STOCKHOLM EVALUATION UNIT

EVALUATION OF

THE ESHOWE HIV PROJECT

EXECUTIVE SUMMARY

APRIL 2021
This publication was produced at the request of Médecins Sans Frontières, under the management of the Stockholm Evaluation Unit.

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ACRONYMS

ART	Antiretroviral Therapy
ARV	Antiretroviral
CAG	Community ART Group
CBO	Community-Based Organisation
CCG	Community Care Giver
CCMDD	Central Chronic Medicines Dispensing and Distribution
CHAs	Community Health Agents
CHAP	Community Health Agents Programme
CHW	Community Health Worker
CHW	Community Health Worker
CI	Confidence Interval
CMOC	Community Models of Care
DoE	Department of Education
DoH	Department of Health
FGD	Focus Group Discussion
FLSA	Fast Lane Spaced Appointment
FTS	Fixed Testing Sites
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HTAs	High Transmission Areas
KII	Key Informant Interview
KZN	KwaZulu-Natal
LO	Life Orientation
LSA	Learner Support Agent
M1SS	Mobile-1-Stop-Shop
M&E	Monitoring & Evaluation
MDR-TB	Multidrug-resistant Tuberculosis
MMC	Medical Male Circumcision
MOU	Memorandum of Understanding
MSF	Médecins Sans Frontières
OCB	Operational Centre Brussels

PCS	Patient Community Support
PLHIV	People Living with HIV
POC	Point of Care
PuP	Pick-Up Points
SAMU	South African Medical Unit
SEU	Stockholm Evaluation Unit
SHINE	Shintsha Health Initiative
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
TAC	Treatment Action Campaign
TasP	Treatment as Prevention
TB	Tuberculosis
TOR	Terms of Reference
TVET	Technical and Vocational Education and Training
UTT	Universal Test and Treat
VL	Viral Load
XDR-TB	Extensively Drug-Resistant Tuberculosis

GLOSSARY

ART Adherence Club	According to the National Adherence Guidelines, in adherence clubs, stable patients are grouped together voluntarily for routine check-ups and repeat prescription collections are managed by a lay healthcare worker (Task shifting). Clubs can take place at the health facility or in the community to save patients time and money. Patients discuss their questions and concerns openly with peers in the clubs and receive basic health education. Members receive spaced appointment dates without having to queue and support one another emotionally. Club membership is also conditional on remaining stable – an incentive to remain in care.
Amakosi	Plural of the word Inkosi - Zulu clan chief
Community ART Group (CAG)	The Community ART Groups (CAG) are small groups, with a maximum of six individuals, and they are stimulated to form according to mutual trust and the geographical proximity of their homes. In each CAG, access to ART is organised by one representative collecting the medication for the other members at a health facility each month. During that visit, each CAG member in turn will have clinical and virological monitoring.
Community Models of Care	The Community Models of Care programme started in 2012, where patients were recruited into Community ART Groups (CAGs), and ART Adherence Clubs, through education sessions that were done by counsellors within the clinics.
Community Health Agents Programme (CHAP)	The Community Health Agents Programme (CHAP) is a door-to-door testing programme launched in 2012 and was one of several HCT strategies deployed by MSF in Eshowe and Mbongolwane aimed at dramatically raising the coverage of HCT in communities and driving improved linkage to care.
Child Care South Africa	Child Care South Africa is a community-based organisation located in Eshowe who formed a partnership with MSF in April 2016 to assist with the CHAP. The community health agents were employees of Child Care South Africa.
Farm Programme	The Farm Programme is part of the High Transmission Area programme, which was designed in 2015 in order to provide HIV/TB related medical services to specific populations who were considered to be more vulnerable and have higher HIV prevalence.
Fixed Site	Fixed testing sites formed part of the community component of MSF's work. There were four fixed sites, three in Eshowe (two in town and one at the TVET College), and one in Mbongolwane. Each fixed site targeted slightly different demographic groups, and all the sites offered HCT, TB screening, pregnancy testing, and STI screening.
Izimbizo/Imbizo	Izimbizo is an African term mostly used by the Nguni Tribe, which means consultative gatherings of the communities in different segments which may comprise of gender, age, or marital status. Izimbizo are not just called by anybody in the community; protocols are observed. Imbizo can only be called by Inkosi or their subjects in the hierarchy of Izinduna if there is an important information that affects the community which needs to be addressed or information to be passed on to the community members. It can

	also be used when there are crucial decisions to be made, which needs an input from the community members.
Induna/Izinduna	Zulu title meaning great advisor or leader
Inkosi	Zulu clan chief
Learner Support Agent (LSA)	LSAs are employed by Department of Education (DoE) to provide support to all learners in high schools. Their original task is to find social cases and refer to other institutions with no particular focus on HIV/TB issues. They are known by learners and physically and psychologically close enough for learners to share their private issues.
Luyanda Sites	In 2018 the project decided to transition the door-to-door testing (via CHAP) to the fixed community sites, known as Luyanda sites. These Luyanda sites are strategically located in proximity to 'hard-to-reach' communities. In addition to HIV testing, prevention, and counselling services, the Luyanda sites are places where the Department of Health (DoH) has a monthly mobile general clinic or provides Philamtwana (well baby) clinics, solidifying their reputations as health services delivery sites in the community. Routine services offered at the Luyanda sites include general health education; HIV testing, prevention, and counselling services; TB symptom screening; blood pressure monitoring; testing for diabetes; pregnancy testing; and symptomatic screening for sexually transmitted infections (STIs).
Mobile-1-Stop-Shop (M1SS)	The Mobile-1-Stop-Shop (M1SS) are mobile testing units providing information, counselling, HIV and TB testing and CD4 count for those who test HIV positive. The M1SS goes to the community, making it easier for people to get tested, know their HIV status, and get referred for treatment and care close to their home or place of work.
MMC Mobilisation	MSF supported the DoH with recruitment of male learners (in high schools) who test HIV negative for MMC, as a lifelong partial prevention strategy, while the HIV positive learners were supported with medical screening prior to circumcision.
Nurse-Initiation and Management of ART (NIMART)	Nurse-Initiation and Management of ART (NIMART) involves nurse-initiation of patients onto ART, re-prescription for patients stable on ART, and appropriate referral to physicians as needed.
Philandoda	Philandoda Male Wellness site was set up in 2017 with the aim of reaching men for whom conventional fixed or mobile health services currently offered by the DoH and/or MSF were not an acceptable/feasible option to access health care.
Schools Programme	Schools Programme mobilized high school learners to know their HIV status, supported learners with key prevention messaging in order to take proactive steps to a healthy lifestyle irrespective of HIV status, increase occurrence of health seeking behaviour, and increase access to support and care for learners who test HIV positive.
Shintsha Health Initiative (SHINE)	Shintsha Health Initiative (SHINE) is a community-based organisation of people living with HIV, and their families and supporters, particularly around patient empowerment and peer support, who collaborated with MSF in

	recruiting community health agents for the CHAP – until Child Care South Africa took over that role in April 2016.
TVET College	TVET stands for 'Technical and Vocational Education and Training'. TVET is a term that is used around the world and it is the part of the education system that combines education, training, and skills development. This is to train students with all the different skills needed for their future job. TVET colleges train students to be skilled in a specific vocation or profession.
Universal Test and Treat (UTT)	A policy of Universal Test and Treat (UTT) was introduced on 1 September 2016, making ART available to all HIV-infected persons regardless of CD4 count.

EXECUTIVE SUMMARY

INTRODUCTION

Since 2011, Médecins Sans Frontières (MSF) have been supporting the Government of South Africa's efforts to "bend the HIV epidemic curves downwards" in reducing morbidity and mortality in an area of the country with some of the highest incidence and prevalence rates of HIV. The *Bending the Curves* catalytic project, sought to demonstrate the feasibility and acceptability of ambitious strategies for testing, treatment and prevention of HIV and TB in Eshowe and Mbongolwane, in KwaZulu-Natal (KZN), representing semi-urban and rural settings, respectively.

It concentrated on four HIV-related components: prevention, HIV counselling and testing (HCT), linkage to care, and retention in care and adherence, with the aim of increasing the number of patients on treatment, and improving adherence, which resulted in exceeding the UNAIDS 90-90-90 targets two years ahead of the deadline. Comprehensive door-to-door testing, a focus on coverage, patient-centreed approaches, and capacity at facilities were at the heart of the MSF strategy. The project's wider objectives concerned influencing policy change and lessons for facilitating HIV management in South Africa and other MSF HIV projects in similar contexts.

METHODOLOGY

This evaluation focused on the effectiveness and replicability aspects of the HIV interventions between 2013 and 2018. The research design adopted a realist evaluation model as it examines outcomes generated by mechanisms in specific contexts, which we view as relevant to the varied sites within the uMlalazi sub-district. When outcomes are considered undesirable, a realist approach allows for fluid interrogations rather than making assumptions about the entire project or operations within the project. The approach looks for unintended or unanticipated results, either positive or negative, and has assisted in interrogating all components of implementation.

Thus, a mixed methods approach was utilised, with a heavy qualitative concentration allowing those closest to the interventions – beneficiaries, providers, and stakeholders – to provide valuable insights. Qualitative methods involved comprehensive literature review, key informant interviews and focus-group discussions, at various sites including farms, schools, and health facilities, among others. The various positions, roles, and interactions with the project enabled triangulation for findings. In addition, quantitative analysis involved the use of the TIER.net database with the pre-ART information and information on ART and clinic visits. Linkage trends were analysed over the evaluation period and possible determinants of linkage to care through univariate analysis, using R statistical software. In all, 166 people participated in the study and due to Covid-19 and related lockdowns in South Africa, a significant number of key informants (23) were interviewed remotely, contributing to a clear picture of the interventions ahead of field visits, which took place in October 2020.

Evaluations within the Eshowe HIV Project, such as this one, fall under the overall agreement between MSF and Government partners to conduct the project and related research activities. Therefore, no

separate ethical clearance was necessary. While no personal or patient data were collected during this process, all participants were fully briefed on the evaluation's objectives and were informed that they did not have to participate, that they could end the interview at any time or refuse any questions. Once respondents granted verbal permission to participate in the evaluation, the informed consent process was completed. For respondents under the age of 18 years, parental consent was given at the time of their enrolment in activities related to the Eshowe HIV Project, including those related to monitoring and evaluation.

The main limitations were as follow: **Covid-19 related delays** - due to Covid-19 and related lockdown in South Africa, the evaluation team experienced delays in undertaking the field visit; **timing of the evaluation, and participants confusing current and past events** - the evaluation took place almost 2 years (in 2020) after the end of the project period (2013-2018), and; **lack of systematic quantitative indicators on programme interventions** - there is a wealth of quantitative data in the project, from the patients in the TIER.net monitoring database, as well as from various operational research activities. However, a systematic project 'dashboard' with main activities, outputs and outcomes of all HIV-related interventions that were part of the Eshowe HIV project has not been maintained.

FINDINGS

The project demonstrated a balanced approach between hard and soft power. Hard power consisting of the material resources and expertise of the project, while soft power involved the negotiation and engagement actions undertaken.

Comprehensive community engagements, patient-centredness, health promotion and treatment literacy, as well as joint data review and planning were prominent features across the project, and contributed to the project's success overall.

With a focus on coverage to reach physically and behaviourally distant communities, the project successfully provided services to homesteads, farms, and schools in deep rural areas, as well as in the peri-urban areas. Within these environments, ***young men, and young women – at higher risk of HIV – were provided with health education, literacy, and testing,*** and later these evolved into a host of general health services. HIV positive cases were provided with the necessary counselling and treatment regimens, and stable patients afforded a choice of community support models.

The Community Models of Care (CMOC) – clubs and groups - were well received across the various personnel at clinics, as well as for beneficiaries and ***the direct benefits consisted of reduced waiting times and ease of access, better quality of care, contributed towards improving adherence for members.***

The main challenges pertained to overcoming stigma, and access, which the project managed with effective involvement of community representatives and members. The latter, in the form of ***Community Health Agents (CHAs), with training and support measures in place, and opportunities that allowed their observations to be included in their approaches, contributed to the soft power***

approach. Representatives such as traditional leadership, were engaged with and traditional health practitioners trained in testing. These measures, with extensive community engagements across civil, faith and leadership structures, gave realisation to 'communities at the centre'.

Gaps were observed in project management in relation to garnering a deeper understanding of the bureaucracy and institutions to be engaged with, as well as in leveraging good practices external to the organisation. ***The 'power' aspects of the project together with the organisation's extensive body of knowledge and values, meant these challenges were overcome and strong relationships built***, especially with the departments of health and education.

High-level and general information from quantitative data shows the contribution of the project in terms of linking people into care on a quantitative scale, and supports the notion how, ***with increasing experience of the MSF team and increasing knowledge in the communities, linkage time improved over the evaluation period***.

Aspects which are ***more specific and developed in the Eshowe HIV Project compared to the South African National Plan include patient-centredness, mentoring and training, health promotion, joint planning, data review, logistical support and being well resourced***.

In consideration of where and how replicability can be effective, it would be determined by the willingness, coordination, capacitation, supervision, monitoring and troubleshooting approach will determine how much these components can be scaled and the resources that are required.

Sustainability and project handover highlight the need to begin such processes early on and must be factored into at the planning stages. Long-term achievements can only be realised if all these activities are co-developed with the relevant departments, noted above.

CONCLUSION

The Eshowe HIV Project achieved the agreed objectives set out at the initial stages of project implementation, including an increase in the uptake of HIV and TB testing and counselling and regular retesting, the development of a Community Model of Care through Facility Clubs and Community ART Groups (CAGs), communities were mobilised for testing, prevention and treatment, and were accepting and supportive of those affected by, and infected with, HIV and TB, Primary Health Care centres and mobile clinics provided an enhanced and integrated package of HIV/TB treatment and prevention care services, Mbongolwane Hospital provided an effective referral service for HIV and TB complications, M&E and operational research systems provided useful and regular feedback on the impact of project interventions, and advocacy to promote project activities took place.

The main barriers faced in the project relate to access and working within government frameworks and guidelines, the lack of understanding or comprehensive analysis (situational, landscape, etc.), which were notable in accessing schools and with farm owners, while at community level, buy-in was

slow initially due to stigma and discrimination against people living with HIV (PLHIV). The main enablers were working directly with, and respecting, local structures, political, traditional, community- and faith-based organisations, CHAs originating from the communities in which they serve, the promotion and messages from trusted traditional leadership, clinics well-resourced and patient-friendly, and soft skills, professionalism (training and mentoring) and preparedness from MSF.

The specific elements of the MSF Eshowe intervention which played the most significant role in project effectiveness were the ability of MSF to deploy resources, community engagements and buy-in, especially with local leadership, capacity building within health facilities and communities, and the flexibility in the disbursement of resources (key personnel, vehicles, tents, etc.). The following interventions implemented by MSF played an important role in effectiveness, the Community Health Agents Programme (CHAP), the Philandoda male clinic, the Schools Programme, TVET College, the Farms Programme, MMC mobilization, and the Community Models of Care. In terms of linkage to care, the closeness of services for counselling and testing together with clinic capability, and dedicated personnel in place at clinics, stand out as being the drivers for linkage to care.

The project was able to approach population at higher risk of HIV as young boys and girls were reached via the Schools Programme, males especially, but also female reached on farms, young adults (male and female) targeted at the TVET College, and men specifically targeted at the Philandoda clinic.

The main elements of the MSF Eshowe Project which are replicable/scalable by the National Department of Health include the CHAP or Luyanda sites (which have currently taken the place of the CHAP), the M1SS, the Schools Programme, the Philandoda male clinic, MMC mobilization, and the Community Adherence Groups (CAGs).

The MSF intervention in Eshowe has contributed to the South African National Strategic Plan (NSP) as it looked at clinical management and implemented interventions which had an impact at the community level. Aspects which are more specific and developed in the Eshowe HIV Project compared to the South African NSP include, patient-centredness, mentoring and training, health promotion, joint planning, data review, logistical support, and being well resourced.

The most important lesson which has been learned from the Eshowe Project was investing in relationships with community, traditional leaders, government structures, personnel from districts and clinics, TVET College management, farm owners, and CSOs. Other lessons learned included having a strong planning and implementation strategy in place, conducting operational research, and having exemplary leadership and teamwork.

RECOMMENDATIONS

⇒ Recommendation 1: Documentation Process

Institutional memory is vital to any organisation, and especially so where there is a high turnover of staff. Weak communications and documentation of processes can result in serious flaws, gaps, missed opportunities, and can be costly.

Within the documentation received from the project, we observed reports written mid-project that should be developed earlier, and reports mis-labelled. There was no single source document to easily identify the timeline of specific activities. While these may appear as minor, in aggregate, can lead to delays and mistakes.

To ensure continuity for smooth handover, a comprehensive and active brief, in the form of an easily accessible document should be developed and updated frequently. A core local team together the Project Medical Referent and Project Coordinator could work together and give these issues centrality for handover and as an active 'lessons' resource.

- A formal documentation process or system needs to be instituted, including a Risk Register, managed by key senior personnel with active involvement of key national staff. The objective should be for internal learning purposes first and foremost.
- For the Eshowe HIV Project, a data visualisation project to develop an Eshowe HIV Project dashboard for ease of access to MSF teams and possibly partners and stakeholders while expanding further the important lessons learned.

⇒ Recommendation 2: Entry and Exit Strategies

The extensive community engagement efforts conducted by the Eshowe HIV Project should be capitalised on. A number of gaps were evident within certain engagement activities, derived from a lack of comprehensive research and analysis, and negatively affecting documentation processes.

Going forward, we recommend that analysis be conducted on each institution separately, with local partners, in order to identify and mitigate challenges. Indeed, instituting a Risk Analysis and a Risk Register would complement the documentation process noted above.

Exiting the project is as important as entry. We learned of many disappointments that MSF are leaving, and that stakeholders were informed second-hand. When handover of a project like this is not planned for, and/or not well done, we ask, what is the point of the whole investment in time and resources of this type of project, especially to local structures and the communities? Exit expectations need to be well-managed.

- We recommend a series of meetings and events to inform stakeholders and community members of MSFs departure, when that will be, and what handover protocols are in place. These should be conducted, in most instances, with key stakeholders and community members.

Recommendation 3-5 (of 5) cont'd →

Recommendation 3: Capitalise on Models and Good Practices from The Eshowe HIV Project

The project instituted innovative and creative strategies and tools in accessing and engaging communities. The 'communities at the centre' and 'CHAP' sections provide insights into the work performed in this regard. The CHAP tool kit and 'MSFs experience' in particular (within the tool kit), stand out as an invaluable resource internally, and for partners. While perhaps less innovative, the health promotion and treatment literacy at every level, and of dedicating resources to ensure this is done, are also important and viewed as good practices. The ways that MSF has been able to do this within the project should also be recorded for learning purposes.

- We recommend MSF retroactively document, and going forward, document in real-time, those practices, models and tools, that could be replicated throughout its project activities. Additionally, the Project could develop a series of user guides or knowledge products for dissemination.

⇒ Recommendation 4: Flexibility, Dependency and Sustainability

Reported as a great strength of the project was its flexibility, and ability to adapt or change streams relatively quickly. Conversely, this ability can potentially lead to inefficiencies where projects or strategies are not given sufficient time to mature.

Flexibility in working practices at clinics were viewed positively. We learned, for example, in the mentoring programme, handover and capacity building were not at the forefront of operations. As MSF are known for 'taking the lead', a negative outcome may result in personnel becoming dependent on these supports. Dependency was most notable in the MSF vehicle fleet and its willingness to support when requested. Such actions need to be considered in line with long-term unintended consequences.

Sustainability as it relates to handover, should be a process integrated into all developments at the outset and aligned to existing structures, where possible. The profile of Community Health Agents was a promising example, mentoring, less so.

- A sustainability plan developed early on with relevant adjustments should be included in all projects going forward.

⇒ Recommendation 5: Capacity-Building of Community-Based Organisations (CBOs)

Community-Based organisations (CBOs) play an important role in the development landscape in South Africa. They act as intermediaries in delivering essential services across government departments often in marginalised settings. Unfortunately, these organisations, even those who secure regular funding, are often weak institutionally in terms of governance, grant and financial management. The Eshowe HIV Project confronted some of these issues first-hand.

The evaluation found that MSF could have cast a wider net in seeking a partner, one with proven innovative experience, and institutionally strong.

- Comprehensive appraisals should be conducted with implementing partners, to include a financial audit, and ongoing support provided to identified weak areas.

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