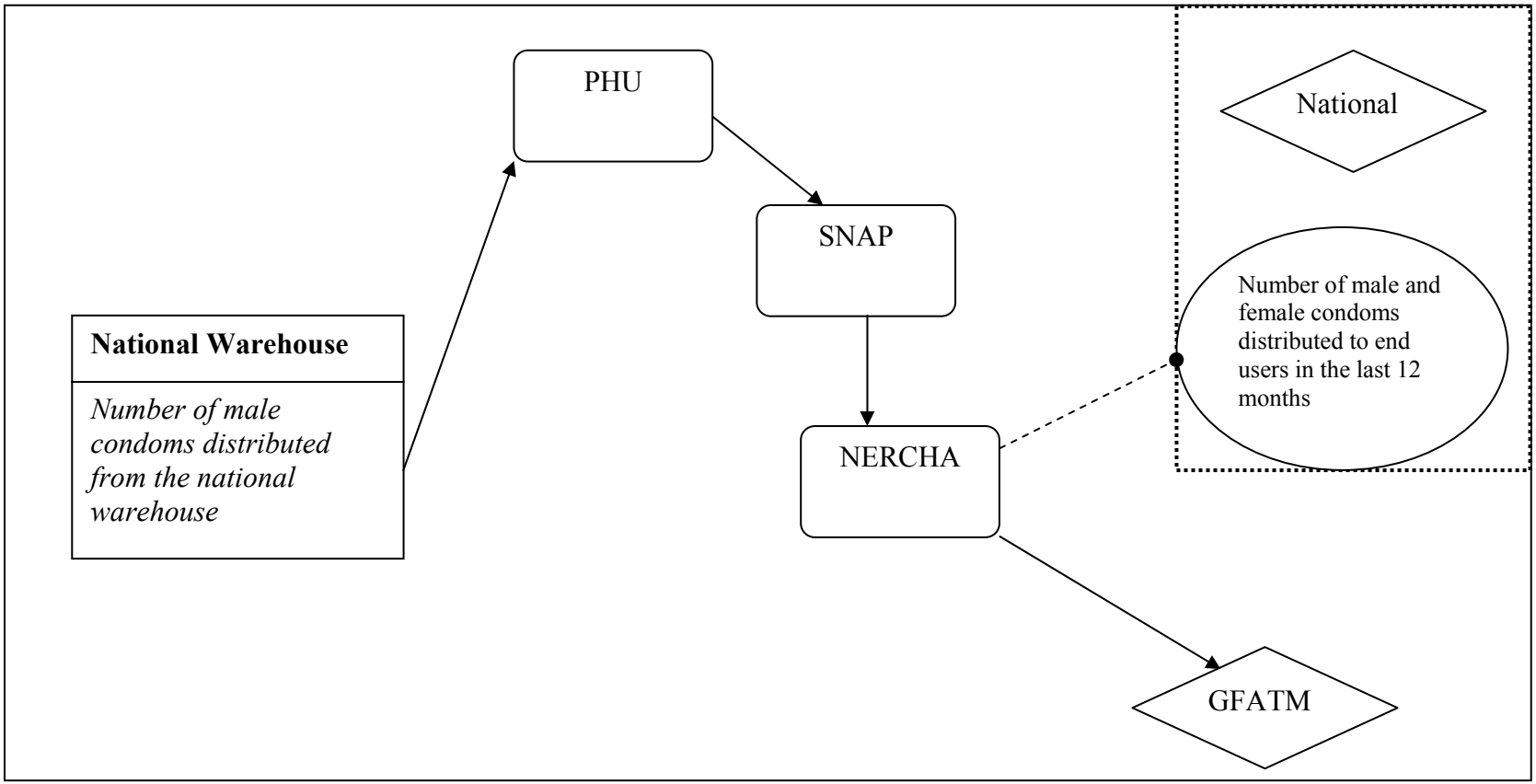


Figure 6: Prevention of Mother-To-Child Transmission of HIV – ANC Register

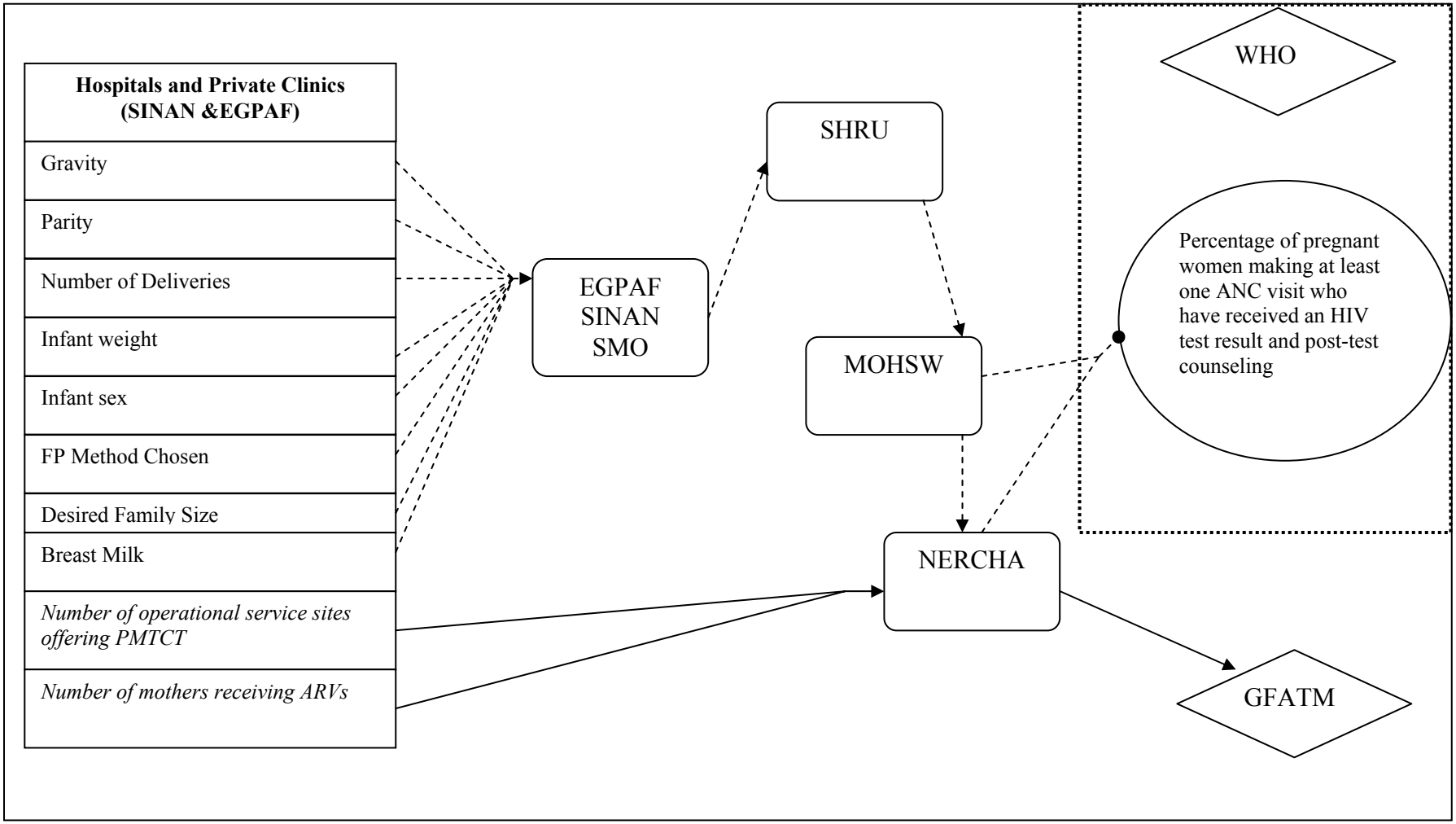


Figure 7: Sexually Transmitted Infections Care

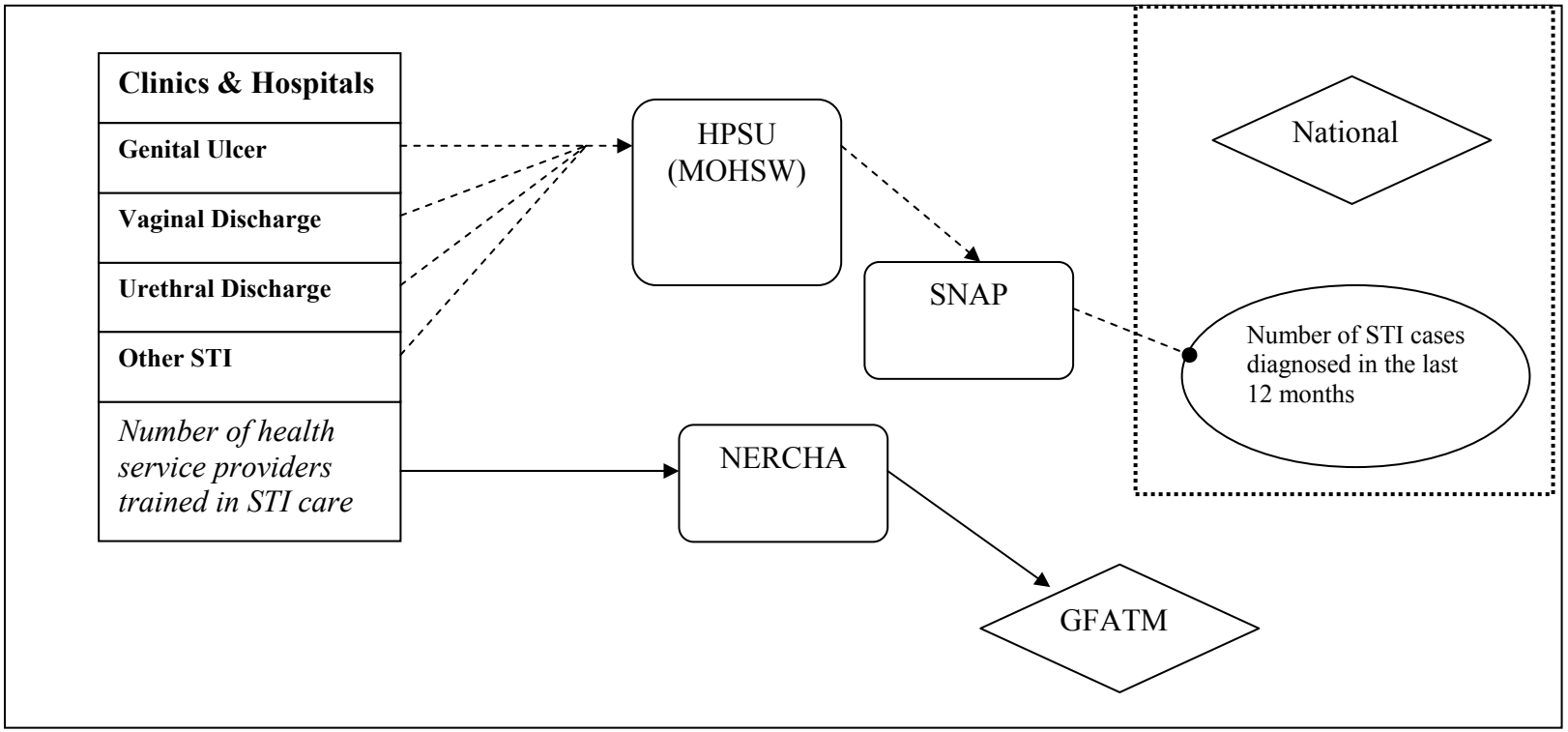


Figure 8: Post-Exposure Prophylaxis

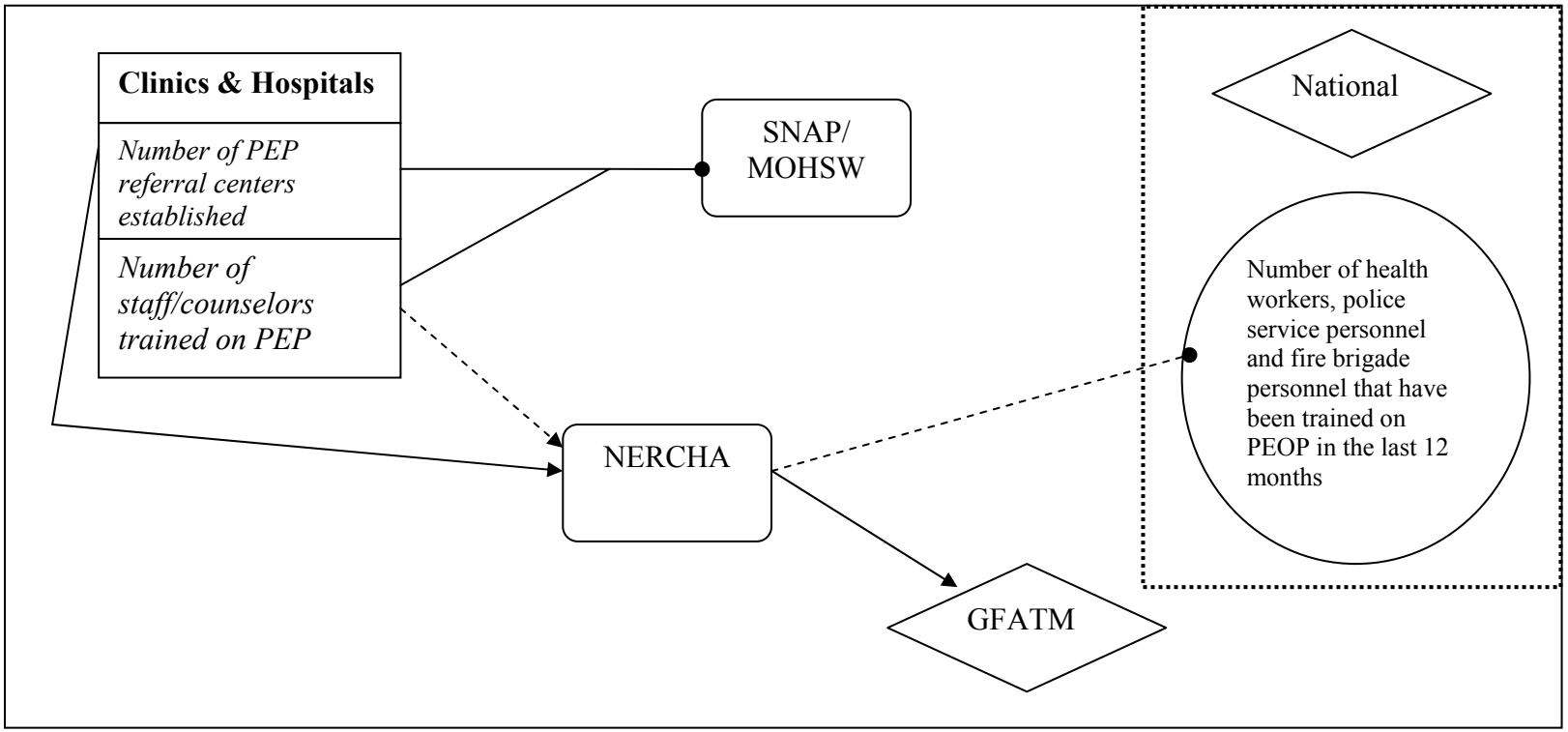


Figure 9: Anti-retroviral Therapy

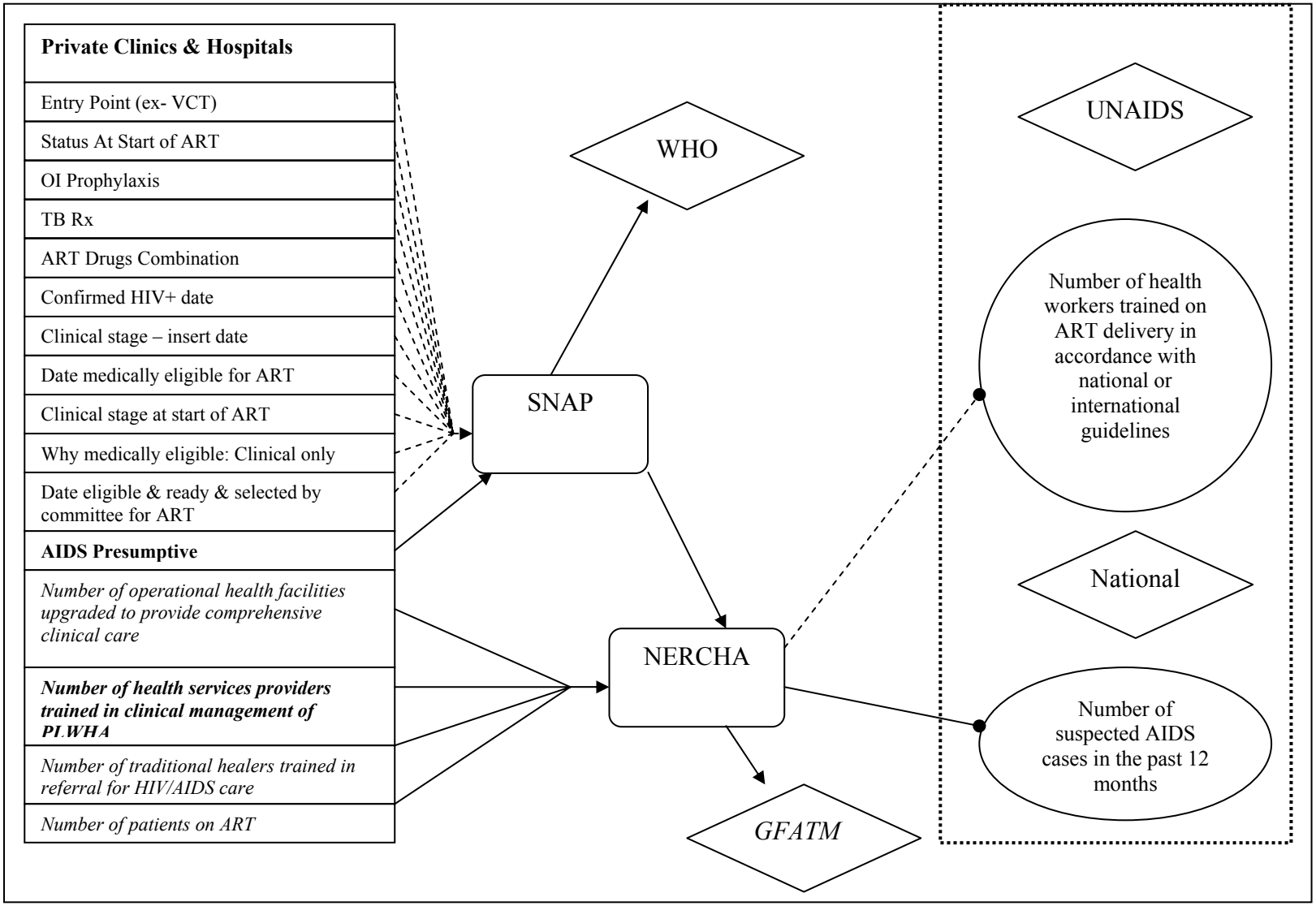


Figure 10: Management of Tuberculosis and HIV

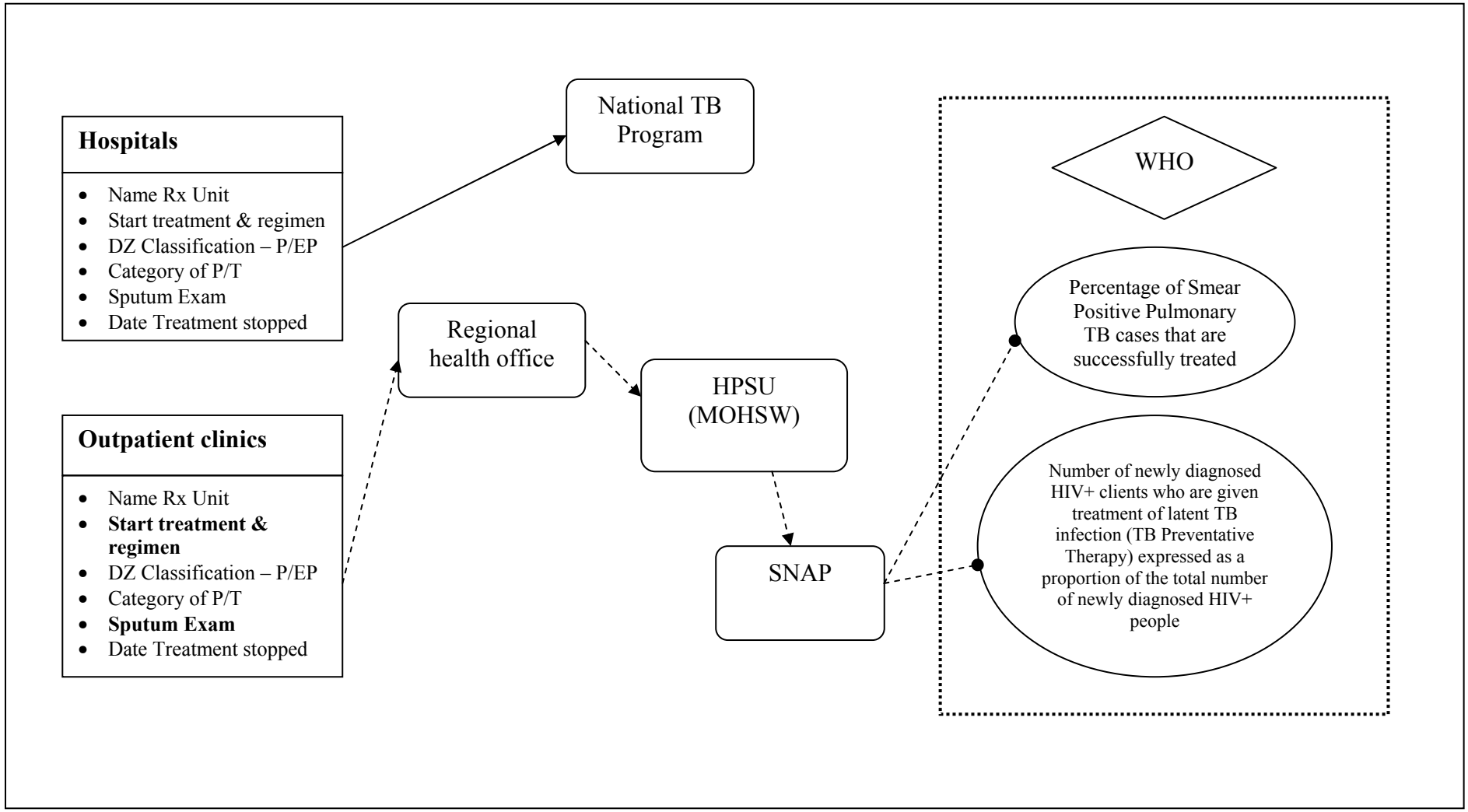


Figure 11: HIV Counseling and Testing

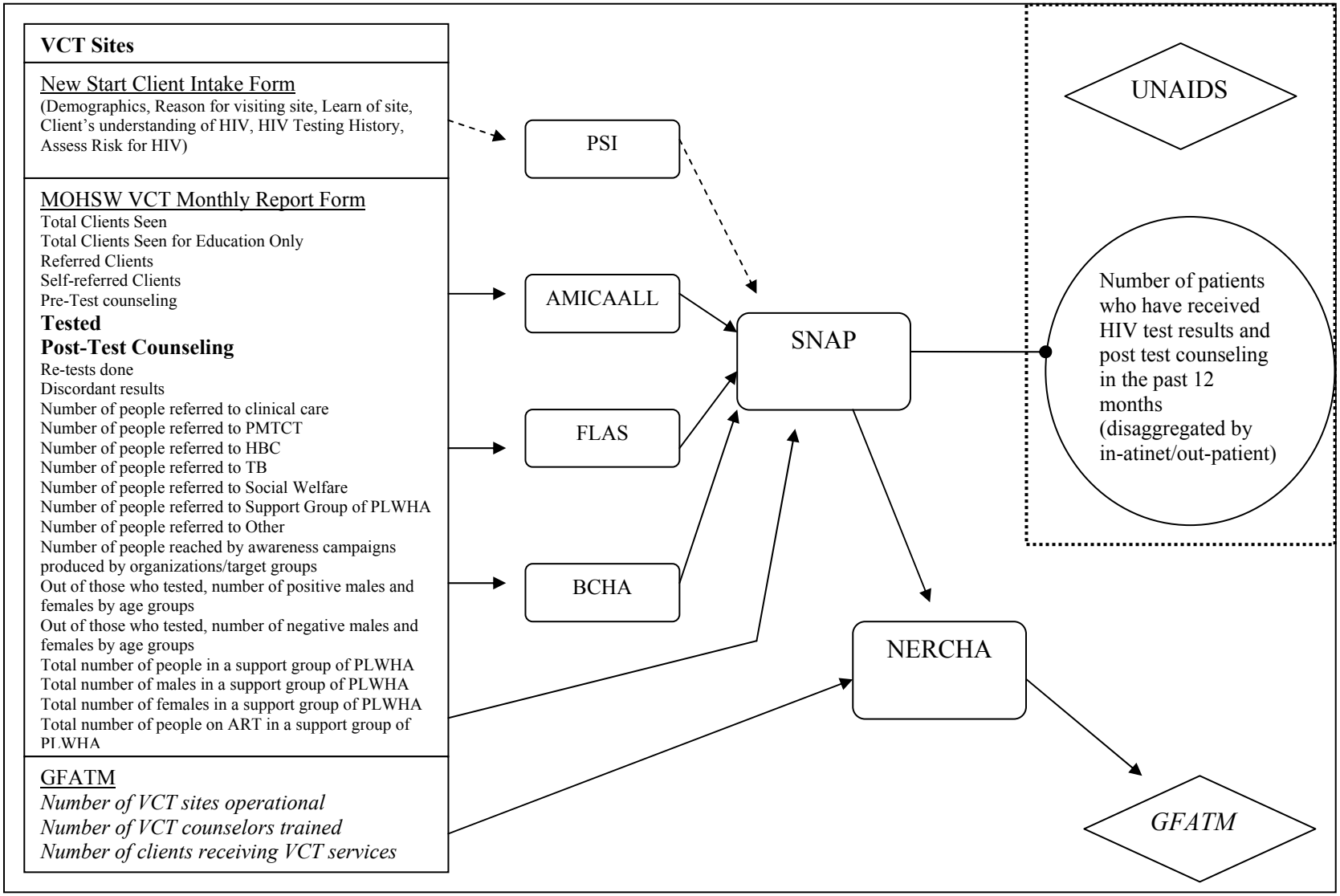


Figure 12: Community-Home-Based Care

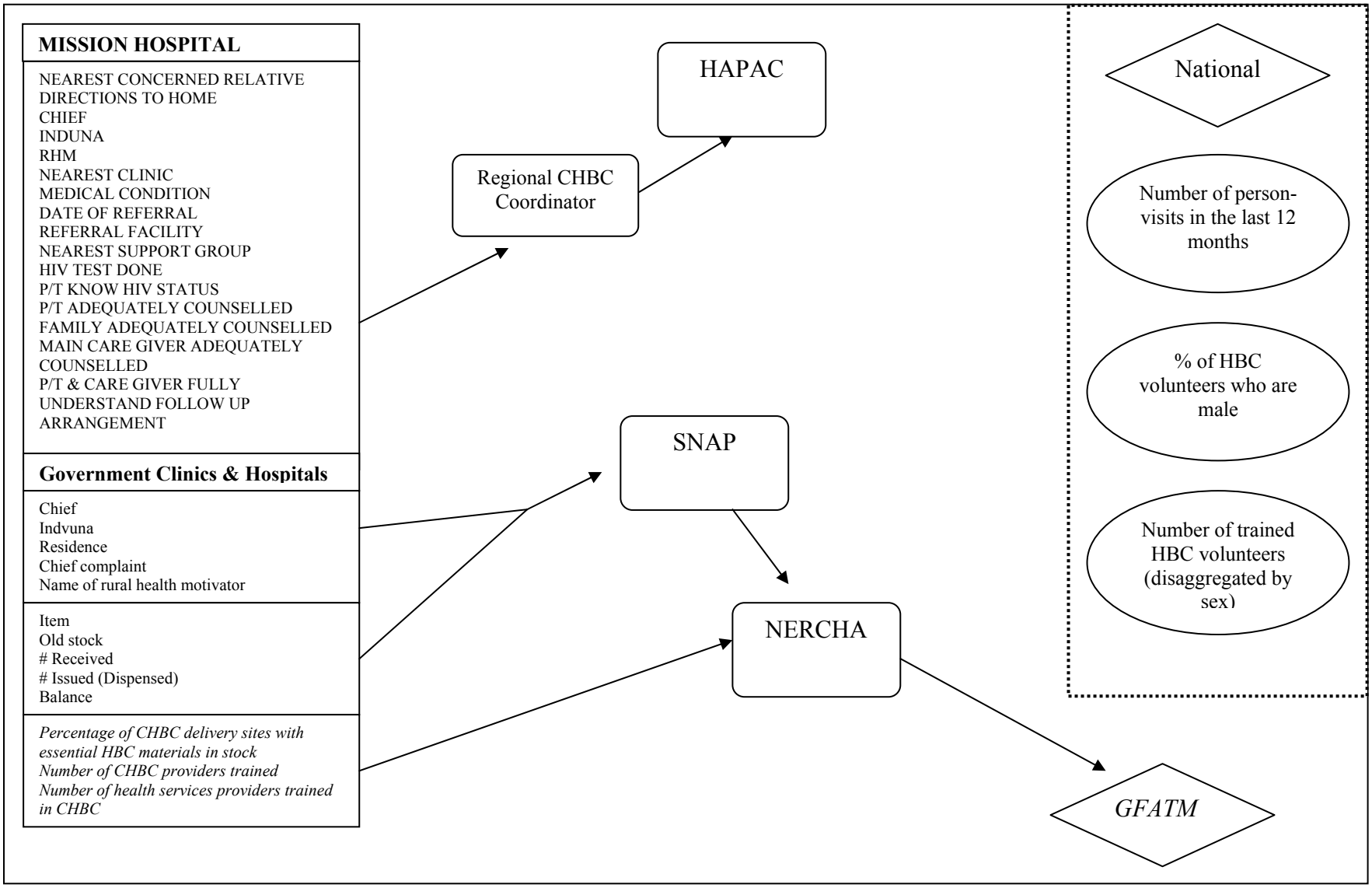


Table 17: National Multi-Sectoral Response Output Level Indicators Lacking Data Collection

Indicator	Program Area	Data Source
Percentage of schools with at least one teacher who has been trained in participatory life-skills based HIV/AIDS education and who taught it during the last academic year	Behavior Change Communication	School data from existing school surveys
Number of active peer/community educators in the last 12 months	Behavior Change Communication	SHAPMoS
Number of young people exposed to life-skills based HIV/AIDS education in the last 12 months (disaggregated by in-school youth / out-of-school youth)	Behavior Change Communication	SHAPMoS
Percentage of districts or regions with access to blood transfusion services which do not pay blood donors, and do not recruit donors from among relatives of the patient	Blood Safety	MOHSW HIV M&E System Data
Percentage of health facilities providing STI care that report no stock-outs of STI drugs of more than one week in the last 12 months	STI Treatment and Management	MOHSW HIV M&E System Data
Number of health workers trained on syndromic management of sexually transmitted infections according to national guidelines in the last 12 months	STI Treatment and Management	MOHSW HIV M&E System Data
Number of eligible persons that have undergone PEP treatment in the last 12 months	Post-Exposure Prophylaxis	SHAPMoS
Number of events that took place to promote community-level involvement in HIV prevention in the last 12 months	Community mobilization and capacity building	SHAPMoS
Percentage of chiefdoms and towns that have implemented programs for HIV prevention in place in the last 12 months (disaggregated by type of program and type of town)	Community mobilization and capacity building	SHAPMoS
Number of PLWHA who are receiving nutritional support from health facilities in the last 12 months	Pre-antiretroviral Therapy	MOHSW HIV M&E System Data
Number of personnel trained to provide palliative care	Palliative care	MOHSW HIV M&E System Data
Number of terminally ill patients receiving palliative care before death	Palliative care	MOHSW HIV M&E System Data
Percentage of registered traditional practitioners trained on HIV/AIDS	Traditional and alternative health therapies	SHAPMoS
Number of persons that have been trained on the rights of PLWHAs, widows, OVC or PWD in the last 12 months	Provision & protection of legal, ethical and social rights	SHAPMoS
Number of abuse cases reported in the last 12 months	Provision & protection of legal, ethical and social rights	SHAPMoS
Number of policies for vulnerability that have been enacted in the last 12 months	Provision & protection of legal, ethical and social rights	SHAPMoS
Number of community based organizations trained in planning, implementation and management of HIV/AIDS initiatives	Community driven impact mitigation programs	SHAPMoS

Indicator	Program Area	Data Source
Number of trained community based organizations that have an action plan for impact mitigation activities	Community driven impact mitigation programs	SHAPMoS
Number of persons, families, and community based organizations that are involved in implementing impact mitigation programs	Community driven impact mitigation programs	SHAPMoS
Number of vulnerable individuals covered by expanded social security system in the last 12 months	Provision of Psychosocial & Economic Support	SHAPMoS
Number of vulnerable groups receiving psychosocial support in the last 12 months (disaggregated by type of vulnerable group and type of support)	Provision of Psychosocial & Economic Support	SHAPMoS
Percentage of ministries, NERCHA units, and coordinating bodies that have developed an annual workplan, with an approved budget, and that have implemented it	Institutional Organization	SHAPMoS
Number of CBOs that are involved in implementing HIV/AIDS activities	Community mobilization	SHAPMoS
Number of Memoranda of Understanding signed with NERCHA	Community mobilization	SHAPMoS
Number of persons that have attended trainings run by NERCHA	Community mobilization	SHAPMoS
Number of communication, advocacy, and PR events that NERCHA have organized (disaggregated by type of event)	Advocacy, public relations, and communication	SHAPMoS

APPENDIX 2: Health Sector Registers Capturing HIV/AIDS Data

Table 18: Health Sector Registers Capturing HIV/AIDS Data

Form/Register Name	Data Element Number	Facilities using Register	Type of facility using Register	Programmatic Area	Who Produced Register
OPD Register	70	Tikhuba Clinic	Clinic w/out maternity	ALL	MOHSW
		Hlatikulu Hosp	Hospital	ALL	
		Ntfonjeni Clinic	Clinic w/out maternity	ALL	
MOHSW Monthly Summary Sheet	7	RFM Hospital	Hospital	ALL	MOHSW
Facility HIV Care (pre-ART Register)	25	RFM Hospital	Hospital	ART	MOHSW
Pre-ART Register	28	RFM Hospital	Hospital	ART	SNAP/MOHSW
ART Register	22	GS Hospital	Hospital	ART	SNAP/MOHSW
Appointment Register	8	GS Hospital	Hospital	ART	SNAP/MOHSW
GS MAIN ART REGISTER	26	GS Hospital	Hospital	ART	GS Hospital
GS Hosp Daily Attendance Register	9	GS Hospital	Hospital	ART	GS Hospital
ART Register 2004-2005	21	RFM Hospital	Hospital	ART	MOHSW
Swaziland HIV Antibody Testing Lab Register	13	RFM Hospital	Hospital	ART	MOHSW
ANC Register	28	RFM Hospital	Hospital	PMTCT	MOHSW
		Tikhuba Clinic	Clinic w/out maternity	PMTCT	
		Phiani Clinic	Private Clinic	PMTCT	
		Imphilo Clinic	Private Clinic	PMTCT	
Post-Natal Follow-up Register for Women	12	Draft Register	Draft Register	PMTCT	SNAP/MOHSW
Follow-up Register for Children	15	Draft Register	Draft Register	PMTCT	SNAP/MOHSW
MOHSW Monthly VCT Summary Form	27	GS Hospital	Hospital	VCT	SNAP/MOHSW
VCT Tallying Book Register	10	Hlatikulu Hosp	Hospital	VCT	Hlatikulu Hosp
PSI NEW START SWD: VCT Client Intake FORM	6	GS Hospital	Hospital	VCT	PSI
SNAP Counseling Report	5	Tikhuba Clinic	Clinic w/out maternity	VCT	SNAP
Monthly STD Surveillance Report	23	Tikhuba Clinic	Clinic w/out maternity	STI Management	MOHSW
ART & VCT Chemistry Results	23	RFM Hospital	Hospital	LAB (ART/VCT)	RFM Hosp Lab
Tikhuba Clinic CHBC Register	10	Tikhuba Clinic	Clinic w/out maternity	CHBC	Tikhuba Clinic
CHBC Register (Tikhuba)	7	Tikhuba Clinic	Clinic w/out maternity	CHBC	MOHSW
GS CHBC Individual patient hospital-based record	24	GS Hospital	Hospital	CHBC	GS Hospital
GS CHBC	9	GS Hospital	Hospital	CHBC	GS Hospital
GS NUTRITION	8	GS Hospital	Hospital	Nutrition	GS Hospital
GS OVC	4	GS Hospital	Hospital	OVC	GS Hospital
The Hope House Monthly Statistics	8	Hope House	Palliative Care	Palliative Care	Hope House
Hope House Access Database	5	Hope House	Palliative Care	Palliative Care	Hope House

APPENDIX 3: Institutional Inventory Lists

Institutional Inventory Lists

One activity of the assessment has been establishing a list of which facilities are operating where and delivering what services. This list will be used and validated by the Service Availability Mapping Exercise to be conducted by WHO during January, 2006. Ideally, this list will form the basis of the health sector response section of a national programmatic database that will need to be housed at the HSR and NERCHA M&E Units.

Table 19: Health Facilities

Name	Clinic	Public Health Unit	Health Center	Hospital	Hhohho	Lubombo	Manzini	Shiselweni	Area Urban/ rural/ Company	PMTCT	STI Care	PEP	VCT	ART
1st Bn Mbangweni USDF	X						X		Urban					
Balekane Nazarene Clinic	X				X				Rural	X	X			
Bethany Clinic								X	Rural		X			
Bhekinkosi Nazarene Clinic	X						X		Rural	X	X			
Bholi Clinic	X					X			Rural		X			
Bhunya Health Centre		X					X		Company					
Bhunya Mill Clinic			X				X		Company			X		X
Bulandzeni Clinic	X				X				Rural		X			
Bulunga Nazarene Clinic	X						X		Rural	X				
Cadbury Industry							X		Company					
Cana Clinic	X						X		Rural	X				
Children's Clinic	X				X				Urban					
Criminal Lunatic	X						X		Urban					
Dvokolwako Health Centre			X		X				Rural		X	X	X	X
Dwaleni Clinic	X						X	X	Rural					
Ebenezer Clinic	X					X			Rural		X			
Ekudzeni Thole Clinic	X						X		Rural					
Ekuphileni Clinic	X				X				Rural		X			
Ekuthuleni Clinic	X						X		Rural					
Emkhuzweni Rural Health Center			X		X				Rural			X	X	X
Emoyeni Clinic	X						X		Rural		X			
Emphelandzaba Clinic								X	Rural		X			
Engculwini Clinic	X						X		Rural					
Esigombeni Clinic	X						X		Rural	X	X		X	
Family Life Association	X						X		Urban				X	
Ferado Clinic	X				X				Company		X			
Flame Clinic	X					X			Rural		X			
Gcina Bethany Clinic	X						X		Rural		X			

Name	Clinic	Public Health Unit	Health Center	Hospital	Hhohho	Lubombo	Manzini	Shiselweni	Area Urban/ rural/ Company	PMTCT	STI Care	PEP	VCT	ART
Gebeni Clinic	X						X		Rural	X				
Gege Clinic								X	Rural		X			
Gilgal Clinic	X					X			Rural		X			
Good Shepherd Hospital				X		X			Rural		X	X	X	X
Good Shepherd Public Health Center		X				X			Rural	X				
Havelock Mine Health Center				X	X				Company		X			
Health Services	X				X				Urban					
Herefords Community Clinic	X				X				Rural		X			
Hillside Clinic	X						X		Urban					
Hlane Clinic	X					X			Rural		X			
Hlatikulu Hospital				X				X	Urban		X	X	X	
Hlatikulu Public Health Center		X						X	Urban		X			
Hluti Clinic								X	Rural		X			
Horo Clinic	X				X				Rural		X			
Ikwezi Joy Clinic	X					X			Rural		X			
Imphilo Clinic	X						X		Urban					X
Jericho Clinic								X	Rural		X			
Kabhudla Clinic	X						X		Rural					
Khuphuka		X				X			Urban					
King Sobhuza II Health Centre			X				X		Urban					
Kwaluseni University Clinic	X						X		Urban					
Lamvelase Zombodze Clinic	X						X		Rural	X	X			
Lavumisa Clinic								X	Rural		X			
Lemlandvo Clinic	X						X		Rural					
Lobamba Clinic	X				X				Rural		X			
Lomahasha Clinic	X					X			Rural		X			
Lubulini Clinic	X					X			Rural		X			
Lunyengo Student Clinic	X						X		Rural					
Lushikishini Clinic	X						X		Rural					

Name	Clinic	Public Health Unit	Health Center	Hospital	Hhohho	Lubombo	Manzini	Shiselweni	Area Urban/ rural/ Company	PMTCT	STI Care	PEP	VCT	ART
Luve Anglican Clinic	X						X		Rural					
Luyengo Clinic	X						X		Rural	X				
Mafutseni Nazerene Clinic	X						X		Rural	X	X			
Magubheleni Clinic	X						X		Rural					
Mahlandle Clinic								X	Rural		X			
Mahlangatsha Sibovu Clinic	X						X		Rural					
Mahlanya Clinic	X						X		Rural					
Mahwalala Red Cross Clinic	X				X				Urban		X			
Malandzela Clinic	X				X				Rural	X				
Malindza Manyeveni Clinic	X					X			Rural					
Malindza Refugee Camp	X					X			Rural					
Malkerns Clinic USDF	X						X		Rural					
Malkerns Family Life Association	X						X		Rural					
Managa College Clinic	X					X			Rural					
Mangcongco Clinic	X						X		Rural	X				
Mangedla Clinic	X				X				Rural		X			
Mangweni Clinic	X				X				Rural		X			
Mankayane Hospital				X			X		Urban	X	X	X	X	X
Mankayane Public Healthe Center		X					X		Company					
Manzini Town Council	X						X		Urban					
Mashobeni clinic								X	Rural		X			
Matsanjeni Clinic								X	Rural		X	X		X
Matsapha Central Prison	X						X		Urban					
Matsapha Tuberculosis Hospital				X			X		Urban					
Matsapha Women Prison	X						X		Urban					
Mbabane City Council Clinic	X				X				Urban					
Mbabane Family Life					X				Urban				X	
Mbabane Government Hospital	X				X				Urban		X	X	X	X
Mbabane Public Health Center		X			X				Urban					

Name	Clinic	Public Health Unit	Health Center	Hospital	Hhohho	Lubombo	Manzini	Shiselweni	Area Urban/ rural/ Company	PMTCT	STI Care	PEP	VCT	ART
Mbasheni Clinic	X				X				Rural		X			
Mdzimba Clinic USDF	X						X		Rural					
Mhlambanyatsi Clinic	X						X		Company					
Mhlambanyatsi Clinic	X				X				Urban					
Mhlosheni Clinic								X	Rural		X			
Mhlume Med. Serv. At Mhlume	X					X			Company			X		
Mhlume Med. Serv. At Tshaneni			X			X			Company					
Mill Clinic	X					X			Urban					
Millsite Clinic	X				X				Rural		X			
Mkhiwa Clinic - Malkerns	X						X		Rural					
Mkhulamini Clinic	X						X		Rural	X	X			
Mliba Nazarene Clinic	X						X		Rural	X	X			
Mondi Forest Clinic	X				X				Company					
Motshane Community Clinic	X				X				Rural		X			
Mpaka Colliers Dressing Station	X					X			Rural					
Mpaka Railway						X			Company					
Mpolonjeni Clinic	X					X			Rural		X			
Mshingishingini Clinic	X				X				Rural	X	X			
Musi Clinic	X						X		Rural					
National Psychiatric Hospital				X			X		Urban			X		
Ncabeni Clinic	X						X		Rural					
Ndzevane Clinic	X					X			Rural		X			
Ndzingeni Clinic	X				X				Rural	X	X			
New Haven Clinic								X	Rural		X			
Ngomane Clinic	X					X			Company					
Ngonini Estate Clinic	X				X				Rural		X			
Nhlangano Public Health Center		X						X	Urban		X			
Nhletsheni Clinic								X	Rural		X			
Nkaba Clinic	X				X				Rural	X	X		X	

Name	Clinic	Public Health Unit	Health Center	Hospital	Hhohho	Lubombo	Manzini	Shiselweni	Area Urban/ rural/ Company	PMTCT	STI Care	PEP	VCT	ART
Nkiliji Clinic	X						X		Rural					
Nkoyoyo Clinic	X						X		Urban					
Nkwene Hill Clinic								X	Rural		X			
Nonhlanhla Clinic	X						X		Rural		X			
Ntfonjeni Clinic	X				X				Rural					
Ntshanini Clinic								X	Rural		X			
Occupational Health Services	X						X		Urban					
Osabeni								X	Rural					
Our Lady of Sorrows Clinic								X	Rural		X			
Philani Clinic	X						X		Urban					
Philani Clinic								X	Urban		X			
Phiwinhlanhla Clinic	X						X		Urban					
Phumelele Clinic	X						X		Urban					
Phunga Clinic								X	Rural	X	X			
Piggs' Peak Hospital				X	X				Company		X	X	X	X
Piggs' Peak Nazarene Clinic	X				X				Company	X	X			
Piggs' Peak Public Health Center		X			X				Company		X		X	
Raleigh Fitkin Memorial Hospital				X			X		Urban	X	X	X	X	X
Regina Mundi Clinic	X				X				Company					
Remand Prison	X						X		Urban	X				
Salvation Army Clinic	X				X				Urban		X		X	
School Health								X	Rural					
Scutt Jubilee Clinic	X						X		Rural					
Shewula Clinic	X					X			Rural	X	X			
Sibonginkosi Clinic	X						X		Urban					
Sicelwini Clinic	X						X		Company					
Sidvokodvo Lomgelatshane	X						X		Rural					
Sidvokodvo Railway Swaziland	X						X		Company					
Sigangeni Clinic	X				X				Rural		X			

Name	Clinic	Public Health Unit	Health Center	Hospital	Hhohho	Lubombo	Manzini	Shiselweni	Area Urban/ rural/ Company	PMTCT	STI Care	PEP	VCT	ART
Sigcaweni	X					X			Rural	X				
Sigcineni Clinic	X						X		Rural	X	X			
Silele Clinic								X	Rural		X			
Simunye Clinic			X			X			Company	X	X		X	X
Sinceni Clinic	X					X			Rural		X			
Siphofaneni Clinic	X					X			Rural		X			
Siteki Health Center	X					X			Company					
Siteki Nazarene Health Center	X					X			Company	X				
Siteki USDF	X						X		Urban					
Sithathaweni Clinic	X					X			Rural	X	X			
Sitobela Rural Health Center			X			X			Rural			X		X
SOS Children's Village Clinic	X				X				Urban					
Spintex Industry							X		Company					
St. Florence Clinic	X						X		Rural					
St. Juliana's Clinic	X						X		Rural					
St. Mary's Clinic	X				X				Rural		X			
St. Phillip's Clinic	X					X			Rural		X			
St. Theresa's Clinic	X						X		Urban	X	X			
Swazi Paper Mills							X		Urban					
Swazican Clinic	X						X		Rural					
Swaziland Bottling Company							X		Urban					
Swaziland Breweries							X		Rural					
Swaziland Meat Industry							X		Urban					
Tambankulu Estates Clinic	X					X			Rural		X			
Tambuti Estate Clinic	X					X			Rural					
The Clinic					X				Urban					
Tikhuba Clinic	X					X			Rural		X			
Ubombo Ranches Clinic			X			X			Company					
Umbutfo Defence Force (Phocweni)	X						X		Rural				X	

Name	Clinic	Public Health Unit	Health Center	Hospital	Hhohho	Lubombo	Manzini	Shiselweni	Area Urban/ rural/ Company	PMTCT	STI Care	PEP	VCT	ART
Vuvulane Clinic	X					X			Rural		X			
Zombodze Clinic								X	Rural		X			

Table 20: Impact Mitigation Implementing Organizations

Name of Organization/Agency/Stakeholder	TYPE	Hhohho	Lubombo	Manzini	Shiselweni	Rural	Urban
ABC Ministry	FBO						
Africa on Screen TV Productions	PRIVATE	X	X	X	X	X	X
African Development Bank	DONOR						
African Development Fund	DONOR						
African Evangelical Church	FBO						
AIDS Awareness Committee "Help Sufferers Project"	PRIVATE			X		X	
Alliance Church of Swaziland	FBO	X				X	X
Alliance of Mayors' Initiative for Community Action on AIDS at the Local Level	NGO						
Association of Students Against Drug Abuse and Trafficking	NGO						
Association of Swaziland Theatre Groups	NGO						
Australian Agency for International Development	DONOR						
Baphalali Swaziland Red Cross	NGO						
Bible Society of Swaziland (The)	FBO						
Bread of Life Ministries	FBO	X					X
Bread of Life Ministries	FBO	X					X
Canadian International Development Agency	DONOR						
Care Nakekela	FBO	X	X	X			
CARE USA	DONOR						
Caritas Swaziland	FBO						
Channel Swazi	PRIVATE	X	X	X	X		X
Cheshire Homes	NGO						
Christian Campaign Against AIDS	FBO		X	X		X	X
Christian Media Centre	FBO						
Church Forum	FBO						
Church of the Nazarene	FBO						
City Council of Manzini	PRIVATE						
City Council of Mbabane	PRIVATE						
Clinic (The)	PRIVATE	X					X
Coordinating Assembly of NGOs	NGO						

Name of Organization/Agency/Stakeholder	TYPE	Hhohho	Lubombo	Manzini	Shiselweni	Rural	Urban
COSAD	NGO						
Council of Swaziland Churches	FBO		X	X	X	X	X
Development Planning and Research Consultants	PRIVATE	X	X	X	X	X	X
Dove Television	PRIVATE	X	X	X	X		X
Ekhaya Consultancy HIV/AIDS Program	PRIVATE	X					X
Ekukhanyeni Inkhundla	CBO						
Entandweni Community: Malindza Miracle Centre	CBO						
Faith Bible School Health	FBO						
Family Life Association Clinic	NGO						
Family Life Association of Swaziland	NGO						
Federation of Organizations of Disabled People	NGO						
Fundza Centre	NGO						
Good Sheperd Eye Project	FBO						
Good Shepherd Hospital	FBO		X			X	
Holy Catholic Apostolic Church in Zion (The)	FBO						
Hope House	FBO		X				X
Humaras	PRIVATE						
Innovir Institute	NGO						
Institute of Development Management	PRIVATE	X	X	X	X		X
Internal Future Living Organization	PRIVATE	X				X	
International Baby Food Action Network Africa	PRIVATE						
International Committee of Red Cross Societies	NGO						
International Federation of National Red Cross and Red Crescent Societies	NGO						
International Labour Organization	DONOR						
International Tabernacle	FBO	X		X		X	X
IPPF International Planned Parenthood Foundation	DONOR						
Italian Direzione Generale per la Cooperazione allo Sviluppo	DONOR						
Japanese International Co-operation Agency	DONOR						
Jesus Army for AIDS Prevention and Care	FBO	X					X
Joint UN program on HIV/AIDS	UN						
Khulisa Umntfwana Project	CBO	X	X	X	X	X	

Name of Organization/Agency/Stakeholder	TYPE	Hhohho	Lubombo	Manzini	Shiselweni	Rural	Urban
Langa Community - World Vision	CBO						
Law Society (The)	PRIVATE						
Leadership for Africa	PRIVATE	X				X	
Leadership Regional Network for South Africa	NGO						
League of Churches	FBO	X	X	X	X	X	X
Light House	FBO	X		X	X	X	X
Lobamba Health & Development Club	PRIVATE	X				X	
Lobamba Inkhundla Youth Association	CBO						
Lubombo Youth Association	CBO						
Lutheran Development Services	PRIVATE						
Lutsango LwakaNgwane	CBO						
Luyengo Community	CBO						
Lwati Training Institute	PRIVATE	X	X	X	X		X
Mafutseni Inkhundla - Thulwane Development Block yard	CBO						
Mahlangatsha Community	CBO						
Manzini Youth Club	CBO			X		X	X
Maphiveni Theatre Arts Performing Organization	CBO		X			X	
Mbekelweni Community	CBO						
Mhlathuze Future's Association	CBO						
Mkhulamini Community	CBO						
Mobile Technical Training Institute "Balolongi"	PRIVATE	X	X	X	X	X	
Motshane Youths Alliance Initiative On HIV/AIDS	CBO	X				X	
Mphembekati Community	CBO						
Mr. Bread	PRIVATE						
MTN Swaziland	PRIVATE	X	X	X	X		X
Mtsambama Inkhundla	CBO						
Multi-Media Communication Resource Unit	PRIVATE	X	X	X	X	X	X
Multisectoral HIV/AIDS Committee Lubombo	CBO						
National Council on Smoking, Alcohol, Drug Abuse	NGO						
National Emergency Response Council on HIV/AIDS	NAC						
National Football Association of Swaziland	PRIVATE						
Ngcampholala Youth Association	CBO		X			X	
Nhlangano HIV/AIDS Training, Info & Counseling Centre	CBO				X	X	X

Name of Organization/Agency/Stakeholder	TYPE	Hhohho	Lubombo	Manzini	Shiselweni	Rural	Urban
Nkhaba Community Inkhundla - Asihlalisane bomake	CBO						
Office of the UN High Commissioner for Refugees	UN						
Office of the United Nations High Commissioner for Human Rights	UN						
Parish Nurse program	FBO						
PSI Swaziland	NGO						
Royal Swaziland Sugar Cooporation	PRIVATE						
Salvation Army	FBO						
Salvation Army Clinic	FBO	X					X
Save the Children Fund (SAVE)	NGO						
Save the Children Swaziland	NGO						
School of Appropriate Farming Technology	PRIVATE						
Schools Health & Population Education	NGO						
Scripture Union Swaziland	FBO	X	X	X	X	X	X
Sebenta National Institute	PARASTATAL						
Setsembiso Sebunye High School	MOE						
SHAPE	NGO						
Shewula Community - Ayibuye Imbeleko	CBO						
Shewula Orphanaid (Aybuy' Mphilo)	CBO		X			X	
Shoba Community	CBO						
Sidwashini against HIV and AIDS	CBO	X					
Siphila Nje Drama Society	PRIVATE	X	X	X	X	X	X
Sithobela Community	CBO						
Siya Embili Arts Society	CBO						
SOS Swaziland.	NGO						
Swazi Med Scheme	PRIVATE	X	X	X	X	X	X
Swazi Paper Mills	PRIVATE			X			X
Swaziland Action Group Against Abuse	NGO						
Swaziland AIDS Support Organization	NGO						
Swaziland Bottling Company Clinic	PRIVATE			X			X
Swaziland Boy Scouts Association	NGO						
Swaziland Breweries	PRIVATE			X		X	
Swaziland Conference of Churches	FBO	X	X	X	X	X	X

Name of Organization/Agency/Stakeholder	TYPE	Hhohho	Lubombo	Manzini	Shiselweni	Rural	Urban
Swaziland Electricity Board	PRIVATE						
Swaziland Federation of Trade Unions	PRIVATE	X	X	X	X		X
Swaziland Hospice at Home	NGO						
Swaziland Infant Nutrition Action Network	NGO						
Swaziland Institute for Management & Public Administration	PARASTATAL						
Swaziland Medical & Dental Association	PRIVATE						
Swaziland Medical & Dental Council	PRIVATE	X				X	X
Swaziland National Association of Journalists	PRIVATE						
Swaziland National Association of the Deaf	NGO						
Swaziland National HIV/AIDS Literacy Control program	***						
Swaziland National Network of People Living With HIV/AIDS	NGO						
Swaziland Network of AIDS Service Organizations	NGO						
Swaziland Nursing Association	PRIVATE						
Swaziland Olympic and Commonwealth Games Association	PRIVATE						
Swaziland Poets Association	PRIVATE	X	X	X	X	X	
Swaziland Private Coalition against HIV/AIDS	PRIVATE	X	X	X	X	X	X
Swaziland Women Against HIV/AIDS	NGO						
Swaziland Work Camps Association	NGO						
Swaziland Youth United against HIV/AIDS	NGO						
Sword & Spirit Ministries	FBO						
The AIDS Information and Support Centre	NGO						
Times of Swaziland	PRIVATE						
Traditional Healers Organization	NGO						
UN Children's Fund	UN						
UN Development program	UN						
UN Drug Control program	UN						
UN Educational, Scientific and Cultural Organization	UN						
UN Fund for Drug Abuse Control	UN						
UN Population Fund	UN						

Name of Organization/Agency/Stakeholder	TYPE	Hhohho	Lubombo	Manzini	Shiselweni	Rural	Urban
United Christian Church of Africa	FBO						
United Methodist Episcopal Church	FBO						
United Nations Development Fund for Women	UN						
US Agency for International Development	DONOR						
US Centers for Disease Control and Prevention	DONOR						
Voice of Victory	FBO						
Women & Law Swaziland	NGO						
Women Together Organisation	NGO						
Women's Resource Centre	NGO						
World Bank	DONOR						
World Food program	UN						
World Health Organization	UN						
World Teach	FBO	X	X	X	X	X	X
World University Services	NGO						
World Vision International	FBO						
World Vision Swaziland	NGO						
Youth Brigade	NGO						
Zondle Women's Organization	NGO						

APPENDIX 4: Dissemination Channels

Data Sources, Information Products, and Dissemination Channels

Two major data sources can be differentiated:

- Indicators (outcome indicators) that will be measured by surveys
- Indicators (output indicators) that will be measured using continuously monitored program outputs.

Information products are generated by collected data for the purpose of feeding back information to those organizations collecting data as well as for wider dissemination purposes. The information products to be produced by the NERCHA include:

- Quarterly service coverage report
- Annual HIV/AIDS M&E report
- Biennial UNGASS report
- Periodic newsletter.

A system is being developed that will allow the NERCHA M&E Unit to ensure proper dissemination of the critical information (information products based upon data sources) to all stakeholders and to the general public. This system includes:

- E-mailing reports in PDF format to selected stakeholders
- Quarterly feedback workshops by regional HIV/AIDS M&E coordinators (RACs) to disseminate results of the previous quarter and plan for the next quarter
- Annual national review meeting during which the NERCHA M&E Unit will present the analyzed national core indicators and the results of the resource and output tracking
- Dissemination through the media of relevant news and results by advertisements on radio and television and in newspapers. (NERCHA, 2005)

The Dissemination Channel Matrix is presented as a baseline matrix. It is expected that this will be a dynamic tool that will be adopted and modified as information products and data sources change. The purpose of the matrix is to be able to quickly identify the data source with an information product and its appropriate dissemination method.

Table 21: Dissemination Channel Matrix

Data Source	Information Products				
	Quarterly Service Coverage Report	Annual HIV/AIDS M&E Report	Biennial UNGASS Report	Periodic Newsletter	Ad Hoc Products
Biological HV Surveillance					
ANC Clients	***	Annual Meeting Review e-mail	Annual Meeting Review e-mail	***	Media e-mail
Blood Donors	***	Annual Meeting Review e-mail	***	***	Media e-mail
STI Clients	***	Annual Meeting Review e-mail	***	***	Media e-mail
TB Clients	***	Annual Meeting Review e-mail	***	***	Media e-mail
Health Facility Survey	***	Annual Meeting Review e-mail	Annual Meeting Review e-mail	***	Media e-mail
OVC Policy & Planning Index	***	Annual Meeting Review e-mail	***	***	Media e-mail
Population-Based Surveillance					
BSS	***	Annual Meeting Review e-mail	***	***	Media e-mail
Census	***	Annual Meeting Review e-mail	***	***	Media e-mail
DHS	***	Annual Meeting Review e-mail	Annual Meeting Review e-mail	***	Media e-mail
Household Budget Survey	***	Annual Meeting Review e-mail	***	***	Media e-mail
MICS	***	Annual Meeting Review e-mail	***	***	Media e-mail
School Data from Existing Surveys	***	Annual Meeting Review e-mail	Annual Meeting Review e-mail	***	Media e-mail
SHAPMoS	Quarterly RAC Workshops	Annual Meeting Review e-mail	Annual Meeting Review e-mail	Media e-mail	Media e-mail
SNAP/MOHSW M&E System	***	Annual Meeting Review e-mail	Annual Meeting Review e-mail	Media e-mail	Media e-mail
Workplace Survey	***	Annual Meeting Review e-mail	Annual Meeting Review e-mail	***	Media e-mail
Young People Policy Index	***	Annual Meeting Review e-mail	***	***	Media e-mail

APPENDIX 5: Health Care Delivery System

Table 22: Health Care Delivery System

Facility type	Health Care Unit	Staff	Capacity	Number
Clinic	Primary	• Nurses	• Outpatient services	162
Public Health Units	Secondary	• Nurses	• Health promotion • Prevention	8
Health Centers	Secondary	• Regional Medical officers • Nurses • Midwives	• Inpatient services (24-42 beds) • Minor surgery • Prevention curative outpatient services	12
Hospitals	Tertiary	• Specialist professionals	• Health Promotion • Prevention • Curative • Rehabilitation • Outpatient Services	7 (4 Regional)

Source: MOHSW, UNDP, NERCHA, HAPAC, World Bank, UNFPA, et al., 2005; HDA, Draft; USAID and CDC, 2004

APPENDIX 6: Definitions

Note: The following tables list definitions gathered during interviews. The items included in this table do not have official, documented definitions.

Table 23: Health Sector Definitions

Blood Safety	Clinic without Maternity	Community Home Based Care	Nutrition Services	Orphan Care	Outreach Site	Public Health Center	Rehabilitation Services
Ensures that blood for transfusion has been properly screened according to internationally recognized standards established by WHO.	An ambulatory facility *not* offering perinatal services.	Patient is being washed, assisted in taking medications (ARVs, OIs, pain medications), and assisted in food security, preparation, and eating. Care-take ensures appropriate supplies (napkins, gloves, soap, detergent, petroleum jelly, plastic linen savers) are issued and/or procured from HBC Containers at the Tinkundla level.	(a) Nutritional health education for proper feeding of children, including breast feeding. Provide nutritional supplements to the elderly and children. (b) Food provision and food security for individuals receiving ART and patients on treatment for TB. Food provision for children living with HIV/AIDS.	Provision of ARVs for orphans	Nurses based in a health center or clinic without maternity travel to remote communities to offer mobile services	A clinic that provides child health and ante-natal care.	Targets individuals who have experienced loss of sight, or other functional loss of a sensory or motor skill; convalescents unable to work; Individuals living with neuropathy.
Program to ensure blood transfusion is safe.	***	Service providers collect needed supplies from Tinkundla center to distribute in the community.	World Vision distributes food to communities through MOHSW.	***	***	***	***
***	***	Care and support (Clean water, medication management, feeding in home)given to a sick person or family member in the home or in the community	For those affected by HIV/AIDS, WFP helps with food deliveries.	***	***	***	***

Table 24: Impact Mitigation Definitions

Entity	Implementing Partner	Umbrella Bodies
An agent or organization that implements HIV/AIDS projects or programs in Swaziland. Undefined, difficulty to systematically differentiate between a project and a implementing partner if an entity is running only one project	An entity – government, private, public, NGO, FBO, CBO, academic, etc. – that implements an HIV/AIDS project or program in Swaziland, whether or not it is funded by NERCHA.	An institution that coordinates HIV/AIDS implementing partners in Swaziland. There are currently nine (9) recognized umbrella organizations operating in Swaziland that are mandated to coordinate the activities of implementing partners. If an implementing partner does not fall under another umbrella body, then that partner is coordinated by NERCHA
***	One of nine umbrella organizations that coordinates programs and projects and reports to NERCHA	***
***	A program or project receiving funding through NERCHA.	***

APPENDIX 7: Methods

Table 25: Instruments and Methods Matrix

Instrument Title	Purpose	Method
HIV/AIDS Program Inventory and HIS Assessment, Part A	To identify the data sources being collected by HIV/AIDS program implementers	Qualitative analysis
HIV/AIDS Program Inventory and HIS Assessment, Part B	To identify all organization and their program partners providing HIV/AIDS services and their routine data collection, management, and reporting to umbrella organizations, NERCHA, and the MOHSW.	Interview
Institutional Inventory List	To identify organizations offering STI/HIV/AIDS-related services. This should include civil sector, line ministries and individuals within the NERCHA and the MOHSW	Review and documentation
Indicator Inventory List	To document information on key indicators collected by NERCHA and the MOHSW or indicators requested by external donors such as UNAIDS	Review and documentation
National HMIS Overview	To provide an overview of the National HMIS	Interview
MOHSW, NERCHA, & SNAP M&E Capacity	To assess MOHSW, NERCHA, & SNAP M&E structures in terms of mandate and institutional capacity	Exploratory interview
Infrastructure Assessment	To assess the institutional capacity of the MOHSW in its efforts to effectively conduct M&E activities.	Interview
SNAP In-Depth Interview Guide	To assess SNAP program/project managers understanding of M&E capacity	Exploratory interview
NERCHA Dissemination Channel In-Depth Interview	To assess current communication between NERCHA and HIV/AIDS program implementers and to identify the most appropriate dissemination channels through which NERCHA can effectively and efficiently communication with the HIV/AIDS program implementers	Exploratory interview
Dissemination Channel Matrix	To identify the most appropriate dissemination channels through which NERCHA, MOHSW, SNAP can effectively and efficiently communication with the HIV/AIDS program implementers	Qualitative analysis
HIV/AIDS Research Inventory List	To identify HIV/AIDS researchers, organizations, and HIV/AIDS research in Swaziland. This should include civil sector, line ministries, universities, and public sector research facilities	Review and documentation[6]

[6] This list should be initiated through collaboration with an appropriate representative at the University of Swaziland and updated throughout the assessment

MOHSW/SNAP Health Facility Assessment

Sampling Methodology

A list of facilities in Swaziland was gathered from the HPSU in the MOHSW, cleaned, and sorted by region: Hhohho, Manzini, Lubombo, and Shiselweni. The facilities in these four lists were assigned sampling identification numbers and entered an Excel Workbook and formed the sampling frame. The four regional hospitals were automatically selected and therefore excluded from the sampling frame. Using the Data Analysis Sampling Tool 5% of facilities in each region were selected. The goal of the sampling methodology was to have all facility types represented in each of Swaziland's four regions. Sixteen facilities operating in Swaziland's four regions were selected to be included in the assessment.

Table 26: Facilities Sampled by Region

Name of Facility	Region	Urban/ Rural	Facility type	Owner	Programmatic Area
Mbabane Government Hospital	Hhohho	Urban	Hospital	Government	VCT, ART, STI, PEP
Mondi Forest Clinic	Hhohho	***	Clinic w/out maternity	Industry	Unknown
Ntfonjeni Clinic	Hhohho	Rural	Clinic w/out maternity	Government	Unknown
Good Shepherd Hospital	Lubombo	Rural	Hospital	Mission	ART, VCT, STI, PEP
Dr Martins Clinic	Lubombo	Rural	Clinic w/out maternity	Private	STI
Mhlume Med. Serv. At Tshaneni	Lubombo	Rural	Health Centre	Industry	Unknown
Tikuba Clinic	Lubombo	Rural	Clinic w/out maternity	Government	STI
Raleigh Fitkin Memorial Hospital	Manzini	Urban	Hospital	Mission	PMTCT, ART, VCT, STI, PEP
Ekuthuleni Clinic	Manzini	Rural	Clinic without Maternity	Private	Unknown
Hope House	Manzini	Urban			Palliative Care
Imphilo Clinic	Manzini	Urban	Clinic without Maternity	Private	ART
Phlani Clinic	Manzini	Urban	Clinic without Maternity	Private	Unknown
Swazican Clinic	Manzini	Rural	Clinic without Maternity	Industry	Unknown
Hlatikulu Hospital	Shiselweni	Urban	Hospital	Government	VCT,ART,STI,PEP
Osabeni	Shiselweni	Rural	***	Government	Unknown
Our Lady of Sorrows Clinic	Shiselweni	Rural	***	Mission	STI

Facility Assessments

Facilities were assessed by interviewing staff who were most directly involved in data collection, management, use, and reporting. Participants were asked a series of questions about the data involved in specific services provided:

- ❒ PMTCT
- ❒ VCT
- ❒ ART
- ❒ PEP
- ❒ TB/HIV
- ❒ Orphan care
- ❒ STI management
- ❒ Laboratory services
- ❒ Community home-base care
- ❒ Nutrition services
- ❒ Rehabilitation services
- ❒ Blood safety
- ❒ Malaria.

All participants were asked questions regarding:

- ❒ Data collection
- ❒ Information reporting
- ❒ Feedback on reported information
- ❒ Information sse
- ❒ Information storage
- ❒ Confidentiality
- ❒ Availability of procedures, manuals and guidelines
- ❒ Equipment
- ❒ Utilities.

A quasi-pilot at two sites (RFM Hospital and Hope House) resulted in changes to the order of the questionnaire's sections and the replacement of dichotomous questions with open-ended ones. Responses were directly recorded on the standardized questionnaires and then entered into an Excel Workbook for data reduction and compilation.

Table 27: Facility Assessment Participants

Name of Facility	Region	Facility type	Owner	Programmatic Area
Good Shepherd Hospital	Lubombo (Rural)	Hospital	Mission	VCT, ART, PEP, OVC, STI, CHBC, Nutrition
Hlatikulu Hospital	Shiselweni (Rural)	Hospital & Clinic w/out maternity	Government	VCT, ART, STI, Laboratory Services, Blood Safety, OPD (TB, STI)
Hope House	Manzini (Urban)		Missioin	Palliative Care
Imphilo Clinic	Manzini (Urban)	Clinic w/out maternity	Private	PMTCT, VCT, ART, PEP, STI, Laboratory Services, Blood Safety, Malaria
Mbabane Government Hospital	Hhohho (Urban)	Hospital	Government	VCT, ART, PEP, STI, Laboratory Services, CHBC, Rehabilitation
Ntfonjeni Clinic	Hhohho (Rural)	Clinic w/out maternity	Government	STI, Laboratory Services, Malaria
Philani Family Clinic	Manzini (Urban)	Clinic w/out maternity	Private	PMTCT, VCT, ART, PEP, TB/HIV, STI, Rehabilitation, Malaria
Raleigh Fitkin Memorial Hospital	Manzini (Urban)	Hospital	Mission	PMTCT, ART, VCT, PEP, TB, STI, Laboratory Services, Social Welfare
Tikhuba Clinic	Lubombo (Rural)	Clinic w/out maternity	Government	PMTCT, VCT, TB, STI, CHBC, Nutrition, Malaria

Table 28: Interviews

Date	Facility	Participants
18 August 2005	NERCHA	Epidemiologist
19 August 2005	NERCHA	M&E IT Specialist
24 August 2005	MOHSW-Statistics Unit	Systems Analyst
		Assistant Statistician
25 August 2005	SNAP	National HIV/AIDS Coordinator
		Project Manager – SADC/DFFD HIV/AIDS Cross Border Initiative
		Psychologist – Psychology Support Unit (2)
		National VCT Coordinator
25 August 2005	NERCHA	M&E Officer
25 August 2005	SNAP (M&E Unit)	M&E Officer
26 August 2005	SNAP (M&E Unit)	National Epidemiologist
31 August 2005	SNAP (SRHU)	Program Coordinator – PMTCT
01 September 2005	NERCHA	Public Relations Officer
02 September 2005	NERCHA	M&E Coordinator
09 September 2005	SNAP	Regional HIV/AIDS Coordinator, Hhohho Region
09 September 2005	SNAP (M&E Unit)	M&E Officer

Table 29: Assessment Field Staff

Name	Position	Agency	Role in the Assessment
Verne Kemerer	Project Manager	MEASURE Evaluation at Tulane School of Public Health	Principal Investigator
Sibongile Maseko	National Epidemiologist	SNAP – M&E Unit	Senior Technical Advisor
Marjorie Mavuso	M&E Coordinator	NERCHA	Senior Technical Advisor
Sandile Dlamini	M&E Officer	SNAP – M&E Unit	Interviewer
Thulani Dlamini	Administrative Assistant	SNAP – M&E Unit	Interviewer
Nomsa Mulima	M&E Officer	SNAP – M&E Unit	Interviewer

Table 30: Validation Workshop Participants

Position	Organization
Nursing Sister	Hlatikulu Hospital
Matron II	Hlatsi Hospital
Nursing Sister	Hlatsi Hospital
Nursing Sister	Hlatsi Hospital
Matron II	Mbabane Government Hospital
Chief Medical Officer	MOHSW
RPH Matron - Manzini	MOHSW
Administrative Assistant	MOHSW/SNAP
Epidemiologist	MOHSW/SNAP
M&E Coordinator	NERCHA
M&E IT Specialist	NERCHA
Nurse	Sithobela Clinic
Nurse-Midwife	Tikhuba Clinic

APPENDIX 8: MOHSW/SNAP Data Flow Facility Assessments Questionnaire

Facility Assessment Instrument

Person Interviewed (name, title, organization)
Facility Name
Facility Address
Facility Type (Hospital, Clinic, etc.)
Ownership (Public/Mixed/Private)
Interviewer:

I am going to ask you a series of yes and no questions about services provided in your facility

1. Services available in this institution:		Yes	No
a.	Do you provide PMTCT services? (If **No**, do **not** answer **Section 2. PMTCT**)		
b.	Do you provide VCT services that are separate from PMTCT? (If **No**, do **not** answer **Section 3. VCT**)		
c.	Do you provide ARV Treatment services? (If **No**, do **not** answer **Section 4. ART**)		
d.	Do you provide post-exposure prophylaxis (PEP) services? (If **No**, do **not** answer **Section 5. Post-Exposure Prophylaxis**)		
e.	TB/HIV co-infection (If **No**, do **not** answer **Section 6. TB/HIV**)		
f.	Do you provide Orphan care services? (If **No**, do **not** answer **Section 7. Orphan Care**)		
g.	Do you provide STI services? (If **No**, do **not** answer **Section 8. STI Management**)		
h.	Do you provide Laboratory services? (If **No**, do **not** answer **Section 9. Laboratory services**)		
i.	Do you provide community home-based care services? (If **No**, do **not** answer **Section 10. Community home-based care services**)		
j.	Do you provide nutrition services? (If **No**, do **not** answer **Section 11. Nutrition services**)		
k.	Do you provide rehabilitation services? (If **No**, do **not** answer **Section 12. Rehabilitation services**)		
l.	Do you provide blood safety activities? (If **No**, do **not** answer **Section 13. Blood Safety**)		
m.	Do you provide malaria services? (If **No**, do **not** answer **Section 14. Malaria services**)		

All participants are to answer Sections 15 – 23

2. PMTCT							
d.	Is PMTCT data currently being recorded? (If **No**, skip to **Section3. VCT**)				Yes		No
		Individual Patient Record	General Register[1]	Dedicated Register[2] (specify name: ____)	PMTCT Register	Not Recorded	N/A
f.	Generally, where is PMTCT information recorded? (If **Not Recorded**, Skip to **Section 3. VCT**)						
g.	Where is HIV pre-test counseling information recorded?						
h.	Where is HIV testing for mother information recorded?						
i.	Where is HIV status of mother information recorded?						
j.	Where is TB status of mother information recorded?						

k.	Where is HIV post-test counseling information recorded?						
l.	Where is ARV prophylaxis for mother (PMTCT) information recorded?						
m.	Where is Post-delivery breast-feeding counseling information recorded?						
n.	Where is HIV testing of infant information recorded?						
o.	Where is HIV status of infant information recorded?						
p.	Where is ARV prophylaxis for infant information recorded?						
q.	Where is Mother infant feeding intention information recorded?						
r.	Is any of the above listed information recorded electronically? If so which ones? (list the letters – if HIV post-test counseling data are collected electronically, then list ‘g’)						

3. VCT (separate from PMTCT)				
a.	Can we see a copy of a register containing VCT information? (make a copy)		Yes	No
b.	Do the VCT registers contain the following information:		Yes	No
	i.	Received pre-test counseling		
	ii.	HIV/AIDS test performed		
	iii.	HIV/AIDS status recorded		
	iv.	Received post-test counseling		
	v.	TB Status		
c.	Is VCT information recorded in a:		Yes	No
	i.	Individual patient record		
	ii.	General register		
	iii.	Dedicated (specific) register		
d.	Is this information recorded electronically?		Yes	No

4. ARV Treatment				
a.	Can we see a copy of a register containing ARV treatment information? (make a copy if possible)		Yes	No
c.	Is ARV Treatment information recorded in a:		Yes	No
	i.	Individual patient record		
	ii.	General register		
	iii.	Dedicated (specific) register		
d.	Is this information recorded electronically?		Yes	No
b.	Do the ARV treatment registers contain the following information:		Yes	No
	i.	HIV Status		
	ii.	CD4 Count		
	iii.	Viral load		
	iv.	Opportunistic Infections diagnosed and/or treated		
	v.	TB status recorded		
	vi.	ARV medications taken		
	vii.	Adverse reactions to medications		
	Viii.	Clinical staging		
	ix.	AIDS related mortality		
	x.	Patient follow-up information		
e.	What are your procedures for following up patients on ARV treatment? Please describe the system.			

5. Post-Exposure Prophylaxis				
a.	Can we see a copy of a register containing PEP information? (make a copy if possible)		Yes	No
b.	Is PEP information recorded in a:		Yes	No
	i.	Individual patient record		
	ii.	General register		
	iii.	Dedicated (specific) register		
c.	Is this information recorded electronically?		Yes	No
d.	What information do the PEP registers contain?			

6. TB/HIV			
a.	Can we see a copy of a register containing TB/HIV palliative care information? (make a copy)	Yes	No
b.	What information do the TB/HIV registers contain?		
d.	Is this information recorded electronically?	Yes	No
e.	Is this information reported to the National TB Program?	Yes	No

7. Orphan Care				
a.	Can we see a copy of a register containing orphan care information? (make a copy)		Yes	No
b.	Do the orphan care registers contain the following information:		Yes	No
	i.	HIV/AIDS status of parents		
	ii.	HIV/AIDS status of orphan		
	iii.	ART for HIV positive orphan		
	iv.	TB status of HIV positive orphan		
	v.	Support services received by orphan		
	vi.	Primary care-taker of orphan (institution, family member, community)		
c.	Is orphan care information recorded in a:		Yes	No
	i.	Individual patient record		
	ii.	General register		
	iii.	Dedicated (specific) register		
d.	Is this information recorded electronically?		Yes	No

8. STI Management				
a.	Can we see a copy of a register containing STI management information? (make a copy)		Yes	No
b.	Do the STI Management registers contain the following information		Yes	No
	i.	Lab diagnosis		
	ii.	Syndromic diagnosis		
	iii.	STI lab test performed		
	iv.	Names of STI tests performed		
	v.	Availability of sufficient medications		
c.	Is STI management information recorded in a:		Yes	No
	i.	Individual patient record		
	ii.	General register		
	iii.	Dedicated (specific) register		
d.	Is this information recorded electronically?			

9. Laboratory Services				
a.	Is the following lab work done on-site?		Yes	No
	i.	Is HIV testing done on-site? (If **No**, Skip to **question 9.a.iii.**)		
	ii.	From where do you receive these samples for testing (If in-patient, from which ward(s))?		
	iii.	Is CD4 count done on-site? (If **No**, Skip to **question 9.a.v.**)		
	iv.	From where do you receive these samples for testing (If in-patient, from which ward(s))?		
	v.	Is Viral load done on-site? (If **No**, Skip to **question 9.a.vii.**)		
	vi.	From where do you receive these samples for testing (If in-patient, from which ward(s))?		
	vii.	Is Lymphocyte test done on-site? (If **No**, Skip to **question 9.a.ix.**)		
	viii.	From where do you receive these samples for testing (If in-patient, from which ward(s))?		
	ix.	Is TB sputum smear done on-site? (If **No**, Skip to **question 9.a.xi.**)		

	x.	From where do you receive these samples for testing (If in-patient, from which ward(s))?		
	xi.	Is Syphilis done on-site? (If **No**, Skip to **question 9.a.xiii.**)		
	xii.	From where do you receive these samples for testing (If in-patient, from which ward(s))?		
	xiii.	Is Gonorrhea culture done on-site? (If **No**, Skip to **question 9.a.xv.**)		
	xiv.	From where do you receive these samples for testing (If in-patient, from which ward(s))?		
	xv.	Is Gonorrhea slide done on-site? (If **No**, Skip to **question 9.a.xvii.**)		
	xvi.	From where do you receive these samples for testing (If in-patient, from which ward(s))?		
	xvii.	Is Chlamydia done on-site? (If **No**, Skip to **question 9.a.xix.**)		
	xviii.	From where do you receive these samples for testing (If in-patient, from which ward(s))?		
	xix.	Is Other testing done on-site? (Specify:_____) (If **No**, Skip to **question 9.b.**)		
	xx.	From where do you receive these samples for testing (If in-patient, from which ward(s))?		
b.	Is lab test information recorded in a:			
	i.	Individual patient record		
	ii.	General register		
	iii.	Dedicated (specific) register		
c.	Is this information recorded electronically?			

10. Community home-based care				
a.	Can we see a copy of a register containing community home-based care information? (make a copy if possible)		Yes	No
b.	Is community home-based care information recorded in a:		Yes	No
	i.	Individual patient record		
	ii.	General register		
	iii.	Dedicated (specific) register		
c.	Is this information recorded electronically?		Yes	No
d.	What information do the community home-based care registers contain?			

11. Nutrition				
a.	Can we see a copy of a register containing nutrition information? (make a copy if possible)		Yes	No
b.	Is nutrition information recorded in a:		Yes	No
	i.	Individual patient record		
	ii.	General register		
	iii.	Dedicated (specific) register		
c.	Is this information recorded electronically?		Yes	No
d.	What information do the nutrition registers contain?			

12. Rehabilitation				
a.	Can we see a copy of a register containing rehabilitation information? (make a copy if possible)		Yes	No
b.	Is rehabilitation information recorded in a:		Yes	No
	i.	Individual patient record		
	ii.	General register		
	iii.	Dedicated (specific) register		
c.	Is this information recorded electronically?		Yes	No
d.	What information do the rehabilitation registers contain?			

13. Blood Safety				
a.	Can we see a copy of a register containing blood safety information? (make a copy if possible)		Yes	No
b.	Is blood safety information recorded in a:		Yes	No
	i.	Individual patient record		
	ii.	General register		
	iii.	Dedicated (specific) register		
c.	Is this information recorded electronically?		Yes	No
d.	What information do the blood safety registers contain?			

14. Malaria				
a.	Can we see a copy of a register containing malaria information? (make a copy if possible)		Yes	No
b.	Is malaria information recorded in a:		Yes	No
	i.	Individual patient record		
	ii.	General register		
	iii.	Dedicated (specific) register		
c.	Is this information recorded electronically?		Yes	No
d.	What information do the malaria registers contain?			

Ask the following sections (Sections 15 – 23) for all participants

15. Data Collection				
a.	May we see a copy of all the registers you are required to complete. Please list all individual register forms in the table below (and attach copies, if available):			
	Register 1	**Register 2**	**Register 3**	**Register 4**
Title of Register				
How many people fill out this register? What are their primary jobs? How often[1] do they fill out the register?				
How many items are to be completed on this register?				
Are there instructions for filling out this register?				
Are the instructions easy to understand?				
Has this site ever run out of the register? If yes, how often does the site run out of this register?				

[1] ***PROBE***: Every time a client is seen; Once a week; Once a month, etc.

How long does it take to get replacement registers?				
Where do you submit this register? How often?				
Who analyzes the data from this register?				

b.	Do you receive feedback on the quality of your data collection? (If **No**, skip to Section **16. Information Reporting**)	Yes	No
c.	From whom do you receive feedback on the quality of data collection?		
d.	How often do you receive feedback on the quality data collection?		
e.	Do you or your office conduct data entry on the computer? (If **data entry** is done **manually**, **SKIP to Question 15.g.**)		
f.	What software is used for data entry (Access, Excel, SPSS, etc)?		
g.	Do you have a specified data entry staff? Is this their only responsibility? If not, what are their other responsibilities?		
h.	How is data entry staff trained/retrained?		
i.	What is the frequency of the training/retraining?		

16. Information Reporting	
a.	List all monthly/periodic reports that are required to be generated by your office:
b.	Who is responsible for producing reports? Did that person or persons receive training on producing reports? Does he or she receiving retraining? If so, how often?
c.	Last month, were you able to generate all of the required reports on time?
d.	Do you ever have data missing from your reports?
e.	Do you produce reports on the computer or manually? How do you make the version that you are going to turn in?
f.	Where, to whom, and how often are the reports sent?
g.	Describe how reports are transferred from the facility to the person or organization to whom you are reporting:

17. Feedback on Information Reported				
a.	Do you receive visits regarding the data you have submitted from your supervisory office? If so, please describe them: (***PROBE***: After interviewee has describe ask: So, that would be X number of reports you received from your supervisory office):			
b.	Are you receiving STI/HIV/AIDS information from the MOHSW? (If **NO**, skip to **question 17.c.**)		Yes	No
	i.	Describe the STI/HIV/AIDS information you are receiving:		
	ii.	What is the process for you to receive this information? On what frequency? From whom do you receive this information?		
	v.	Do you receive reports directly relevant to your program's activities? (If **NO**, skip to question **17.b.vii.**)	Yes	No

	vi.	Please list them:		
	vii.	Do you receive regular/operational reports? (If **NO**, skip to question **17.c.**)	Yes	No
	viii.	Please list them:		
c.	**What channels are available for you to communicate with the MOHSW regarding STI/HIV/AIDS information?** *PROBE:* **If you need more information, if there is a problem with the information (there is not enough information or there is not the right information) are you able to communicate this to the MOHSW?**			
d.	How is MOHSW STI/HIV/AIDS information helpful to you? (***PROBE:*** How is this information used? Can you give me an instance? PROBE: Strategizing resource allocation; targeting program to specific needs/populations; advocacy)			
e.	Would you see receiving STI/HIV/AIDS information from the MOHSW **based on your reporting** as useful?			
f.	What additional information from the MOHSW would be helpful to your organization?			
g.	How best could the MOHSW provide you with information that is useable for programming planning and resource allocation? ***PROBE****:* Workshops, reports, graphs, "best practices" manuals?			

18. Use of Information				
a.	Do you use the information you reported for your own program? (if **NO**, skip to **18.b.**)		Yes	No
	i.	Health Planning?		
	ii.	Preparing plans of activities?		
	iii.	Requesting drugs or vaccines?		
	iv.	Personnel management?		
	v.	Preparing budget?		

	vi.	Supervision?		
	vii.	Evaluation?		
	viii.	Epidemiological surveillance?		
	ix.	Implementation of priority health programs?		
b.	Do you display reported information in your health facility? (If **No**, skip to **Section 19. Storage of Information**)			
c.	Do you display information in your health facility using any of the following methods?		Yes	No
	i.	Catchment area map [Date last updated (MM/YY): __ __/__ __]		
	ii.	Graphs or charts [Date last updated (MM/YY): __ __/__ __]		
	iii.	Tables [Date last updated (MM/YY): __ __/__ __]		
	iv.	Other, please specify:_____ [Date last updated (MM/YY): __ __/__ __]		

19. Storage of Information	
a.	How do you store records? Registers? Reports?
b.	Would you say that the status of the information stored is good, fair, or poor? Why?

20. Confidentiality					
a.	Does your institution have a written policy on confidentiality?			Yes	No
b.	Have any of the following staff received specific guidance about confidentiality?		N/A	Yes	No
	i.	Counselors			
	ii.	Nurses in ANC/MCH services			
	iii.	Midwives			
	iv.	Laboratory staff			
	v.	Non-counseling medical staff			
	vi.	Ward attendants			

	vii.	Ancillary staff (e.g., cleaners)			
c.	Does your institution (or office) provide test results? (If **No**, skip to **question 20.d**)				
	i.	Are test results disclosed directly and only to the person tested?			
	ii.	Are test result disclosed to the spouse of the person tested before obtaining consent of the tested person?			
	iii.	Are test result disclosed to other family members without obtaining consent of the person tested?			
d.	Do patient records contain information on HIV status?				
e.	Do clinic registers contain information on HIV status?				
f.	Are registers containing HIV/AIDS information kept in a locked filing cabinet or room?				
g.	Does your institution have a secure system of handling HIV test results? (If **No**, skip to **question 20.i.**)				
h.	Please describe this system:				
i.	Is there a system to protect confidential computerized information? 1.1.1.1.1 (If **No**, skip to **Section 21. Availability of HIS Procedures Manuals, etc**)				
j.	Please describe this system:				

21. Availability of HIS Procedures Manuals, Guidelines and Similar Documents	
a.	Do you have guidelines for data collection? If so, what is the title? Who produced it? What year was it produced?
b.	Do you have guidelines for data handling and use? If so, what is the title? Who produced it? What year was it produced?

22. Equipment (Interviewer: Please verify if the following equipment is available in the facility)			
Equipment	Year Purchased	Quantity	Working Condition (Y or N)

a.	Computer (Hard-ware: CPU, HD, RAM, OS)			
b.	Data Back-up Unit (e.g. floppy, CD, zip)			
c.	Printers			
d.	Modems			
e.	UPS			
f.	Generators			
g.	Regular telephone			
h.	Radio telephone			
i.	Access to the internet			
j.	Calculator			
k.	Off-site Storage Facility			
l.	Mobile phones			
m.	Satellite links			

23. Utilities			
a.	Is the electricity supply ever interrupted? (If NO, skip to **23.e.**)	Yes	No
b.	If so, How often is the electricity supply interrupted?		
c.	How does this impact your work?		
d.	Is the facility air-conditioned? (If **NO**, skip to **23.g.**)	Yes	No
e.	If so, is the room where the computer hardware is kept air-conditioned?	Yes	No
f.	Is running water available in the facility?	Yes	No