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EVALUATION OF

THE ESHOWE HIV PROJECT

APRIL 2021

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DISCLAIMER

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

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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 Philamtswana (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-centred 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.

INTRODUCTION

PROJECT BACKGROUND

PROJECT TITLE

Bending the Curves: Reducing HIV & TB Incidence in a Hyper-Endemic Setting in South Africa

The “Bending the Curves” project was introduced in 2011 and aimed to reduce the incidence of HIV and TB in Eshowe and Mbongolwane, King Cetshwayo District, KwaZulu-Natal (KZN), South Africa, in addition to reducing HIV and TB related morbidity and mortality (bend the epidemic curves downwards) in line with the South Africa National Strategic Plan (2012-2016) aimed at fighting HIV, sexually transmitted infections (STIs) and TB.

Médecins Sans Frontières (MSF) selected the project area¹ mainly for the high incidence and prevalence rates of HIV and TB in KZN compared to the rest of South Africa. Overall adult HIV prevalence in KZN at the beginning of the project was 25%.² Equally, KZN had the highest annual TB incidence rates of any province in South Africa at 1,094 per 100,000 population.³ Willingness of authorities to work with MSF, and the mixed setting provided additional rationale to choose the project area: Eshowe and Mbongolwane represent a semi-urban and rural setting respectively.

PROJECT OBJECTIVES

General Objective: *To reduce HIV and TB incidence in addition to HIV/TB related morbidity and mortality in Eshowe Municipality and Mbongolwane Health Service Area, KZN, South Africa.*⁴

Specific Objective: *To demonstrate the feasibility and acceptability of ambitious strategies for testing, treatment and prevention of HIV and TB.*

In line with this Specific Objective the project interventions were based on:

- 1) achieving widespread testing for HIV and screening for TB;
- 2) promoting and facilitating all methods of HIV prevention (biomedical and non-medical) including early initiation of ARVs (those with CD4 <500, pregnant women regardless of CD4 count and discordant couples) and ensuring that once started patients remain on treatment; and
- 3) TB prevention including infection control and early and consistent treatment of all TB including MDR and XDR TB.⁵

¹ MSF OCB. KwaZulu-Natal Project Document. January 2011 (revised).

² As quoted from the South African Department of Health in the Project Document.

³ Ibid.

⁴ This was the original objective, but it also evolved to cover wards 1-14 uMlalazi Municipality

⁵ MSF OCB. KwaZulu-Natal Project Document. REF: 2013/South Africa/Project Code/HIV/AIDS/ARO 2011

EXPECTED PROJECT OUTCOMES (ORIGINAL 2011 EXPECTED RESULTS)⁶

The following were the initial seven expected project results⁷:

- ER 1: Uptake of HIV and TB testing and counselling and regular retesting increased.
- ER 2: Community model of care developed and implemented through Facility Clubs and Community ART Groups (CAGs).
- ER 3: Communities mobilised for testing, prevention and treatment, and to be accepting and supportive of those affected by and infected with HIV and TB.
- ER 4: Primary Health Care Centres and Mobile Clinics providing an enhanced and integrated package of HIV/TB treatment and prevention care services.
- ER 5: Mbongolwane Hospital providing effective referral service for HIV and TB complications.
- ER 6: Monitoring and Evaluation and operational research systems provide useful and regular feedback on the medical and public health impact of the project interventions.
- ER 7: Advocacy to promote activities of the project to the local community and to national and international communities is successful in promoting change in both policy and practice leading ultimately to achievement of project goals.

PROJECT COMPONENTS AND INTERVENTIONS

The Eshowe HIV Project included four components, **prevention, HIV counselling and testing (HCT), linkage to care and ART initiation**, and **retention in care and adherence**. Included in these components are the various interventions that formed part of the Eshowe HIV Project.

The *prevention* component of the project included health promotion activities such as community mobilization and awareness, condom distribution, medical male circumcision (MMC), prevention of mother-to-child-transmission (PMTCT), and an HIV prevention package for students via the Schools Programme. *HCT* included expanded community testing at clinics and fixed community testing sites, through a mobile van at schools and at events. This component also included door-to-door testing, through the CHAP, which was replaced by the Luyanda sites in 2018. *Linkage to care and ART initiation* was done through follow up of people who tested positive at community and health facilities, and those lost to follow up tracing by CHAP. Other activities included conducting clinics in the Technical College (TVET) in Eshowe, a mobile clinic visiting farms, and the establishment of the vertical male clinic, Philandoda. *Retention in care and adherence* for HIV-infected people was done through HIV initiation and adherence counselling conducted by lay counsellors, differentiated models of care, including community and facility clubs, Community ART Groups (CAGs), Fast Lane Spaced Appointment (FLSA) or community Pick-Up Points (PuP) and mentoring on implementation of the national adherence guidelines.

In addition to these four components, two important surveys (2013 and 2018) have helped inform the Eshowe HIV Project. In 2013, MSF, Epicentre, and the DoH implemented a population-based survey to assess parameters of the HIV epidemic in the sub-district of Eshowe and Mbongolwane, where MSF had been working since 2011. These findings assisted MSF and the DoH to implement activities and

⁶ In 2015 the Expected Results were changed to follow the cascade of care and 90-90-90 (prevention, testing, linkage, treatment, adherence, VL suppression) more closely – please refer to any log frame from 2015 – 2019.

⁷ Taken from the logical framework 2013; as the project went along the expected results changed, for instance by focusing more on prevention and high-risk populations.

adapt strategies in the uMlalazi sub-district. In 2016, the DoH introduced a Universal Test and Treat (UTT) strategy, which they expected would improve the entire HIV prevention and treatment cascade (i.e., HIV positive status awareness, ART coverage and viral load suppression).

A second cross-sectional population survey was then conducted in 2018, which confirmed that the overall UNAIDS 90-90-90 coverage targets were achieved in Eshowe and Mbongolwane. More specifically, data showed that HIV positive status awareness increased to 90% in 2018 (up by 15% from 2013), ART coverage among those testing positive was 94% (up by 23% overall from 2013), while viral suppression among those on treatment was up by 1% at 94% overall. The survey therefore confirmed that MSF activities and national level policy changes contributed to a dramatic increase in viral suppression and ART coverage at the population level, and that community-based interventions implemented by MSF were successful across the treatment cascade. Data also suggested a reduction of HIV incidence at population level.

The evaluation will focus on the interventions that took place between 2013-2018. A timeline of start and end dates of each of the key interventions that will be highlighted in this evaluation are presented in Table 1. The table also showcases the interventions within components further elaborated on in the findings section of this report. These include: (1) the community interventions, such as Mobile-1-Stop-Shop (M1SS) - Schools Programme and Farms Programme, and the fixed sites - TVET College and Philandoda Clinic; (2) the CHAP;(3) the community mobilisation activities - MMC; and (4) the facility component - community models of care (youth adherence clubs).

It should also be noted that MSF is still present in Eshowe and Mbongolwane, however the focus of their work has now shifted from HIV to TB. The evaluation team has not been informed of when MSF will formally leave the project area.

Table 1. Timeline of the MSF Eshowe HIV Project interventions⁸

		2011	2012	2013	2014	2015	2016	2017	2018	2019
1. Community Interventions (M1SS and fixed sites) ^{9,10,11}	M1SS: Schools Programme		Begin						End	
	M1SS: Farms			Begin						End
	Fixed sites: TVET					Begin				End
	Fixed sites: Philandoda							Begin		End
2. Community Health Agent Programme (CHAP)	CHAPs		Begin ¹²						End	
3. Community Mobilisation	MMC				Begin				End ¹³	
4. Facility Interventions	Community Models of Care: Support Groups/ Adherence Clubs		Begin						End	

POLICY CHANGES

A number of policy changes occurred during the project period and are therefore important to note as certain changes within the project may have been affected by a change in policy or implementation of policy. As relayed by a MSF staff member, “for example, and most importantly, eligibility criteria for starting ART have changed several times over the course of the project. This is very likely to impact time to linkage to ART for groups in the higher CD4 categories, as well as children, who all became eligible at some point”. Table 2 provides a summary of WHO guidelines and DoH mandated changes.

⁸ Table 1 was created using both consulted documents and inputs from members of the Consultation Group.

⁹ Information provided by a member of the Consultation Group : The initial M1SS was not in schools but in high frequentation community sites such as taxi ranks, shopping centres, MMC camps, tribal court meetings, community groups etc.; it later evolved towards adding schools to these community sites. See KZN Project Documents 2011, 2012, 2013.

¹⁰ Information provided by a member of the Consultation Group: In 2013, expert patients are part of the M1SS in “community link stations” to improve linkage (PD 2013).

¹¹ Information provided by a member of the Consultation Group: The first fixed site started in August 2012 in the centre of Eshowe; 2 more were introduced in 2013 in Sunnydale and near the main mall. (PD 2013)

¹² Information provided by a member of the Consultation Group: Door-to-door testing by CCGs happened from 2011 to August 2012 when DoH withdrew support of CCGs. CHAPs were then started in 2012.

¹³ Information provided by a member of the Consultation Group: In 2017 we were handing over to partners. Potentially 2018 by the time we were fully out, but our collective memory is failing us here. At the project we feel we were out in 2017 already.

Table 2. Timeline of Department of Health policy changes¹⁴

WHO guidelines		NACM scenario (date)	South African guidelines	
Date	Recommended changes ¹		Date	Mandated changes
		SA 2004	Apr 2004	See section 1 in the Appendix (S1 File)
WHO 2010 Nov 2009 (rapid advice) [5]; July 2010 (full guidelines) [6]	<p><i>Adults:</i> Eligibility at 350 CD4 cells/µl; universal treatment² for patients with active TB or hepatitis B (HBV) co-infection</p> <p><i>Children:</i> Early paediatric treatment (< 2 yrs)</p> <p><i>Adults:</i> Replacement of d4T by TDF or AZT in first-line regimens</p> <p><i>Children:</i> Replacement of d4T by ABC in first-line regimens</p> <p>Respective second-line regimens (TDF + 3TC/FTC + LPV/r or AZT + 3TC+ LPV/r)</p> <p>Fixed-dose combinations</p>	SA 2010 (Dec 2009)	Apr 2010 [7]	<p><i>Adults:</i> Eligibility at 350 CD4 cells/µl for patients with TB and pregnant patients, at 200 CD4 cells/µl for everyone else</p> <p><i>Children:</i> Early paediatric treatment (< 1 yr)</p> <p><i>Adults:</i> Replacement of d4T by TDF/ ABC in first-line regimens</p> <p><i>Children:</i> Replacement of d4T by ABC in first-line regimens</p> <p>Respective second-line regimens (TDF + 3TC/FTC + LPV/r or AZT + 3TC+ LPV/r)</p> <p>NIMART and ART at PHC level</p> <p>Fixed-dose combinations and internationally competitive prices</p>
		SA 2011 (Dec 2009)	Aug 2011 [8]	Eligibility at 350 CD4 cells/µl for all patients
WHO 2013 June 2013 [9]	<p><i>Adults:</i> Eligibility at 500 CD4 cells/µl; universal treatment for patients with TB or HBV co-infection, pregnant patients (PMTCT option B +), HIV-positive partners in serodiscordant couples, and pregnant and breastfeeding women</p> <p><i>Children:</i> Early paediatric treatment (< 5 yrs)</p>	SA 2015 (including 350, no B+; 350, B+; 500, no B+; 500, B+) (Mar 2014)	Jan 2015 [10]	<p><i>Adults:</i> Eligibility at 500 CD4 cells/µl; universal treatment for patients with HBV or TB and those who are pregnant, breastfeeding or within 1 year post-partum</p> <p><i>Children:</i> Early paediatric treatment (< 6 yrs)</p>
WHO 2015 Sept 2015 [11]; June 2016 [12]	Universal treatment for everyone	SA 2016 (including 500, B+ (90-90-90); Universal treatment) (Nov 2015)	Sept 2016 [13]	Universal treatment for everyone
		(Nov 2015)	Jan 2016	Adherence guidelines (including adherence clubs)
<p><i>TB</i> tuberculosis; <i>HBV</i> hepatitis B; <i>d4T</i> stavudine; <i>TDF</i> tenofovir; <i>AZT</i> zidovudine; <i>3TC</i> lamivudine; <i>FTC</i> emtricitabine; <i>LPV/r</i> lopinavir boosted with ritonavir; <i>ABC</i> abacavir; <i>NIMART</i> nurse initiation and management of ART; <i>PHC</i> primary healthcare clinic; <i>yr</i> year.</p> <p>¹ Throughout the table, eligibility also includes patients in WHO clinical stage 3 or 4 who have been eligible regardless of CD4 cell count since the WHO ART guidelines from 2003.</p> <p>² Universal treatment signifies universal eligibility for treatment regardless of CD4 cell count for these patient groups.</p>				
<p>https://doi.org/10.1371/journal.pone.0186557.t001</p>				

EVALUATION SCOPE

The results from MSF's 2018 impact survey, showed project success in surpassing the UNAIDS 90-90-90 targets with a cascade of 90-94-95. This achieved a level of linkage that is on average 27% higher than that achieved by South Africa overall,¹⁵ although these results need to be interpreted with caution due to the difference in methodology between the MSF survey and the South African national survey. MSF, prompted by discussions with the National Department of Health (NDoH), would now like to understand which were the most effective elements within the project, and which elements may be scaled-up and replicated elsewhere in South Africa or in other similar MSF contexts.

As outlined in the Terms of Reference (ToR) in Annex I, the evaluation will cover **the four components of prevention, HIV counselling and testing (HCT), linkage to care and ART initiation, and retention in care and adherence**. The evaluation will also focus on activities related to the **linkage to care** component (proportion of people tested positive for HIV who started ART within 30 days of

¹⁴ Gesine Meyer-Rath, G. et al. (2017). Changing the South African national antiretroviral therapy guidelines: The role of cost modelling. Available at <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0186557>

¹⁵ Based on the calculation of the difference between the treatment cascade from the MSF 2018 survey in Eshowe and Mbongolwane, 89.9*93.8*94.5=79.8% (Conan 2018. Mbongolwane & Eshowe HIV impact in population survey), and the South African National Survey, 84.9*70.6*87.5=52.4% (HSRC July 2018: The fifth South African national HIV prevalence, incidence, behaviour and communication survey, 2017).

diagnosis)¹⁶ and community interventions, including the **community-based activities that supported the four components**.

This evaluation seeks to unearth evidence of those effective elements within the four components through the lens of those interactions or intersections between supply and demand for services, including activities with a direct relation to the desired outcomes (e.g., ART initiation), and activities with a more indirect relation to the desired outcomes (e.g., training, campaigns, etc.).

Furthermore, the evaluation seeks to understand, through the overarching questions as provided in the ToR, what enablers, barriers, and lessons can be drawn from this successful intervention, by listening to those at the coalface, both practitioner and beneficiary. In addition, the project design, management and intervention elements (including strategy, objectives and activities) will be especially informative towards developing a model or models for patient-centric health services.

EVALUATION PURPOSE

The purpose of this evaluation is to assess the effectiveness and replicability of MSF's Eshowe HIV Project, and to identify those elements of the intervention (including project components like strategy, objectives and activities) within the project which played a key role (overall and related to linkage to care). As stated in the ToR, this evaluation is aimed primarily at informing MSF-OCB (MSF Operational Centre Brussels) in their conversations with the South African Department of Health (DoH) on the national HIV programme, with the aim to advise on how to better implement (or scale back) activities in order to improve the performance of the HIV cascade with focus into linkage to ART services. It may also be used by MSF in their conversations with other regional and international actors. This evaluation covers the project period 2013 to 2018.

EVALUATION OBJECTIVES

The two main objectives of this evaluation are to identify what were *the most effective elements* of the MSF intervention in Eshowe, and *what specific elements of the intervention can be replicated elsewhere*. To better understand what elements were the most effective of the MSF intervention in Eshowe, we investigated if the agreed objectives were achieved, and what were the main barriers and enabling factors for achievement or non-achievement of these objectives. This evaluation also looks at what specific elements of the MSF Eshowe intervention played the most significant role in the project's effectiveness, and to what extent did it reach populations at higher risk of HIV (i.e., adolescent girls and young women, young boys, and migrant workers), and what could have been done to make the intervention more effective.

In terms of replicability, the evaluation looks at how the MSF Eshowe intervention compares with the South African National Plan, and what MSF did in Eshowe that was identifiably different. Elements of the intervention that are scalable and could be incorporated into South Africa's national HIV

¹⁶ The proportion of people tested positive for HIV who started ART within 30 days of diagnosis, takes into account that ART needs to be started quickly (preferably same day) after diagnosis, and that ART is the most significant intervention, not clinic visit per se.

programme have also been identified. Finally, lessons learned from the intervention, and how these can facilitate HIV management (with special attention to linkage to care) in South Africa or in other MSF HIV projects in similar contexts are shared.

The evaluation focuses on the sub-district of Umlalazi Local Municipality (Ward 1-14 which includes Eshowe/Mbongolwane) located in the King Cetshwayo District in KwaZulu-Natal (South Africa) where the project was implemented.

METHODOLOGY

STUDY DESIGN

A “realist evaluation” model has been adopted, which is an approach that examines outcomes as generated by mechanisms in specific contexts, which we see as relevant to the varied sites within the King Cetshwayo District, within the sub-districts of Eshowe and Mbongolwane, and within the health facilities, be they fixed or mobile. 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. Further, we sought to understand if there were personnel issues, lack of staff, type of training or other, that affected outcomes either positively or negatively. Of particular importance, and in an effort to respond to, the evaluation’s overarching objectives – to gather information on the effectiveness and replicability of the project – we have utilised a strategic and organisational management’s, operations’ and communications’ lens. This has been mainly achieved through analysis of project documentation and key informant interviews.

OVERALL APPROACH

The overall approach of this evaluation is a qualitative approach, especially through key informant interviews (KIIs) and focus group discussions (FGDs). Both techniques have provided valuable in-depth information that highlights findings about potential returns on the Bending the Curves approach, and specifically on service providers’ (those at the coalface of delivery) experience with the project. This work has also provided important insights into lessons, suggesting barriers to success, innovations and successes, as well as any unintended consequences associated with project participation. The results provide a sound evidence base for strategic decision-making and targeted improvements or adjustments and options for replicability.

Important to context, project planning and decision-making, we seek to understand relevant changes in the strategy or delivery over the duration of the project. That is, we seek to understand why changes occurred, why they were necessary, and their effects.

An analysis of secondary quantitative data, based on routine monitoring data complements the approach outlined above, focusing on linkage to care and, where applicable, the contributions of MSF

interventions to linkage to care. The quantitative analysis is another source of triangulation of the qualitative data.

ETHICAL CONSIDERATIONS

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. However, the MSF team in Eshowe received permission from relevant officials, including at facilities to conduct this work. The evaluation team shared the Inception Report with the MSF Consultation Group, prior to conducting field work, which included the questions to be asked of potential respondents together with an introductory script.

While the evaluation team is well versed in the various protocols in both the handling and securing of interview data, 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 the teams 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. FGDs and KIIs were captured on digital voice recorders and for remote interviews, via Zoom or Skype. For all interviews both recorders and pen and paper interviews were conducted to distil key points.

Research assistants who were both native Zulu and fluent English speakers, conducted interviews with those more comfortable in speaking Zulu. Those interviews were translated into English. All interviews were then prepared for analysis.

SAMPLING

The evaluation team, in consultation with the Project Coordinator, have used the following sampling strategy. The number of proposed sites were taken from the total population of facilities where there has been a high intensity of MSF work conducted, and from the community-based models of care under the Bending the Curves project. Further, the sample represents urban and rural activities.

The respondents who participated in the evaluation, as provided by the Project Coordinator and the MSF Evaluation Consultation Group, have either been involved in or have knowledge of the project. These include MSF representatives (current and previous staff members), Department of Health (DoH) and Department of Education (DoE) officials (provincial, district and sub-district), service providers (operations managers and healthcare workers from participating clinics), partners (Shintsha Health Initiative (SHINE) and Child Care South Africa), Community Health Agents Programme (CHAPs) leaders, Youth Support groups leaders, Schools Programme counsellors, Technical and Vocational Education and Training (TVET) College Learner Supporter, farmers (including the members of the Farm Owners Association), HIV Ambassadors (PLHIV representatives/advocates), Traditional Leaders, members of the uMlalazi Coalition, Community ART Groups (CAG), and Traditional Health Practitioners.

A selection of beneficiaries who took part include youth who were members of the Youth Support group, learners who participated in the Schools Programme, permanent and temporary farm workers, as well as beneficiaries linked to clinics (adults/young women/young men), to M1SS (mobile one stop shop), to CHAPs and to Medical Male Circumcision (MMC).

Table 3 provides a breakdown of the approach (KIIs or FGDs), the respondent type (stakeholders and beneficiaries) and the number of respondents who participated in the evaluation in Eshowe and Mbongolwane. A detailed list of the respondents including their names and functions can be found in Annex II.

Table 3. Number of Respondents for KIIs and FGDs

APPROACH	RESPONDENTS		NO OF RESPONDENTS
Key Informant Interviews (KIIs) with Stakeholders	MSF	Current (staff members)	15
		Former (staff members)	9
		SAMU	2
		Consultant	1
	Department of Health	Provincial (KZN)	3
		District (King Cetshwayo District)	4
		Sub District (Eshowe - Government Officials)	4
		Sub District (Eshowe - Clinics - operations manager and healthcare providers such as nurses, counsellors, and doctors)	1
		District (Mbongolwane - Government Officials)	4
		Sub District (Mbongolwane - Clinics - operations manager and healthcare providers such as nurses, counsellors, and doctors)	1
	Department of Education	DoE District (King Cetshwayo District)	1
	Youth Support groups	Nurses in charge of clubs in Eshowe	2
		Nurses in charge of clubs in Mbongolwane	1

	Schools Programme	School Counsellors in Eshowe and Mbongolwane	2
		Life Orientation (LO) Teacher	1
		Learner Support Agent (LSA)	2
	Child Care South Africa	Director	1
	CHAPs	CHAPs	4
	SHINE	Former Director	1
	Broadreach	Sub-District Manager	1
	TVET College (Eshowe)	Learner Supporter	1
	Farm Owners	Farm Owners	4
	HIV Ambassador	HIV Ambassadors/PLHIV	2
	Traditional Leadership	Chiefs/Traditional Leaders	2
	uMlalazi Coalition	Deputy Chairperson of Civil Society	1
	Traditional Health Practitioner	Traditional Health Practitioner	1
CHAI	Technical Advisor	1	
Focus Group Discussions (FGDs) with Beneficiaries	Youth	Member of Youth Support group in Eshowe	7
		Member of Youth Support group in Mbongolwane	6
	Learners	Participated in Schools Programme in Eshowe	14
		Participated in Schools Programme in Mbongolwane	10
	Farm Workers	Permanent/Temporary Farm Worker in Eshowe	11
		Permanent/Temporary Farm Worker in Mbongolwane	10
	Beneficiaries from Clinics	Beneficiaries linked to clinics (adults/young women/young men) in Mbongolwane	9
	Beneficiaries from CHAPs	Beneficiaries linked to CHAPs in Eshowe	12
		Beneficiaries linked to CHAPs in Mbongolwane	6
	Beneficiaries from MMC	Beneficiaries linked to MMC in Eshowe	9

DATA COLLECTION METHODS

Our approach sought to maximise the diversity amongst the beneficiaries and stakeholders, and their involvement in the project. This diversity is viewed as a positive aspect of the project, and we have involved all stakeholders in data collection.

QUALITATIVE DATA

Key informant interviews (KIIs) have been conducted before, simultaneously and after the focus group discussions (FGDs) with key individuals who, because of their role, were best interviewed separately. These interviews addressed the elements of the intervention which may be replicated elsewhere. Due to COVID-19 travel restrictions, several KIIs (23) were conducted online via Skype or Zoom, these were recorded once consent was obtained.

During the field visit (5-15 October 2020), and to facilitate data management, the field team used digital voice recorders to record all KIIs (49) and FGDs (15), once consent by each respondent was provided. At the end of each day of data collection, the team conducted a fieldwork debriefing to discuss the interview processes and any challenges that they encountered. The audio files have been transcribed, and interviews conducted in Zulu were translated into English by the Research Assistants who are fluent in Zulu and English.

The KII and FGD guides can be found in Annex III.

QUANTITATIVE DATA

As linkage to care is central to this evaluation, we decided early on to focus analysis of quantitative project data on this evaluation question. There is a lot of operational research available about the Eshowe Project, and some of the datasets are accessible. Often, these datasets concern a specific intervention for a specific group, at a specific point in time, whereas this evaluation concerns the whole project over the full implementation period of the HIV interventions. Therefore, we decided to use data that cover the full catchment area of the project, and the full evaluation period. These data are present in the TIER.net database of the project.

TIER.net is an electronic patient management system that is used for monitoring and evaluation of HIV care and treatment programmes in government health facilities throughout South Africa. The TIER.net database contains information on clinic visit attendance, laboratory results and ART dispensing records for all patients on ART. The MSF TIER.net data also contains pre-ART visit information, and some information about HIV testing, which make TIER.net data in principle suitable to examine questions around linkage to care. TIER.net data include some information if patients participated in an intervention, e.g. on treatment adherence or Central Chronic Medicines Dispensing and Distribution (CCMDD). These are all interventions for patients on treatment rather than on new patients that need treatment. Therefore, these interventions are less likely to show their contribution to linkage to care.

DATA ANALYSIS

DESK REVIEW

Prior to fieldwork the evaluation team conducted a systematic review of relevant MSF Eshowe Project internal and external documents related to the Project's activities and developments over the project duration (2013-2018). The reviewed documents can be found in Annex IV. The evaluation team was furnished with project documents and reports such as annual, quarterly, and sitreps, as well as tool kits, fact sheets, and concept notes. The review process assisted greatly in the development of both the Inception Report and Interview Guides. The document review provided an important source in the analysis phase for contextual information and for understanding the timelines of activities, among other areas.

QUALITATIVE DATA

All KIIs and FGDs have been captured and transcribed into English to facilitate data analysis and report writing. The evaluation team have met to compile emerging topics, ideas, concepts, terms, phrases and keywords. After the development of the codebook, subsequent data was coded, with newly identified codes which were added on an on-going basis. Analysis included the review of the frequency of appearances of codes in the transcripts, as well as creating a qualitative synthesis of themes and topics. Common or crosscutting issues which have emerged from the group discussions and interviews are referenced in this report, this seeks to generalize findings meaningfully across respondents and respondent groups in the various sites.

QUANTITATIVE DATA

We obtained the TIER.net database with the pre-ART information and information on ART and clinic visits covering the evaluation period. This database includes 462,283 observations, including multiple observations per patient. After cleaning duplicate records and selecting the desired information, 86,147 individual patients remain. Only a small proportion of these patients are completely covered within the evaluation period, 19,320. From these, 9,408 have complete enough data to derive meaningful information on linkage to care.

We operationalised linkage to care as the number of days between the date of HIV diagnosis, and the date on which the patient started antiretroviral therapy (ART). We have less focused on the initial definition - start of ART taking place within 30 days from HIV diagnosis - as generally this seemed already to be the case at the start of the evaluation period. We analysed linkage trends over the evaluation period and possible determinants of linkage to care through univariate analysis, using the statistical software package R. These factors are gender, age, facility, disease stage and CD4 count before ART. We also looked at being lost to follow-up as an indicator of (non-) linkage to care, and the contribution of various factors, notably participating in any community model of care or not, using logistic regression analysis.

LIMITATIONS

The following are limitations of this evaluation:

- **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). This made it difficult to locate some informants (beneficiaries and stakeholders) and even towards the close of the evaluation work we were learning of prospective respondents. The timing of the interviews and evaluation meant a reliance on respondents' memories which was problematic, with many blurring the lines between activities during and after the evaluation period.
- **Covid-19 related delays:** Due to the Covid-19 related lockdown in South Africa, the evaluation team experienced delays in undertaking the field visit. While adding to delays, they managed to interview stakeholders via online platforms such as Skype and Zoom.
- **Presence of researchers:** Data collection process and the presence of the researchers might influence responses. To mitigate, we informed participants there are no right or wrong answers, and that the evaluation was focused on processes and not individuals.
- **Generalizability:** These results will only reflect the reality or views of participants in Eshowe and Mbongolwane (Wards 1-14) and are not generalizable to the entire sub-district (Umlalazi Municipality) or district (King Cetshwayo). However, there are important lessons that can be adapted to other environments.
- **(Co-)selection of respondents:** The (co-)selection of respondents in consultation with MSF staff may create bias, as these were respondents that were familiar to MSF staff members and respondents may be influenced by this closeness. To mitigate, we informed participants there are no right or wrong answers, and that the evaluation was focused on processes and not individuals. A considerable complement of informants was current or former MSF staff members. No MSF staff were present during interviews.
- **MSF's departure from Eshowe/Mbongolwane:** During the field visit, the evaluation team learnt, although not formally, that the project will be ending, and that MSF would be leaving the area in 2021 or thereabout. The imminent departure of MSF from the area may have introduced bias as many spoke highly about MSF, which also indicated a level of dependency. Mitigation measures, as noted above.
- **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. This limits the evaluation in terms of assessment of the development over time of quantitative key indicators of outcomes, coverage, and achievement of programme objectives. Therefore, this limits ultimately the assessment of the potential for impact of MSF's interventions on the HIV epidemic in Eshowe, KwaZulu Natal and South Africa.
- **Limited or no suitability** of quantitative datasets to generate information on linkage to care relevant for this evaluation. In TIER.net, data are entered decentralised by data clerks, and are compiled later at a more central level. Loss of data or inaccuracies may occur in the process. Indeed, many records have incomplete data, and the selection of individuals that have records with complete data on linkage to care was limited to a small proportion of eligible patients. This may have created a bias in the data, although it is difficult to determine in which direction bias might go. By analysing trends over time, we have sought to deal with this bias. Although the absolute median or average values of days from first visit until start of ART may not be entirely correct, it is unlikely that the group with complete data shows an utterly different trend over time than patients whose data are incomplete in the database.

REPORT LAYOUT

In line with the ToR, the main findings section specifically deals with the two areas of Effectiveness and Replicability.

Effectiveness required a thorough understanding of the interventions first and foremost, with analysis drawn thereafter with the inclusion of respondents' voices. It was deemed important to the evaluation team to include numerous and sometimes quite lengthy perspectives in this section, particularly as they are central to the qualitative process. This longer section then also prepares the reader for the following shorter section, of replicability.

Furthermore, in our review process and again during fieldwork, the evaluation team recognised the centrality of the idea of 'communities at the centre' and the related work conducted within the CHAP. Owing to this, a relatively lengthy section introduces 'communities at the centre' to reflect this importance. It is also intended to provide the reader with in-depth insights into the project, and the work conducted, often prior to, the main activities or interventions in the project area. The CHAP also received greater focus, and length, due to its importance to the project overall.

The reader will therefore be first introduced to the notion of communities at the centre, and what these constitute in the Eshowe HIV Project. Within effectiveness, they will be introduced to the interventions and the specific work surrounding door-to-door testing (via CHAP), facilities and clinics, school and farms programmes, among others. Thereafter, we focus on those areas where we view specific aspects of the project can be replicated. These sections are then followed by the conclusion and recommendations.

FINDINGS

A project with the intensity and variety of activities as ‘Bending the Curves’, makes it difficult to single out a specific element as key to its success overall. A niche driver of the project however can be understood as that which underpinned each of the components and is credited to the professional, energetic, and resourceful team at MSF, as well as an extensive body of partners. These aspects are augmented by extensive resources, and a flexibility in how such resources can be deployed.

Thus, we have found the reasons for the achievement of the 90-90-90 UNAIDS targets, and for project success overall, to be multifactorial. At the centre is the ‘power and the machinery’, as one respondent put it, which was poised for ‘pure implementation’, first and foremost. This is what MSF does, as was relayed. Throughout implementation, and especially in the early stages of the project, as well as for new activities, MSF ensured they had comprehensively planned, engaged with all the necessary stakeholders, and had their support, as well as the necessary administrative and logistical infrastructure in place. While there is a strong leaning towards the community-based activities as being the most important aspect, we have found that the interconnectedness of the various components, were necessary for the project to work overall.

Ensuring strong links between the activities and the cascade components made the project work, especially evident with linkage to care and adherence. For instance, if door-to-door testing were conducted with weak education and weak linkage, this would have reflected poorly on the door-to-door activities and along the cascade. Similarly, if another part of the cascade of care, such as adherence was weak, it too would have reflected upon HCT and the education (health promotion and literacy) provided at the household and community level. The strength of each component part made the other components stronger.

Related, respondents talked about, while not always explicit, what can be understood as MSF’s patient-centred approach. In fact, we see throughout the project, how MSF put the patient and community at the centre of all activities. This was visible at the household level in terms of building trust with communities, at facilities, with stakeholders, including traditional leadership. So much so, that the latter participated in bridge-building and enabling access to ‘hard-to-reach’ communities – both physically and behaviourally – in order for MSF and the team of well-trained Community Health Agents (CHAs) to provide much-needed services.

COMMUNITIES AT THE CENTRE

In 2014, the UNAIDS Gap Report under a special features section, noted the need to view and respond to the HIV epidemic differently. In particular, this new response required a concentration on certain populations and locations. In our view, MSF’s work in Eshowe can be considered a leader in this effort, evidenced in their extensive and proactive approach. Since 2011, MSF has developed community-based models within the HIV cascade from prevention to adherence. They have brought services into hyper-endemic and hard-to-reach communities and populations, most notably of these, their door-to-door model of HCT, as well as their Community Models of Care (CMOC).

MSF recognises that *‘when communities organize and people empower each other, oppression can be replaced by rights and access to HIV services can be accelerated.’*¹⁷ Seeking solutions towards community empowerment are, of course, a multi-faceted effort, and one that requires buy-in from government, traditional and local structures, faith-based and civil society organisations, technical experts, as well as community participation.

The overall focus of the project was on the entire population due to the high incidence of HIV in the catchment area. As the 2013 survey found, it was clear that the target population should be young women aged up to 30 years, and young men. Therefore, unlike other interpretations of key populations in other HIV projects, MSF did not specifically target key populations such as sex workers, MSM, etc. Different interpretations were provided in the targeting of populations at higher risk, with some overlaps with key populations.

In order to understand the valuable lessons from this catalytic project, we must first try to understand the meaning of communities at the centre, and how communities participate and take charge of interventions that affect their everyday lives.

MEANINGFUL ENGAGEMENTS

Community-based primary health care interventions imply a certain closeness, engagement, and ownership by the intended beneficiaries. Closeness and engagement suggest that interventions are designed based on community input and need. Ownership means that key stakeholders within communities participate in, and reinforce those activities that underscore the interventions themselves, while offering longevity to those more successful aspects.

For the Eshowe HIV Project, a well-versed line reported by MSF and non-MSF staff, including government, was that the project was designed *‘not for, but with, the community’*. Somewhat of soundbite, we have found it has depth and real meaning as respondents elaborated in their understandings of this notion. In our interpretation, this idea translates into *‘communities at the centre’* and is visible in partnerships with the DoH and the DoE, traditional leadership, with farm workers, school learners and teachers, and community inhabitants. The supports in place, for example, via Learner Support Agents (LSAs), HIV Ambassadors and the capacity and education they bring to public health, mentoring at clinics and the provision of *‘substitute nurses’*, training traditional healers in the administration of HIV tests, concretise the notion of *‘with’*, as does the recruitment of CHAs from within the communities they serve.

Another signifier of ownership may be viewed in the openness towards MSF visible in a change in attitudes within the communities, especially regarding testing. *‘When can I get tested’*, was reported on numerous occasions from CHAPs and MSF staff, by farm workers, school children and community members, and is understood as a change in willingness to get tested and acceptance of these

¹⁷ UNAIDS. (2019). Communities at the Centre – Global AIDS Update 2019. Available at https://www.unaids.org/sites/default/files/media_asset/2019-global-AIDS-update_en.pdf

interventions. Indeed, such responses are a testament to the prevention messaging and education component that accompanied each activity.

‘Not for, but with, the community’, is hard work. It does not simply mean meeting with the necessary authorities, present your case and expect to be given permission, and thereafter the community will accept you and your interventions. We have learned from Eshowe HIV Project that ‘with the community’ requires real and sustained engagement and dialogue over time - and building trust at all levels.

RESPECTING LOCAL STRUCTURES

First and foremost, given the makeup of the province of KwaZulu-Natal, the inclusion of traditional and formal political structures, especially in the initial phases, but also at opportune times throughout the project, was necessary.

The introduction of the project through and by traditional leadership meant the cadre of health agents, from the communities and providing testing at the household or homestead level, was significant to the realisation and success of the door-to-door model (under section Community Health Agents Programme below). The inclusion and sanction by the Inkosi (Zulu chiefs) with some community activities conducted by the Izinduna (councillors to the chiefs), among these, announcing in villages who MSF are, what they were doing, and that they could be trusted, provided a robust foundation for community acceptance. As one Traditional Leader noted:

“...we used to discuss in the meetings, they used to tell us this is our plan, and we used to accept what they have planned and work according to their plan...It was because we were part of the discussions, and if you are part of the discussion, then you know, and if you trust those people who were representing them...”

-Traditional Leader 1 (#44)

The importance of trust and confidence instilled in the community by traditional leadership, and with community members living with HIV, reinforces the messages of the Eshowe HIV Project, as this HIV ambassador states:^{18, 19}

“In the community, there were places you can go to and you talk in front of the Amakosi and tell them the true stories of being HIV+; lots of Imbizos. All kinds of people will be there, and we’ll explain the good of taking the medication, testing, and they understand very well, and they go to MSF. On the second day we get calls and we refer them to the MSF staff. Prior to this we didn’t have these supports – no CHAPs, no CAGS”

-HIV Ambassador 1 (#23)

¹⁸ *Amakosi* in quote: Plural of the word Inkosi (several Zulu clan chiefs)

¹⁹ Imbizos in quote: Imbizo Concept Note, 2016. Imbizo can only be called by Inkosi or their subjects in the hierarchy of Izinduna if there is an important information that affect the community which needs to be addressed or information to be passed on to the community members.

Prior to conducting the door-to-door testing, MSF through their community coordinators together with the traditional leadership, invited community members to participate in specially designed fora at the community and village level.

The intention of these meetings was to meet with all representative communities. In most cases the elders, the warriors, the teenagers, and women are called separately from each other in the village to address specific issues.²⁰

These consultative gatherings allowed for community dialogues which included inputs from the community on what they wanted, their expectations, but also allowed for initial dialogues surrounding health and HIV. Such efforts meant that MSF could better understand the needs of the community, how they could involve them, as well as possible gaps and barriers to the intervention.²¹

HIV ambassadors,²² people living with HIV (PLHIV) activists, some of whom were already working on these issues, were invited to participate with MSF teams at community events and engage with certain groups deemed difficult to engage with, such as churches. Their proactive nature, courage, visible through wearing their status on their tee-shirts (though perhaps all were not HIV+), where some used themselves and their experiences as examples of life not being limited to status, enabled important inroads to groups characterised as inaccessible, as relayed here:

“When they are going to have a community meeting, they would announce in the meetings what is going to happen, that a good thing is going to happen, so the community is ready for this. The various leaders would attend and build that confidence and trust... before we were not even allowed in the church and into meetings... now we are going into the community and engaging, meeting with the churches... we used to be together and talk about HIV and how to fight the stigma and discrimination.”

- HIV Ambassador 2 (#28)

Government department representatives were unanimous in their praise for the project and its staff, and in how MSF services serve to better the community, as well as their immediate offices, in a complimentary manner. That is, government departments relayed a two-way relationship between themselves and MSF in how they both benefit from each other’s activities and thus provide better service to their communities.

Government structures, provincial and district departments of health and education, provide the required authority and oversight to conduct health and education related activities within the

²⁰ Internal document: Imbizo Concept Note, 2016.

²¹ The grouping and segmentation of the community were given the themes and names that honor the community leaderships in different levels. Amakhosi were given a workshop title “Ubuhlakani bendabuko” (“The wisdom of Traditional leadership”). The village’s first ladies workshop title was given to the wives of the “Amakhosi (Omama Besizwe)”. Village men commons were given the title “Esibayeni”, village women titled “Siluka amacansi”, Boys given “Ekwaluseni” and the girls’ “emthonjeni”. This is taken directly from Imbizo Concept Note, 2016.

²² MSF also provided HIV Ambassadors with training and counselling, as one reported, they had not been provided with this previously.

communities, clinics, and schools. These structures commended MSF on their work and acknowledged the centrality of the community-based approach as being fundamental:²³

“...whatever they were doing it was community-orientated. They had to sell their strategies through the community structures at the community level and they got good buy-in from the key leaders at the community. Like the issue of where they would move around screen and test for HIV it was something that was acceptable; it was something that was never done before but it got accepted through MSF because they had to market it through the relevant structures and had to fixtured in on the OSS structures that are existing in the areas, and some other categories like traditional health practitioners they brought them on board, they even trained on testing, they capacitated traditional health practitioners to be part of the team. That is making a difference at the community level.”

– Official, DoH District (#31)

Political leadership also acknowledged the centrality of traditional and local leadership:

“That approach becomes an enabling factor for everything else to receive fertile ground to deal with actual issues. You need to start at that point and engage local leadership whether traditional or political it creates enabling factor or platform for everything else you do. That strategy worked well for MSF and district as well”

– Official, DoH Provincial (#4)

Recruiting community coordinators, one male and one female, who were experienced in community engagements and traditional structures and customs, provided much needed discussions in the preparation stages, prior to the deployment of cadres, as this community coordinator relayed:²⁴

“The focus of the position was to develop these cadres to be able to go to the community and render the services. But what was going to be a challenge is ‘sending people to be unprepared ground’, right, so this element of engaging with Amakosis, Indunas, Ward Counsellors was ‘levelling the ground’ so that when you send your cadres, they will be respected in the community, and they will be protected by this leadership in the community. Knowing that they are not there to do something wrong, but they are there to help the community”

– MSF Staff Member (#86)

Community Coordinators also assisted in understanding the dynamics between the political and traditional authorities²⁵ that exist in the province, and the need for transparent relationships, while remaining neutral or apolitical. It is understood that MSF made some initial missteps in this regard, but quickly learned via the community coordinators on how to navigate these important structures.

²³ OSS: Operation Sukuma Sakhe:

<http://www.kznonline.gov.za/images/Downloads/OSS/Operations%20Handbook/OSS%20Operations%20handbook.pdf>

²⁴ *Induna* in quote: Zulu title meaning great advisor or leader

²⁵ It may also be important to be aware of the inter and intra dynamics that exist for these structures.

Conscious as to how one may be viewed, even if unintentionally, meant respecting the various authorities and remaining focused on the goals of the project. Respecting the structures and understanding the context, and where the approach takes those aspects into consideration, enables the management of these dynamics more easily. As noted,

‘...you need to understand that so that you are not going to find yourself in a situation where you get used by one of these parties’

- MSF Staff Member (#86)

The political-administrative system of the department of health is complex, bureaucratic, and layered (National, Provincial, and District levels). Understanding the hierarchies, their interactions, and the areas of autonomy that exist at hospital and facility level, can contribute towards buy-in across the spectrum of facilities, and their respective leadership and personnel. Although it was necessary for the project to engage at province level - as province has overarching authority - by doing so, it can be viewed as being a top-down approach, which early on was met with some resistance at the local level. Engaging at the facility level and understanding their challenges, and using a multi-pronged approach (at all levels) was therefore essential, as is detailed below:

“...so we had to relook at that strategy and start from the bottom, we engaged with the clinics and we created an understanding, and we do not just come with a you know “a baked cake”, but we come into them and bake cake together, we identify the bottlenecks and look at what relates to what we are to do. We are coming to an agreement on the facility level which is the clinics and getting buy-in of the clinics, obviously when you meet with them at the district hospitals, the clinics will be supporting what you are doing and what you intend doing in the future. And the hospital, seeing that you are contributing to the work of the clinics then they will support you when you go to the district, you go with them having to speak the same language, and if you go to them you want a letter that recommends you to start a certain program within the project, you’ll get those kind of letters stamped and signed, so it means it’s something that has been worked on the ground before it goes up...”

-MSF Staff Member (#86)

Some of these aspects were observed in other respondents’ explanation of buy-in, transparency, and sharing information, and especially understanding the projects objectives. This was particularly necessary for the CHAP activities, but also across the various stakeholders.

“The transparency and also the importance of understanding and knowing the objectives from the word go, and not just MSF, but also for people implementing on the ground. So regular feedback and meetings, so every time we would provide feedback on how far we are to reaching the targets. And for the people on the ground it was very important to understand what they are working towards, what are we trying to achieve. And for them to understand their contribution as an individual, what you bringing to the table. So, for every person that you find, for every person that you test, for every person that you link to care, what does that mean in the overall goal of the organisation.”

- Ex-MSF Staff Member (#11)

This last excerpt also represents community inclusion, as CHAs are from the communities. Under the CHAP section below, we find more evidence of this level of community involvement and decision-making.

COMMUNICATING OBJECTIVES AND PLANNING

Project activities were reported as being well-planned for with extensive stakeholder involvement and the necessary logistical support in place. Naturally, there were challenges especially at the outset of the Project, some of which are noted further below.

Internally, MSF staff were found, to a great extent, to speak of the organization in similar ways. This is recognised as an important aspect to the project overall and for community engagement. MSF staff interviews, across the board, revealed a strong understanding of the programmes' mandate, goals and achievements displaying a certain intimacy and knowledge sharing within the organization, which we observed through the descriptions of similar activities, project successes, as well as the challenges noted.

Good working relationships, both within the organization and with relevant stakeholders also speaks to efficiency, where some stakeholders were only a phone-call away.

In developing a roster for HCT visits in advance and communicating these sites to local leadership, and traditional and ward authorities, was central to the promotion of community and school sites for the M1SS for the HTC mobilisers.²⁶

The closeness between the DoE, the schools, and MSF, was another example of joint participation and was also acknowledged in the close planning activities, and how *'at the beginning of each term they plan together, so that at least the activities in schools are totally organised'*, as a DoE official relayed. Building capacity or skills transfer is essential on several fronts, including for ownership and sustainability. By building capacity at all levels, even for those who may not actually be implementing the activity, is also empowering as a DoE official noted the engagement and inclusive aspects of their relationship with MSF, as follows:

"I talk about Eshowe and everybody is clear about HIV/AIDS information including officials because they have been updating us on the latest information. With training they will start with the coordinator in Life Skills Coordinator, Life Orientation (LO) teachers, district officials, they will train circuit officials, so that we are all on board and then go to schools. There is also a component called Learner Support Agent, they are the first line information people in schools they identify programs, they were training so well with regards HIV/AIDS information."

-Official, DoE District (#33)

²⁶ Internal document: Project document 2016, ZA1 - 81

Coverage required a breadth of services, as recalled by an ex-MSF staff member *‘we were rich in our strategy for testing because we had testing in the community, at fixed sites and mobile van, and schools, and the testing was happening in household...and having different modalities we managed to catch different people.* Another ex-staff member recalled, *‘we did a bit of everything’.*

At the same time, stakeholder engagements and community buy-in can be understood as uneven, non-linear processes. They consist of stop-and-start efforts, with setbacks, as they are recurring features of similar projects anywhere.

“...We didn’t have a roadmap in 2012 of where we wanted to be in 2014... and how we could achieve it, it was not a smooth ride like that... there are some things we might have done quicker or differently, we had to adapt a bit. It was not planned and implemented in a smooth A to B kind of fashion, it was a bit chaotic at times...”

-Ex-MSF Staff Member (#13)

One example within the Eshowe HIV Project related to changes in personnel, in some instances this was the case with government officials, and so unavoidable. Also turnover of the community health agents who may have secured work elsewhere, presented certain challenges, including at the household level.

Within the CHA cadre, agents would sometimes take opportunities to progress to what may be understood as more secure work with MSF. The challenge for the CHAP would mean to recruit and reintroduce the new agents to the various stakeholders. It appears that this could happen quite frequently. At the same time, providing for career progression is necessary, and MSF have been proactive in this, as we have heard of numerous advancements and promotions, including for many of the drivers. The point here reflects change over the lifetime within the project.

In reference to the previous quote above, MSF were not, in the initial project phases, comprehensively aware of some of the obstacles that it may face. For instance, not being able to involve Community Health Workers (CHWs)/Community Care Givers (CCGs) in the employ of the DoH, to conduct the door-to-door testing. This aspect, we can be certain added to delays in roll out given the recruitment and capacity exercises that needed to be conducted.

While the organisation was proactive in the project design and in securing the right location for the project, there are instances that the evaluation found where more due diligence, in the form of a situational analysis or similar activity, could have helped to avoid some delays. The delay in securing the MOU, while perhaps unavoidable, in our view, a more comprehensive understanding of the issues may have assisted MSF to better plan for that eventuality. A more in-depth appraisal of MSFs approach in engagements and understanding of the landscape in its varied forms might reveal important learnings. Our evaluation however is limited to more high-level insights in this regard. These would include engagements with a variety of stakeholders prior to project commencement, inside and outside of the project area. For instance, South Africa has many examples of programmes where multiple learnings could be garnered. One example that engages with traditional leadership (albeit in

a different sector) is the Thohoyandou Victim Empowerment Programme, based in Limpopo. Our example above speaks to DoH and the CHWs and not being able to utilise that cadre, as well as the MOU. Closer engagement might include the installation of a liaison officer, or similar personnel, to work in partnership at DoH offices and appreciate and assist in the resolution of their challenges with the intervention or parts thereof. Such a move would first and foremost require the fulfilment of a department need.

Furthermore, the evaluation found that the project documentation reports received were written mid-project that should have been developed earlier, and some reports were 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. The lack of strong documentation leads to potential gaps in handover and this was reported to be the case within the project.

VISIBILITY AND INFRASTRUCTURE SUPPORTS

The rural communities that make up the intervention area are known as hard-to-reach, a point emphasised by DoH and one reason as to why those communities are unable to have regular access to health services.

As noted by one ex-MSF Staff Member, the intervention conducted a 'bit of everything', especially in the early stages. While this approach has some drawbacks, dealt with later in this report, it also gave MSF a presence that made them easily identifiable, including in farms, located in deep rural areas. Such visibility, together with their reputation as hands-on and being available to assist stakeholders at community-events and in problem-solving, positioned MSF as a reliable partner, underpinned by comprehensive planning and coordination, with a well-managed logistics infrastructure, comprising of approximately 10 vehicles. In navigating the rural environment in which the project took place, these assets, proved vital. The project has to be seen in the communities it serves.

We learned from DoH and DoE that they have at times relied on MSF for transport, sometimes outside of the project scope, and geography. For example, at the request of the DoE, MSF conducted training for LSAs in a number of other districts. On the prevention side, a key element to the Medical Male Circumcision (MMC) project was the ability to transport patients, pre- and post-procedure, to the clinics (or hospital) and back to their homes. Without this service, the project would have expected significantly lower numbers of volunteers. The coordination and logistical support provided by MSF meant that being deep in the community did not translate to exclusion of such services, but that these services are for them.

Door-to door testing under the CHAP is detailed in another section. However, as the activities actually involved bringing the services to the communities, the following excerpts are examples of community members' perspectives on the value and advantages of the CHAP, along with the acknowledgement of the provision of a better quality of service, as recalled by two community members, and reinforced by a traditional leader:

“You would travel a long distance even for the smallest thing, what was even more discouraging, besides transport, at the clinic we would spend the whole day, and it was discouraging because you would be there until there is no transport to go back home.”

- Community Member, Ngudwini 1 (#68)

“We knew our status. We saved money for transport and time that I would have spent at the clinic. We received information about health. They were patient with us, had time for us as individuals, they provided counselling, we trusted her, unlike at the clinic, there were so many things.”

- Community Member, Ngudwini 2 (#68)

“Coming closer to the people it made that effective because it is difficult for people to take a taxi going to town to say I am going for testing. For MSF to come to rural areas to where people are, it made that effective... people would go for testing only when they were not OK...”

-Traditional Leader 1 (#44)

The role of the clinic was the other important factor for the community-focused approach, also addressed in another section. While testing at home removed a burden on households and clinics, referrals after a positive test necessitated a clinic visit. The processes in place ensured a relatively smooth transition towards linkage to care.

Dedicated trained MSF staff to retest or administer ARVs at the clinic and providing additional information, contributed of bringing the services closer to the client. The availability of trained staff, with a focus on quality, as relayed by community members, assisted in a holistic experience for the client. Once stable, patients would then be offered the opportunity to join clubs or CAGs designed for higher adherence rates. While clubs assisted in adherence during clinic visits, CAGs on the other hand reduced clinic visits, where visits were rotated among members, which might also depend on members’ ability to travel. This latter point highlights yet another link between the community and the health facility and services.

In addition to visibility within the catchment area, the evaluation also learned of MSF’s presence in media and other fora that gave exposure to the Eshowe Project. In this regard, several advocacy activities to promote the Eshowe HIV Project took place within local, national, and international environments. For example, at the local, provincial, and national levels, MSF’s work was promoted in newspapers, radio and TV, and local MSF personnel were provided the opportunity to speak of the programme and their experiences. At the international level, MSF had the opportunity to promote the Eshowe HIV Project since it had exceeded the 90-90-90 UNAIDS targets, and this information is available via the multilateral platforms that UNAIDS utilises. MSF also showcased the project at various conferences, including the International Aids Society (IAS) Annual Conference. Furthermore, MSF

showcased the project on posters, fact sheets and tools kits. The CHAPs Tool Kit in particular can be adapted to up skill CHWs in other sectors in South Africa and elsewhere.

Throughout the evaluation we learned of MSF's commitment to the work in Eshowe, which is viewed as a core driver in the project's overall success. The MSF Charter makes the humanitarian values that underpin the organisation clear. It states as follows: *Médecins Sans Frontières provides assistance to populations in distress, to victims of natural or man-made disasters and to victims of armed conflict. They do so irrespective of race, religion, creed or political convictions.* In our view, the values brought to the medical-development intervention such as the Eshowe HIV Project, are central to the realisation of the project goals overall.

In interviews, we found that some overlaps in the descriptions of MSF's work were notable, due to the time lag between conducting the evaluation on the project, and activities that occurred more recently, for example, with Covid-19. In this regard, respondents relayed the great work that MSF was doing (currently), as their Covid-19 screening tests were visible at medical facilities. Some also observed their work in Durban during xenophobic violence*, and how they were involved in providing assistance. These activities, besides their importance on the ground, contribute to MSF's image as a humanitarian organisation to those in the project area, and reinforces the idea of MSF's wider commitment. A commitment we consider as having a cascading effect within and beyond the organisation.

The extensive engagement and commitment of MSF cannot be understated. Though the organisation did not always make the 'right' decisions or approaches all the time, great efforts were made to understand the environment, structures, and people, with the project objectives as their core focus. MSF personnel have themselves acknowledged their propensity to be somewhat arrogant – 'we know what you need, let us do it' – and while such sentiments were perhaps well-founded, especially at the early stages, the organization made great efforts to learn, and work with an extensive list of stakeholders and community members. In addition, the ability of the organisation and the project to reflect on their approaches, and change these, contributed in how they dealt with communities in more inclusive and participatory ways. Such reflections were recognised in particular within the CHAP.

The commitment and acceptance of the organisation may be summed up in the example of the MMC and Schools Programme, a testament to the extensive planning conducted at various stages prior to the intervention itself.

"Community acceptance, took some time. One good example, the MMC and schools programme: to be able to go into a school and do SRHR education and recruitment for MMC in schools, means you have a good acceptance in the community because you need agreement from traditional leaders, parents, teachers, principals, agreement of the whole community. CHAPs program the same, a lot of effort to get into the houses. That helped both the work in clinics and community link from one to the other."

– Ex-MSF Staff Member (#81)

MSF is a unique humanitarian organisation with an impressive body of knowledge. They are well-resourced, with a dedicated team of professionals, not only within their medical complement but visible in their well-trained and committed local staff, as we have learned from the Eshowe Project, with an appetite for learning, adaptability, and flexibility. These aspects, in our estimation, contributed towards a successful integrated patient-centred and community-based model.

* Emergency intervention in Durban responding to Xenophobic attacks; A three-month intervention managed by Eshowe Project. Project document 2016-ZA1-81

EFFECTIVENESS

Effectiveness focuses on the extent to which the intervention achieved its objectives. Per the project document, the five main evaluation objectives/questions relate to the following interventions: **Community Interventions; Community Health Agent Programme (CHAP); Community Mobilisation; and Facility Intervention.** We sought to understand and analyse these interventions from the perspective of a variety of respondents as listed under the methodology section and detailed in Annex II. A timeline of when these interventions started and stopped can be found in Annex V.

COMMUNITY INTERVENTIONS

The community intervention of the Eshowe HIV Project played a significant role in not only providing services but bringing services closer to the community. While the project conducted various additional activities, including campaigns, the main community interventions included the M1SS (Mobile-1-Stop-Shop), which include the Schools Programme and Farms Programme, and the fixed sites, which include the TVET College and the Philandoda (male clinic). High Transmission Area (HTA) is considered under the sections M1SS (farms) and fixed sites (TVET College). These various interventions are highlighted below as having been effective within the four components of the project, specifically prevention, HCT, linkage to care and ART initiation, and retention in care.

MOBILE-1-STOP-SHOP (M1SS)

“What I can say it, we all know how it feels like when you talk to a parent about HIV and AIDS, but when you talking to an MSF person, you are free, it’s like talking to a friend, it’s easy to ask something.”

- High School Learner

“It was with open arms - no reluctance with MSF coming into the community.”

- Farm Owner

Our main focus within this section relates to two interventions: Schools Programme (began in 2012) and Farms Programme (began in 2013). In late 2011, MSF launched Mobile-1-Stop-Shops (M1SS), which are mobile testing units providing information, counselling, HIV testing, TB screening and point of care (PoC) CD4 count for those who test HIV positive. Following a schedule, three to five MSF counsellors went to different places every day with a van to conduct HCT, TB screening, pregnancy testing, and STI screening. The schedule is made by the M1SS/fixed testing sites (FTS) Coordinator by the beginning of each month. *“They go to high schools, farms, busy places in Eshowe town (shopping areas, busy streets, taxi rank etc.), and industrial areas, making it easier for people to get tested, know their HIV status, and get referred for treatment and care earlier and closer to their home or place of work”.*²⁷ The M1SS was handed over from MSF to the DoH in the third quarter of 2019.²⁸

In keeping with the project design, as above, these programmes intended to reach those less likely to uptake services at formal health facilities, and therefore sought the inclusion of farm workers and

²⁷ Project Document 2015

²⁸ Project Document 2019

learners. Respondents from both environments were extremely complimentary towards the interventions. A number of commonalities between the programmes were evident, and pertain to the quality of services provided, the openness and transparency in discussions, and the confidentiality which would be maintained by MSF. Put simply, MSF could be trusted, and were sincere in the delivery of quality services.

Comparisons were made in both programmes, but especially amongst farm workers, between government and MSF approaches. Stark differences were identified, with the above noted qualities of trust and sincerity weaker on departments' side.

Schools Programme

Background²⁹

At selected schools³⁰ in Eshowe and Mbongolwane³¹ MSF implemented HIV Testing Services (HTS) through the Mobile-1-Stop-Shop (M1SS) component. The objectives of the school testing were as follows: (1) mobilise high school students to know their status; (2) support high school students with key prevention messaging in order to take proactive steps to a healthy lifestyle irrespective of HIV status; (3) increase occurrence of health seeking behaviour; and (4) increase support and access to care for high school students who test HIV positive.

In addition to the HTS, students were offered health education on HIV/AIDS, TB, Sexual Transmitted Infections (STIs) and risk of teenage pregnancy, usually during the Life Orientation (LO) lesson. The messages for health education were different according to the grades (15-25 years).³² For example: Grade 8: *health education covers information about HIV/AIDS, prevention and treatment importance of knowing your HIV status*; Grade 9: *health education covers risk of getting HIV and sexual life*; Grade 10: *health education covers sexual gender-based violence and steps to stop it*; Grade 11: *health education covers teenage pregnancy and HIV correlation*; and Grade 12: *health education covers life after school (how to protect yourself from STI/HIV, how to negotiate for safe sex)*.

HCT services started in 2012, with some disruption surrounding testing on school grounds, due in part, to a lack of clarity on testing guidelines. During that period, MSF provided HCT to learners just off school grounds in tents. In 2016, the DoE introduced a policy³³ allowing HCT onto school grounds.

Due to schools allowing access only 3 days per school year, there was no space for continuous support and care, education and awareness activities. This challenge gave rise of the idea of training and working with the Learner Support Agents (LSAs) as the HIV/TB focal persons in schools.³⁴ In turn, this enabled the delivery of services to meet the project goals.

²⁹ Internal documents: Learner Support Agent Programme Concept Note. January 2016. School Fact Sheet

³⁰ We were informed that schools were chosen within the catchment area based on permission granted by the school principal and/or governing body. DoE now has a much more rigorous process in place.

³¹ In agreement with the DoE district, HCT services started in 2012 in 34 schools (14 in Eshowe and 20 in Mbongolwane), with them only allowing 3 days per school per year LSA Schools Document 2016

³² Learner Support Agent Programme Concept Note. January 2016

³³ National HIV Testing Services: Policy 2016

³⁴ Learner Support Agent Programme Concept Note. January 2016

With MSF services being operational among this age group (15-29 years) as a population at higher risk of HIV (young men and women), the aim was to reduce new incidents and empower and promote prevention methods amongst learners. The Schools Programme intervention was handed over from MSF to the DoE in the fourth quarter of 2019.³⁵

Pathways into school curricula and access to schools was found to be uneven and somewhat *ad hoc* in the initial phases, the result of weak planning in this area by MSF and a lack of comprehensive engagements with DoE, as well as perhaps uncertainty on the part of DoE as to what the programme entailed, and how it may be received by parents.

It appears that MSF did not conduct a comprehensive situational analysis or similar activity in order to understand the school system in the proposed programme areas. Internal documents show MSF could only directly access schools 3 days per school year, as elaborated below. This would have been highly insufficient to meet the programmes objectives. A revised approach included training Learner Support Agents³⁶ (LSAs) as conduits to the intervention goals.

Although this approach was ultimately workable, where MSF provided training and support to the LSA, it was not planned. Furthermore, we learned that accessing schools (not only for testing) was determined by principals, and so depending on how receptive a principal was would determine access at individual schools. We are unsure as to why a more collective approach and engagement process, similar to the CHAP engagements, to access schools was not pursued. For example, fora that would include DoE representatives at various levels, school boards and/or parent bodies, would have been useful to engage with and understand more completely what would be workable, identify gaps and such like. The initial phase was registered by the DoE as a learning opportunity for everyone.

On reflection of the programme overall, DoE were extremely complimentary towards MSF's work, their innovative approaches, especially in providing trainings including to a wide complement of DoE officials, as well as the dedication of MSF staff.

With regards to following protocols in informing parents and on the consent/assent processes, MSF adhered to a strict process as explained in this example:

³⁵ Project Document 2019

³⁶ LSAs are employed by DoE to provide support to all learners in high schools and primary schools. Their original task is to find social cases and refer to other institutions with no particular focus on HIV/TB issues.

“...when we’re in grade 8 they never just came, we would first be given a letter to parents stating that MSF is coming, gave forms to parents to permit us to be checked by MSF. In the form the parent would tick yes and then include contact details, then bring it back to the teacher, then MSF would come to perform testing. However, should you want to change your mind about testing, you were allowed to do so, you were given a choice, you were not forced to do it.”

- Learner 1, Mav High School (#78)

Learners’ and Teachers’ Perspectives and Experiences of The Schools Programme

As per MSF documentation, HCT in schools provides an essential opportunity to promote HIV prevention among students by providing health education and allowing learners to know their status and begin a long-term habit of regular HIV testing.

Responses from interviews show the programme, including on-site testing, as being generally accepted across communities and stakeholders, including learners. We were informed that due to stigma and parents’ concerns surrounding the perceived ‘promotion’ of sexual activity amongst learners, as problematic, as condom distribution in schools was viewed in this way by some. Related, some learners mentioned a ‘generation gap’, while others noted a lack of HIV literacy within communities, which they themselves were being exposed to. Further, learners expressed their perspectives in the changes they were seeing at home as recorded here:

“I think they starting to adapt to what the programme is about on what MSF people are doing, the time is changing, the way they think about HIV and learning and everything, they are starting to have a different mindset about everything.”

- Learner 1, Mav High School (#78)

“I think the parents are happy about the program; the reason being parents fails to their children, they are scared that if they talk about sex to their children, it will seem like they are availing themselves to say you are ok now grown you can do if, if someone else teaches about HIV and STI’s, so they appreciated it even though they won’t show it, because they not able to talk to children about it but if there someone who is able to talk about it so that they know.”

- Learner 2, Mav High School (#78)

A general acceptance may also be informed via the many other interventions ongoing in the communities around the same time, including the CHAP. As previously reported, the Schools Programme also penetrated the communities, thus having a reinforcing effect on the health messaging that families were being exposed to. Those messages of testing early and building a culture of testing amongst young people was found to be important, especially among programme activity managers, LSAs, LO teachers, and learners.

School Counsellors explained what MSF was able to do effectively within the bigger picture of the project, which was to include the entire community through a sort of ripple effect. They explained at

school they worked with children, providing health education, and these children would then go home and teach their parents, their parents in turn would go to church and teach at the church on how to deal with HIV, and on how not to discriminate. The education provided to learners was therefore able to reach a wider audience beyond targeted schools.

Additionally, they explained the Schools Programme was successful in offering innovative and youth-friendly ways of providing health education, as one of the MSF School Counsellors shared:

“In schools MSF would talk and talk, what helps us engage with children in the schools is to be like their age, be in their situation, not judge them in their situation, give them the information, and not hide anything. Understand the mission and vision of MSF when you go out there, not to be judgemental, be neutral... MSF is here to fill the gap with the community.”

- MSF School Counsellor (#18)

“MSF has played a huge role in helping and opening the eyes of these learners you know teaching them about HIV/AIDS and TB, basically social ills, because they also have camps for learners...they also teach them about adolescence, teenage pregnancy stuff like that, and when they come back they (the learners) don't just keep the information to themselves, you know they also teach other learners, like we have peer educators here, learners who teach other learners. I also think that they also take that information about HIV, teenage pregnancy, and use it at home and in the community.”

- LSA, Bam High School (#76)

Life Orientation (LO) teachers who were provided training on Sexual and Reproductive Health (SRH) education gave insights into the value and effect on learners. Positive aspects pertain to giving each student within the school the opportunity to decide to test (with a signed parent consent form). They noted that the intervention taught learners to speak and stand in front of the rest of the school and explain what was done by MSF and the messages that they understood from the programme. Those speaking skills and creative aspects are captured here:

“It taught our learners to speak out, it taught our learners public speaking, they gain confidence in that, we attended a particular workshop where learners were entertained, there were also people who were entertaining, they were having some sketches and displaying some charts with HIV and TB, because in most cases they are friends they go hand in hand, so they were so fruitful.”

- LO Teacher, Bam High School (#75)

There was a strong sense that LO teachers themselves were more empowered through the knowledge gained from training and were now equipped to deal with new and difficult situations.

“... I have got cases where there was a learner who came to me to report, she was herself HIV positive, that was the story, so I had to try and help her. Still now we are connected at all the particular time because I had handled her situation in a professional manner... and, ...they were able to come to me and talk about their issues some they come to report issues from home that they got some people who are sick, but no one is watching them. They assume just because what MSF has said and what I have said during life orientation period, to relay their personal stories, so I have to report them to the clinic or they actually refer them to social workers to talk about those issues. So, when MSF came, they talk to them, they request them to come voluntarily in testing...”

- LO Teacher, Bam High School (#75)

Similarly, learners recalled that the programme taught them not only on how to protect themselves, but also how to accept HIV positive people and not to discriminate against them.

“I think MSF have really helped me as an individual, because at first, I thought when somebody had HIV, I thought we should not get near that person, that was discriminating against them. I thought I was just protecting myself because I thought of the way I grew up, we really never heard of HIV, the first time the HIV strike many people died.”

- Learner 1, Bam High School (#73)

“So, I thought if I become friends with her maybe I will also be HIV positive or maybe my other peers will think that I am also HIV positive because I am hanging out with these HIV positive people. So, MSF really changed that, I started seeing things in a new perspective, I realised that if you are HIV positive it’s okay you can take your ARVs you will be fine, you can suppress the virus even though it won’t disappear in your blood, but you can still suppress and you can survive.”

- Learner 2, Bam High School (#74)

“When we have to write about HIV we are able to write about HIV freely because we have learned they ask if you know how you get infected with HIV as those question do come up in LO something like that how do you infected how can prevent it something like that and how do you take treatment if you take ARVs like people who are drinking that does not mean they must stop drinking they can continue and take ARVs as well.”

- CHAP Beneficiaries/Learner, Eziq (#60)

The core message reinforced by MSF, was that learners should get tested and know their status early. That this specific message is recalled during the evaluation period is a testament to the content and modes of delivery of the positive health messages received by high school learners.

“One thing they really do highlight is that you should get tested, because you need to know your status early, as a person because when you are infected by HIV virus your immune system is vulnerable to disease that you may have not gotten when you are taking your treatment. They highlighted things like that, and they said that being HIV positive isn’t necessary the end of the road.”

- Learner 3, Bam High School (#74)

When asked about testing on and off campus, an LO teacher said that on-site testing influenced learners to get tested and that it was better on-site. Further, they reported observing learners convincing each other to go for testing, as friends tend to pressure each other, and if one is going, others follow.

Grade 12 learners from Mavumengwane High School who were part of the programme from Grade 8, offered a lot of insights on the various themes covered, and in doing so, displayed a high level of maturity and confidence as the excerpts below show:

“They told us how to prevent, with boys they said you can circumcise, but they told that it is not 100% guaranteed, but it will reduce the chances of transmitting the disease; When we were grade 8, they told us that if you sleep with someone without using the protection you might get HIV/AIDS. But you grow up to grade 9 and 10 then you experience those things happening, they also told us about pregnancy, when we were in grade 8 some learners were not pregnant when we grow up you realised that what they were saying was true, it is happening; I would say they are very assuring when it comes to prevent.”

- Learner 3, Mav High School (#78)

Opportunities to ask questions and offer perspectives were said to have been useful as was the position of not being forced to participate. The approachable manner recalled earlier by the MSF Counsellor as to how they wish to be perceived in delivering health messages, was interpreted similarly by learners.

“MSF people were approachable and friendly, and they always told us that if we want to have a private conversation, if you want a basic information on, ask them directly because they said they would leave their numbers... they would get our number from the office they would ask us how we are doing, all in all they were friendly and very approachable.”

-Learner 4, Mav High School (#78)

When asked about the differences between discussing SRH topics with MSF and LO teachers, learners felt that teachers were more like parents and would likely tell other teachers, and so there would be no confidentiality in such exchanges.

“When it’s a person from MSF you are free, because you don’t see them every day, it’s someone you would see to advise you on that day and then they are gone. Unlike the teacher that you see every day, they’re not going to tell everyone that, that one has HIV...”

- Learner 5, Mav High School (#78)

While condoms were reported to be freely available at this school (Mavumengwane), learners said that even though you could freely take them from the tuck shop, they were still under the eye of an adult. This may, according to some learners, act as a deterrent. An LO teacher also said that she keeps condoms in her pencil case, and that learners can and do, freely access them. Some learners suggested that every learner should be given condoms and then it was up to the individual if they wanted to use them. This way, they said, was more equal.

Youth camps was an important aspect of the intervention and spoken about favourably. They were noted as a safe space for young people to not only learn about HIV, but also learn about themselves, as recalled here:

“Going to the camp I was just expecting to be taught about HIV, but I was exposed to such an environment that I was able to make new friends and friends that I am studying with each and every day here, so they did not only help me produce more knowledge on HIV, but they also helped me academically, but they didn’t even know, we were in such an environment where we can speak and be ourselves, I hardly do that anywhere so the MSF people, my school marks they improved but I’m not going to necessary say it’s was all from MSF but mostly because of the programme I was able to understand that education is important in such a way that I would get marks from 50 percent to 60 percent so what I’m trying to say is that they expressed everything in a fun vibrant way, they let you be yourself and there is no fear.”

- Learner 3, Bam High School (#73)

“Me I was lucky because last year I got to attend MSF youth camp, that was at Eshowe we did drama and role plays on how to prevent HIV /AIDS and TB, I am one of the people who did. It was sort of a play on how to prevent HIV and TB.”

- Learner 4, Mav High School (#78)

Multiple and consistent messaging – that are detailed and within a behaviour change framework – across different structures within the communities: households, churches, organisations, schools etc., provide for an increase in the level of acceptance of health education more broadly. As the Schools Programme required specific acceptance via consent from parents, teachers, principals, officials, and perhaps tacit consent from some institutions, churches, and community-based organisations, illustrate the effectiveness of the programme.

In interviews, learners displayed sophisticated understandings of the model, its objectives, and were confident in their interactions amongst their peers in discussing topics, and how important SRH education is to themselves and their communities.

Given the issues of condom distribution in schools (available yet not freely accessible) and the incomplete acceptance amongst parents of health education (perhaps needing more information), we have learned that focus groups with learners together with the ability to speak anonymously, provided what may prove to be important insights, as well as perhaps an opportunity for MSF to garner additional information on these issues.

Some barriers to achievement as identified in the initial phases were quickly turned around and positive relationships built across stakeholder groups. The consistent learning for working with government in this context, is to engage in the early phases and keep in lockstep with policies and frameworks as well as on-the-ground realities.

Farms Programme

Background

As part of the Mobile-1-Stop-Shops (M1SS), launched in 2011, mobile testing units provided information, counselling, HIV testing, TB screening and point of care (PoC) CD4 count for those who test HIV positive. Three to five MSF counsellors went to different places every day with a van, following a schedule. The schedule was made by the M1SS/FTS Coordinator by the beginning of each month. They went to high schools, farms, busy places in Eshowe town (shopping areas, busy streets, taxi rank etc.), and industrial areas, making it easier for people to get tested, know their HIV status, and get referred for treatment and care earlier and closer to their home or place of work.³⁷

The farm intervention aimed to provide comprehensive medical services related to HIV, TB, and SRH corresponding to the needs of the farm workers, with minor ailments also covered, to increase the attraction of the services. All drugs were provided by DoH and blood samples and sputum were examined in the lab in the Eshowe Hospital. The mobile clinic operated at least one day a month on each farm, and due to the working hours on the farms, the MSF team visits after 13:00 and operated for 2-3 hours. The M1SS was handed over from MSF to the DoH in the third quarter of 2019.³⁸

Efforts to reach higher-risk populations is exemplified in the M1SS component, as one ex-MSF staff member recalled:

³⁷ Project Document 2015

³⁸ Project Document 2019

“there was constant seeking and attention to reach the unreached. Things like the M1SS, they moved all the time and tried to be in places where people would be tested. We also found vulnerable and unreachable people in farms. Migrant farm workers are vulnerable high risk underserved population in KZN, all those interventions allowed to reach the first 90.”

-Ex-MSF Staff Member (#83)

In line with MSF’s approach of ‘catch all’ or ‘a bit of everything’, the organisation made concerted efforts to find new ways to access those outside of their current activities, and go deeper into existing projects, as we have seen under the ‘new strategies’ for CHAPs. In 2014, it was recorded (in an internal document) that the mobile testing unit (M1SS) ‘adapts to find new settings in which people can get HTC in the community’. Integral to the approach was to bring back those who were lost to follow-up and relink them to care.

“we rediscover most of them they were in ARVs before, and now have defaulted, so we had to restart them again, and initiate the new ones, they were a lot of discover that we did there and you find that some of them are there, they are not getting social grants, they were not even registered, that they are here in South Africa working, what we do we were just referring them to DoH social workers, they will see how they can assist them, but mostly for us it was HIV testing, TB screening and PHC services that we were giving to them; what we are doing basically we are taking Primary Health Care to the farms.”

-Nurse, DoH Sub-district (#30)

Engagements with Farm Owners and Workers

As has been the case throughout the evaluation, with farms, we find the trend of positive feedback and self-reflection in the work of MSF. Strategically, MSF’s engagement with the Eshowe Farmers Association in the project area was a valuable method in gaining access and building trust, as one member expressed:

“I think it had become a community rather than individual kind of the effort thing, there is good cohesion amongst the commercial farmers and our farmers association, so it’s always good for any organisation like MSF wanting to do something to work with us through our association like that”

-Farm Owner (#67)

Given the high morbidity and mortality rates on farms, as expressed by respondents, it was with enthusiasm that Farm Owners accepted the intervention. Indeed, some farms were already proactive in this area and had some of their staff or staff representatives given training to counsel and advise on getting tested and take medication. There awareness and acceptance are evident:

“We were only too glad to be able to have them coming around. We provided a facility for them to come to see people and to also have some testing sessions which is where they set up the tents and people went in they to get tested, whether they were positive or not, and once all that is done the whole thing run itself through contact with MSF people and Nurse Y.”

-Farm Owner (#67)

“At the beginning MSF came to the farm, and talked with them all, and thereafter staff would come to them privately. MSF provides a bit more discretion and privacy compared if they went to the clinic in town. Stigma is still a problem and so if they went to the clinic in town, this would not be private. At the farm site, there is more discretion. The only people that know are those around the compound at the time when they are collecting their medication – compared to being at the clinic”

-Farm Owner (#5)

Communications and Feedback

While most farm owners were positive about MSF’s work on their farms, and more generally within the communities, some expressed issues of communication and engagements such as a ‘top-down approach’; ‘not really consulted but informed’; and ‘operating in isolation’. They also relayed an attitude of ‘farmers are letting people die’. The fact that Farm Owners are there all the time and the intervention was temporary, was not acknowledged in that the farmers could possibly play a greater role, if consulted. A lack of continuous engagements then, resulted in a kind of (silent) rift between the various entities. In addition to a lack of communication, and farmers were clear they were not seeking to know farm workers’ private information, they expressed disappointment that they were not formally informed of MSFs departure and handover to DoH.

Farm workers registered, with disappointment, the change in the delivery and management of services, and relayed that they too were not informed. While they were very positive about MSF’s work overall, they were disappointed that MSF left, especially given the lower quality of service now being delivered.

Government and MSF Services

Due to the recent departure of MSF, respondents from farms visited, embarked on comparisons between MSF and the services currently being provided by the DoH. Although efforts were made to talk specifically about the evaluation period, they felt it necessary to talk a lot about their current circumstances. As the excerpts below show, they are extremely unhappy with the current level of service.

The poor level of service and the opportunity to talk with us, allowed them to make such comparisons. The main issues that arose relate to poor quality of service (DoH not getting out of their vehicles), lack of complete services (not testing or provided with results), breaching confidentiality (giving medications to others), poor communications (workers do not know the day or time when they will

visit); files misplaced or lost, among other issues. At best the DoH services, informed by farm workers, could be described as sub-optimal.

The current experience contrasts vastly with their expectations of a higher level of service, previously delivered by MSF. In short, MSF were approachable, trustworthy, and professional:

“...when they [MSF] arrived here they were bringing counsellors along, that made it easy for people to go and tested for HIV. Even when they arrive, people were not scared as they were not going to see a lot of people like in the clinics, as they were visiting us where we are working, as they were people who were supposed to be on ARVs as we were supposed to fetch our medication in the clinic but it was easy for them to bring the medication here to us everything was easy now it was good even those who were afraid they were not afraid anymore, I was one of those who were afraid to go the clinic but now when they arrive we were motivated as they were coming to us here at work.”

-Farm Worker, previously trained by Thukela Aids Project*

* The evaluation was informed that Thukela Aids Project who had an office in Eshowe in early 2000s conducted training with key farm workers to become lay counsellors. It is understood that a one-week training was conducted and reached 6 or 7 farms.

“I don’t know when last I saw mobile clinic, it’s been a long time, this is really hard because everything that were used to get here, it is no longer the case; if possible for the old team should come back, they must come back; They did everything, if you have a stomach problem they would attend to that, they also provided us with family planning.”

-Farm Worker 1 (#37)

“To be honest, the ones that were providing services together with the sister outside, they were very good. The ones that are proving service currently [DoH], their service is very poor, even when come, they do not check us, they just call us in the vehicle to come and collect treatment. All the time they tell us excuses either their testing machines are not working or do not have a battery; They do not test us anymore; The new team sit in the car, they don’t come out; They sit in the car, we give them cards, they give us treatment.”

-Farm Workers (#37)

“They only come for chronic illness, even when they do come, they would call us into the car they don’t even get off, we collect our treatment, if you are not around, they leave your treatment with someone else which is totally wrong, they are not supposed to give our treatment to any other person.”

-Farm Worker 2 (#37)

“I can say we worked well together, most of the time when they took bloods they would give us results, now things have changed, we are not receiving blood results and we would like to know what our results, they tell us that “when we are not saying anything it means everything is fine”, but we want to know what is happening after taking bloods. With MSF, when they do a blood test, they would tell us what the results are, if the results are not good they would tell you and repeat blood, right now they do not tell us about our results...”

-Farm Worker 1 (#46)

The quality and consideration of MSF are detailed here, and speak to a high level of sensitivity, that is patient-centred.

“They would first do the test , provide you with your results, you would then if there is something that requires you to go to the clinic you would then go the clinic, if there is nothing you would then take your results and move on with your life; I will speak for myself, I did counselling several times, but I did not do the test until I was ready, I even lied and said I have tested before and I know my status, because they were very patient with us eventually I was brave and got tested; They spoke to us individually, we were never forced to test, there was pre and post counselling, there was privacy.”

Farm Workers (#37)

Being cognisant of stigma, and the lack of privacy on farms, due to the close confinement of workers, MSF ensured to offer additional discretion of medication, by placing them in brown paper bags. This was recognized by farm workers as significant. Again, adding a layer of trust, unlike their government counterparts, who left medication labelled, for others to see.

“...she was very friendly, and she maintained confidentiality, no one knew what was going on in our individual health lives, even when she sees you in the presence of our employer, she behaved normal and she wouldn’t expose you to the boss, she knows her job well. After receiving my medication, I took my medication, hid it and walked out with a smile; She used a brown packet in packaging our treatment.”

Farm Worker 3 (#37)

FIXED TESTING SITES

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 Technical and Vocational Education and Training, TVET, College³⁹ close to King DiniZulu township), and one in Mbongolwane area. Each fixed site targeted slightly different demographic groups, and all the sites offered HCT, TB screening, pregnancy test, and STI screening. The sites opened from Monday to Saturday except for the college site (Monday to Friday). In 2017, MSF opened one more fixed site located in the main taxi rank, the Philandoda Clinic,

The services delivered by MSF and partners were well-received and considered thorough, especially in comparison to the services now being delivered by the DoH. Since handover, somewhat of a disconnect between MSF, DoH, Farm Owners and Farm Workers, has arisen in the time that MSF has departed and the time of the evaluation. The result of weak services on the part of DoH and poor communications on the part of MSF. As with entry into communities that are characterised by in-depth exchanges and transparency, exiting from certain programmes is left wanting. Clear communication strategies for exiting are perhaps as important as entry strategies.

which is a male-friendly health facility. Project M&E data showed that more men than women did not know their HIV status, so the site operated collaboratively with the male wellness team. In addition to the basic package of the services, MSF offered STI treatment, minor ailment, and referral to the male wellness clinic in the Eshowe Hospital. This following section will highlight both the TVET College and Philandoda Clinic.

TVET College

The TVET College intervention took place at the uMfolozi College (Eshowe Campus) in Eshowe. The intervention/clinic officially started in February 2015 as a fixed HTC site and wellness hub,⁴⁰ and was operated jointly by MSF's Clinical and Patient Community Support (PCS) units, with support from one DoH nurse. The TVET College was identified as one of the best locations for an intervention targeting young people aged 16 years and above and was open from Monday to Friday for HCT and screening. The human resources team consisted of the M1SS/FTS Coordinator and the fixed site Counsellor who were both involved in the site operation, while the Medical Activity Manager and the PCS Manager were mainly involved in designing and adjusting strategies. Additionally, events on campus were organised at least once a year to raise awareness and promote appropriate health-seeking behaviours, including the presence of the MSF clinic on campus. The TVET College intervention/clinic was handed over from MSF to the DoH in the second quarter of 2019.⁴¹

³⁹ Included in High Transmission Areas (HTA)

⁴⁰ Project Document 2015

⁴¹ Project Document 2019

The TVET College regularly organised activities on campus to help their students, but they soon realised they needed to partner with MSF who could provide health education (HIV and AIDS, teenage pregnancy, drug awareness, etc.) on campus. Initially MSF worked outside the college grounds, putting up their tents and providing services such as HTC, STIs screening, recruiting for MMC, etc.. It was then that college management saw the attendance of students visiting the MSF tents and decided to bring the services inside the college campus.

“When MSF came here they first talked to the management of the college to try and help the student with regards to HIV. Because initially they were working outside the college, putting up their tents and stuff like that, and they saw the attendance of our students going to them and then they thought, ok, let’s come inside the college. And then we also negotiated with them and said we can partner with you because this issue of the HIV and AIDS pandemic is a serious problem, not to the college only, but to the whole society around this area. So, that’s how we made partnership and we started.”

-Admin Clerk, TVET College (#65)

Once on campus, MSF was provided with a space and the campus clinic started providing many services, including ARVs, as students were going off campus to get ARVs when they were supposed to be studying, and some clinics are far away, so the college saw a need for MSF to come on campus to offer services, and provide ARVs.

One key part of the TVET College intervention was MSF’s role in providing health education, and as part of this, they visited different classes to encourage students to get tested and access services at the campus clinic. Linkage to care was an important component of the work provided on campus. When a HIV positive student was identified, they were linked to the nurse onsite and MSF ensured that they would start treatment as soon as possible and provide adherence support via follow-ups. The ability to access ARVs at the clinic on campus was observed by the evaluation team as a good strategy for adherence and retention, especially in the elimination of travel costs and time associated with clinic visits. MSF’s contribution to the TVET College was viewed in a very positive light.

“What I can say, MSF has made a good contribution it is true I don’t want to lie, it made a huge positive impact in the TVET College, especially among the staff and the students and also to the population of Eshowe and Mbongolwane”

-MSF Counsellor, TVET College (#72)

One important part of the intervention on campus was the MSF events and campaigns. The first campaign that MSF would organise was always planned for the start of the academic year, every year at the beginning of the year, to target the new students who came to attend the TVET College, so that the message that everyone must get tested was passed along. Campus events were successful as they were well attended, and students were informed of the events ahead of time. They knew that MSF would participate, they would interact directly with the students in the Main Hall to provide health education and inform them about the services that they offered to students at the campus clinic.

“In deep rural areas where the students don’t even listen to the TV...or some of them do not even have TVs and stuff like that. Some of them may have radios, but they do not listen to them. When they come here, they come in a mixed community, different backgrounds. So, these events help to slowly, gradually plant this thing of taking care of yourself, of ensuring that you are not infected, the ways of ensuring that you don’t...even if you are involved in sexual activity, try by all means to do this protected sex. All these other issues to slow down the rate of people who are getting infected by this HIV and AIDS. That is what actually planted into the minds of students; these events that we used to have.”

- TVET College, Admin Clerk (#65)

MSF would put up tents on campus, where various MSF staff, nurse, and counsellor would attend to different health issues. Students came in large numbers to the campus events. The TVET Admin Clerk, who had first-hand experience with MSF’s work at the college, indicated that the events were one of the successes of the project, and were effective in providing health prevention, HCT, linkage to care, ART initiation and retention in care, especially for those beginning their student careers. They were now getting the necessary information, were getting tested, and provided with treatment (if necessary). The MSF Counsellor shared that those students who found out that they were positive (and many did not know they were positive) were now on ARVs, highlighting once again the success of linkage to care.

Philandoda

The Philandoda Male Wellness site was set up in 2017, with the aim of reaching men reluctant to access conventional fixed or mobile health services currently offered by the DoH and/or MSF in Eshowe and Mbongolwane service areas. MSF and DoH aimed to provide community-based adaptable services to increase prevention and diagnosis of HIV, TB and STIs and other common chronic conditions. Philandoda was seen as a promising concept for reducing barriers for men to attend preventative and diagnostic services, especially for HIV prevention, testing, and ART follow-up. Understanding and addressing structural and individual factors that affect health-seeking behaviour among men are important to ensure sustainability of a service, such as Philandoda.⁴² The Philandoda Clinic was handed over from MSF to the DoH in the second quarter of 2019.⁴³

⁴² Client Satisfaction Survey -Philandoda Male Wellness Clinic in Eshowe, KwaZulu-Natal. 11 March 2019

⁴³ Project Document 2019

The idea of Philandoda was for it to be set up in an area that would easily target men, because MSF realised that men were not visiting the clinics in the surrounding areas. MSF even conducted a small survey among males in the taxi rank, and the clinic set up was based on the feedback received from the respondents.

"we did a small questionnaire amongst the male in the taxi rank, then based on the answers we set the clinic at the taxi rank so when they are waiting to get into the taxi they could come and get tested, they could get ARVs, they could be treated for STI"

- MSF Staff Member (#24)

This highlights how MSF was listening to the community (of men) to develop and implement an intervention that fits to their needs, therefore bringing the services closer to them. Also, Philandoda was staffed by male nurses and counsellors, which seemed to attract men to come and access health education and health services. This was noted by a MSF Staff Member and an official from the Provincial DoH.

"what we were doing was listening to the community themselves and according to our capacity we would implement a programme that fits well, for example for Philandoda men were saying it takes long for us to access services at the clinic, and they would want a clinic where they can receive services, also clinic that be run by a male. We have listened to that and provided that, we also know that they are at the fixed sites, and it's important where you situate a clinic"

- MSF Staff Member (#26)

"...best to use a male to consult a male...that had a good impact in reaching males, who are not keen to come to health facilities. They have a clinic at the taxi rank in Eshowe to access services - those using public transport would access services at taxi ranks, and receiving services by other males gives them more confidence to stay on treatment"

- Official, Provincial DoH (#6)

In addition to being located in a central area (a taxi rank), which was easily accessible by men, Philandoda also offered several different services, which also seemed to attract men to the clinic. For example, men were offered HCT, MMC and cancer screening, among others.

"It did well because this place (Philandoda) is for MEN only, I did well because it was placed at the taxi rank, the taxi drivers go there because it is a men's clinic. I was there in the day at Philandoda, I would talk with the guys working there, they had good communication with them it's not only MMC at Philandoda, prostate cancer, other men report about other stuff like lack of information, especially as guy, like testing and their body, MSF is having cancer screening, no other clinic is open about prostate cancer and other men issues."

-MSF Staff Member (#30)

“Philandoda is doing a good job for men in Eshowe. MMC they are very good at that, many guys came in numbers from Philandoda and were asking about MMC, what is the date for MMC around Eshowe, they called that guys they are coming for MMC, they are testing, Philandoda is good for recruitment.”

-Official, DoH Sub-district (#85)

Philandoda is an example of an effective MSF intervention, in that it was able to reach a hard-to-reach target group, men. It was also seen as successful by one MSF Staff Member due to the fact that it was successfully handed over to the DoH and to Broadreach, as is highlighted below.

“I can say that it was successful in a sense that we handed it over partly to the DOH and partly to Broadreach, and Broadreach is now stepping up as the DOH said that they like the concept so much of what we did will keep on running, so in that sense I feel that it was the success.”

-MSF Staff Member (#24)

Both fixed sites described above (TVET College and Philandoda) highlight the ways in which MSF was successful in providing not only health prevention to hard-to-reach or higher-risk populations (i.e., men and young people), but they were also able via these interventions to provide HCT, linkage to care, and in many cases as shared by respondents, ART initiation and retention in care. Ease of access and location of services were key in these two interventions. As well as a reduction in waiting times, that includes transport to a formal health facility, and waiting for the services to be rendered when there, facilitated convenient and comprehensive services.

COMMUNITY HEALTH AGENTS PROGRAMME (CHAP)

Community Health Agents (CHAs), unlike some of their CCG or CHW counterparts, were well equipped to perform their duties within the objectives of the programme. The extensive initial training and frequent refresher trainings supports via team leaders and coordinators, backpacks with all the necessary equipment, name badges, tee-shirts with identifiable organisation name and logo, all contributed to a professional outlook. Being so thoroughly equipped, in our view, provided for a confident cadre of health agents which in turn provide for a more effective delivery in meeting the programme objectives.

Creating space for agents to offer their perspectives and to build together better strategies added another positive layer, and the additional motivation to work harder and reach deeper into communities, and to work on weekends. A strong sense of ‘one-purpose’ was still audible almost two years after the project closed. Related, similar responses from the CHAs speaks to a strong sense of unity, that we view is a product of the training, reinforcement of objectives, and feedback sessions, as detailed above.

Planning, leadership, and stakeholder engagements contributed enormously towards the CHAP successes. The preliminary engagements conducted by the MSF team, noted under the communities

at the centre section, provided the necessary groundwork for door-to-door testing and counselling. Traditional leadership, the community gatekeepers, loud hailing to inform communities who MSF are and that they can be trusted, including some getting tested publicly, assisted in unveiling the notion of testing and status, as something to fear or to hide. Without their presence, sanctioning, and participation, in our estimation, the project would not have reached the UNAIDS targets, and much more.

We concur with the idea that the work of the CHAs as having a ripple effect, noted by some respondents, not only within the clinics, but in setting the scene for the other components of the wider project, such as the schools' programme.

BACKGROUND⁴⁴

The CHAP started in 2012 with 30 CHAs recruited in Eshowe and Mbongolwane covering uMlalazi Municipality Wards 1-14⁴⁵. All CHAs were recruited in collaboration with *amakhosi* (chiefs) and *izinduna* (advisors), who helped MSF identify the various *izigodi* (villages).

In 2013, the CHAs performed two main activities, namely HCT and TB screening, and referring patients to health facilities. In the rural area, households are scattered, and often CHAs need to walk long distances to visit from one household to another. Although the CHAP was driven by MSF, the CHAs were employees of Child Care South Africa⁴⁶ (before 1 April 2016, they were employees of SHINE⁴⁷)⁴⁸. The partnership with Child Care South Africa started in April 2016, and the plan was to hand it over after three years, however this did not happen. In 2018, due to the proportion of those testing positive for HIV falling dramatically together with the number of tests in general, and testing became concentrated among the very young and the very old,⁴⁹ the project decided to transition the door-to-door testing to the fixed community sites, into the now known Luyanda sites. These Luyanda sites are strategically located in proximity to "hard-to-reach" communities.

Also, in 2016, MSF's Stockholm Evaluation Unit (SEU) conducted an evaluation of the CHAP and thereafter the Eshowe HIV Project developed a 'new strategies'⁵⁰, document, reflecting the following to strengthen the intervention, as follows:

1. Collaboration with Traditional Health Practitioners and set up the referral system
2. Recruitment for testing in mobile clinic points
3. Recruitment for testing through community ART Group and community adherence club (couple testing and family testing)

⁴⁴ More extensive information on the CHAP can be found at CHAP Toolkit at <https://samumf.org/en/resources/hiv/hiv-testing-and-linkage/msf-chaps-toolkit>

⁴⁵ The maximum number of CHAs rose to 86 at the height of the CHAP operations (Q4, 2014).

⁴⁶ 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.

⁴⁷ 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.

⁴⁸ The Eshowe Project utilized two different Community-based Organisations (CBOs) - SHINE and Child Care South Africa - to provide door-to-door services.

⁴⁹ MSF. CHAP Toolkit available at <https://samumf.org/en/resources/hiv/hiv-testing-and-linkage/msf-chaps-toolkit>

⁵⁰ Internal document: New strategies for Community Health Agents Program, 16 February 2016

4. Scheduled churches visits
5. Enhanced defaulter tracing system
6. Spaced retesting for old women and children (every 6 months)
7. CHAs to work over the weekends from Tuesday to Saturday/Sunday
8. To strengthen collaboration and referral with CCGs since they also visit similar households
9. Strengthen condom distribution by the CHAs

PLANNING AND IMPLEMENTATION

The Eshowe HIV Project had to conduct numerous activities in order to achieve its objectives, beyond the main project components. Planning and strategy development in how to access these communities and possible barriers to entry, needed to be comprehensive, which they were, with the inclusion of an extensive complement of stakeholders, and community members.

Interviews, especially with MSF staff (current and ex), conveyed that the vision and focus of the project to be on implementation and coverage. The modus operandi focused on a large number of personnel covering a vast area, characterised as hard to reach, and accessible mainly on foot. For MSF, it was clear that a large number of personnel would be needed to conduct door-to-door testing. The vision,⁵¹ starting and knowing where they wanted to end, was vital to the project, and informed by strategies towards that goal. However, this was an evolutionary process, and although the vision may have been well defined, the initial operationalisation, was not, as noted under the *'Communities at the centre'* section.

Initial planning concerning the new model for testing at households envisaged the use of Community Health Workers (CHWs) or CCGs already in the employ of the Department of Health (DoH). However, DoH withdrew availability of CCGs for door-to-door testing program in July 2012.

A re-look at the situation meant the provision of a cadre of health workers, trained by MSF and partners, with sufficient HIV and TB knowledge, along with basic training to conduct HIV testing and ongoing support. Central to the planning was the recruitment of health agents from the communities themselves in consultation with traditional leadership. It was reported that being from the community added a layer of ownership and acceptability to the project in addition to direct knowledge of the targeted communities, which was viewed positively. It was reported that even if an agent lived in another area, this may prove challenging, as one CHA said:

“they wanted a person they will understand and trust in the area. I could not, being here from Eshowe, and go and work in Mbongolwane because when I arrive there, people don't know me they don't understand me.... in my community they know me as Mam Y...they know where my home is”

-CHA, Ezi (#61)

There were some instances reported where being from the community could have a negative effect, in that directly knowing a household or member could result in avoidance or refusal. In such

⁵¹ MSF KZN Project Document 2011 (revised)

circumstances, health agents from other wards stepped in. A visible closeness with CHWs/CCGs, as they tended to need each other and share information on households, developed over time, and which also portrayed a positive outlook to the communities.

MSF sub-contracted this community effort, and the hiring of the cadre of health workers, to a local Community-Based Organisations (CBOs), SHINTSHA HEALTH INITIATIVE (SHINE) and later to Child Care South Africa, as noted under the background above. The former organisation we learned, was created by MSF with a group of five people living with HIV (PLHIV) who were already active in their communities. MSF provided extensive and regular training, and planning for the roll out of door-to-door services. SHINE recruited and managed the health agents with a series of supports, including oversight, from MSF.

After challenging relationships with both CBOs, due to weak institutional structures and governance, which in turn resulted in mismanagement, led MSF to ultimately subsume SHINE under its own management, in order to complete the project. It is understood that MSF provided much support to both CBOs especially with recruitment, training, planning and such like, however the CBOs were weak at their core. That is, the ability to mobilise resources, governance and oversight, and financial management, were weak within the CBOs.⁵²

Although MSF provided support in these areas, these weaknesses affected the implementation, and therefore MSF needed to take more direct action. This was one area we have found to be a persistent challenge for MSF, yet the organisation managed to implement CHAP activities according to the project plan.

The MSF Community Health Agent Programme Toolkit, developed towards the close of the project, includes details as to how health agents' approach and interact with households, and topics to be covered, amongst other areas. Almost two years post-intervention, we found the recall of those activities by the Agents as quite thorough.

Community members too recalled with less detail, but more on what the relationships were like and how well they were treated. This level of recall is both a testament to the training and commitment of CHAP personnel, while it may also be a product of some of the CHAs currently working at the Luyanda sites.⁵³ Overall, their insights speak to a sophisticated understanding of their roles under the umbrella of HIV and TB related services that they provide.

⁵² Unfortunately, South Africa has a high number of CBOs that are in need of institutional strengthening and are founder managed. One respondent suggested that MSF perhaps could have looked for a visionary organization, not necessarily based in the project area.

⁵³ In 2018, the project decided to transition the door-to-door testing to the fixed community sites, (CHAP), into the now known Luyanda sites. These Luyanda sites are strategically located in proximity to "hard to reach" communities.

Community health agents took on several roles, with the aim of conducting tests with households. A typical role is detailed below:

“We enter in the home, each home we do health education about illnesses, HIV, TB an STI’s and chronic diseases, we enter for doing health education. We also recruit people who can voluntary do HIV testing and also if there is a suspect for TB, we take sputum for TB, and also do pregnant tests and also give them HIV test counselling pre and post, if we find a person who is HIV positive, we give a referral letter to their nearest hospital or nearest clinic. We did a lot of follow ups, we train and train all the time, after three months we did training, if there is something new they call us for refresher training.”

-CHA, Ngu (#70)

CHAs met numerous challenges in performing their work, and especially at the initial stages. Avoidance behaviours by households when seeing MSF vehicles were recalled, barking dogs as barriers to households, unruly and dangerous situations in households where husbands or males were intoxicated, patriarchy, and polygamy, amongst other challenges, were recalled.

Perhaps given the programme is now over seven years old, these issues were not dwelt upon in conversations. In all, CHAs relayed the work positively, and perhaps one of the greatest challenges was the long distances to walk between homesteads.

While initially there were changes of leadership positions, and staff turnover, in some cases high - in MSF, Government, and with partners - being able to maintain operations of the project was challenging. Such challenges were met with a practical approach of getting the work done. For example, the high turnover of CHAs meant recruiting, retraining and reintroducing CHAs to key stakeholders. Changes in leadership resulted in a lack of institutional memory and a repository for information. This meant a practical approach of assembling key documents and developments.

As relayed, the team realised their strength was in the community programme (the CHAP) and invested more in this area than the other activities, so as to maximise CHAP output. Implementation is what MSF do, as some respondents mentioned.

Credit for this work was towards all personnel, within and beyond MSF. Especially singled out, were the CHAs themselves, along with the community activists or HIV ambassadors.

In terms of planning and strategy, the leadership of MSF, and the stability from those positions: Medical Referent and Project Coordinator, were instrumental in providing much needed continuity of activities. This was observed by government officials, as this example shows:

“MSF had outstanding management or leadership team driving services and holding lower categories accountable. MSF had outstanding systems to manage their performance. Who was appointed is what we needed, both MSF and DOH were involved in interviews... leadership, management structures and administrative systems of MSF were outstanding.”

- Official, DoH Provincial (#4)

MSF senior staff in turn recognised and credited the door-to-door success to the dedication of the CHAs and Ambassadors, as they recognised the challenges they confronted as well as their commitment and stamina over a long period of time.

Revealed in interviews with MSF (ex-staff) found that the comprehensive nature of the work of CHAPs was likely more successful than they realised, in that:

“CHAPs did a bigger and better job ensuring linkage to care, more than we anticipated, and the fact that they continued, and continued to follow people up.”

- Ex-MSF Staff Member (#81)

Part of this continuous follow up and planning on the part of programme, and, after incorporating of feedback from CHAs which was informed by the evaluation, meant a flexibility on the part of the CHAs, and a reflection of their contributions as to how to reach everyone within households.

“...using different days, Sunday, when people and children are home, a lot of organisation, having people telling them when we are coming on a particular day, so they are prepared for testing or screening. Normally people won't leave their homes to get tested, if they are not sick. But if you go to them with the information, and inform them, even if they are not sick ... so this information and outreach... inform them about privacy and privacy of their own home, and link them immediately, and no one can see.”

-Ex-MSF Staff Member (#11)

DOOR-TO-DOOR TESTING – ACCESS AND BUY-IN

Door-to-door testing was reported by the vast majority of respondents, including clinical staff and government officials, as being the main contributor of project success overall, and in reaching the UNAIDS 90-90-90 targets. This was usually followed by the intermediaries who conducted this work, the community health agents, and the sanctioning by and participation of, traditional leadership.

It was both informative and encouraging to listen to government officials relay their experiences and insights into the CHAs' activities, given their distance from the particulars of the project, and their expressions on the importance of this work, and the results thereof.

They attributed door-to-door activities as being important on a number of fronts including in accessing hard-to-reach communities by bringing the services to them, in the fight against stigma through education, and recognised CHAs being from the communities who facilitated smoother access due to their knowledge of the contexts of these areas. Some of those sentiments are revealed in the following:

“The whole community-based model had a lot of impact bringing services to the people at their doorstep helped a lot, and when you are there you can understand their environment and make things work well for them, because you are exposed to their environment, rather than when you just see them at a facility.”

“The community ownership, which resulted in community education on the disease and treatment generally. The part the community component played and using local people especially, as community care givers and integrating the whole thing with OSS and structures that people were aware, and also making sure there was good coverage with all the tool kits...”

-Official 1, DoH Provincial (#6)

“They were able to infiltrate far better in the communities and were well known in the community because of the structure and the way they actually function in the community of Umlalazi. They were well-known and they contributed resources well beyond HIV and AIDS. They were covering HIV and AIDS, yes, but also healthcare as a whole and household access - key to that was being able to quantify the actual contribution of a health partner to health services within the district.”

- Official 2, DoH Provincial (#4)

Traditional leaders voiced similar positive responses on the work of CHAs, and their commitment to reaching those communities, as follows:

“Coming closer to the people it made that effective. For MSF to come to rural areas to where people are, it made that effective... it was not easy, they worked very hard, they walked long distances.”

- Traditional Leader, Ntu (#44)

“MSF showed they love their work, to work with the people going up and down even in Mbongolwane, these are places now you can't drive the vehicle, they used to walk down. Yes, MSF had people to work there.”

- Traditional Leader, Kwa (#64)

As noted under the ‘communities at the centre’ section, the work of traditional leadership, and especially the Nduna, provided the necessary groundwork towards access and acceptance within the communities. However, their work according to themselves, did not stop there. They continued to promote MSF when challenges arose and showed leadership in getting tested in front of the community.

“It so happened that at some homestead they were not easily accepted, some people are still reluctant to do testing, but they reported those cases because we had said if they come across homestead like that, who do not allow them, we had to pitch in and talk to the people and to explain to them how important it is to know their status, that it’s not just know the status, we had to pitch in and assist there.”

- Traditional Leader, Ntu (#44)

Community members, those recipients of services, were overwhelmingly positive about the work of MSF, and the CHAs. They spoke in familiar terms of those Agents, whom they had gotten to know and trust, over the project duration.

“When they arrived at home the first thing they did was to greet us, introduce themselves, who are they and we will introduce ourselves as well, and tell them our surname, and they will educate us where they come from and what they do as well and what they will be doing here, and we will give them time and listen to what they have to say. They will educate us on all things: opening windows and sanitising, we have started that a while ago, they taught us to wash our hands something like that, the cleaning of the house hygiene keep it clean all the time, they started by educating us, and then they will do the testing.”

- Community Member, Vuma (#58)

“They were patient with us, had time for us as individuals, they provided counselling, we trusted her, unlike at the clinic, there were so many things; They visited us every three months, they knew as to when last they attended to us and would come after three months; We spoke about health issues, what is bothering you emotional, and would advise, where there other issues they would encourage us to go to the clinic where necessary.”

- Community Members, Ngu (#68)

“Yes, because we were provided with information, she would also tell us as what to do if the results are positive and how the medication should be taken.”

- Community Member 1, Ngu (#68)

“Mine (husband) was fine, when I checked, he would check as well because I check all the time and still check and all is well. Even if I was positive, it wouldn’t be a problem because there is treatment.”

- Community Member 2, Ngu (#68)

“Before them, lots of people were dying from different sicknesses, they followed up on people to take their treatment.”

- Community Member 3, Ngu (#68)

“...okay Mother B arrive at home, she explained to us about MSF that they help people, who are they actually help people by checking them their status of HIV, because when you go to the clinic you are not comfortable, sometimes you are afraid to test in front of people, all those things, she told us that even here you get a chance to speak with her 1 on 1 even if she helps you she would do that with you alone in the room, even when she gives you the results you will be alone, it will depend on you what you do with the results, you share them with your family or not that’s what we like about it, the arrival of MSF we were happy about it because we are able to test at home freely.”

- Beneficiary 1, Eqiz (#62)

“she explained a lot to us that made us to relax and be comfortable as she is the person we know and we decided to test”

- Beneficiary 2, Eqiz (#62)

MSF ensured at the outset a well-trained team which was complemented by ongoing refresher training. In doing so, CHAs were provided with a high level of proficiency in meeting households and gave them the confidence to educate and conduct HIV testing. A number of supports were also in place, with CHA team leaders and coordinators providing backstop duties, as well as direction, when needed.

Knowing and understanding their individual roles and the objectives of the project were reported as important for CHAs to understand, in order to be able to situate their work and themselves within the wider project contexts. We found this to be an empowering and informing aspect provided through the support and feedback sessions within the programme, as noted here:

“The transparency and also the importance of understanding and knowing the objectives from the word go, and not just MSF, but also for people implementing on the ground. So regular feedback and meetings on how far we are towards reaching the targets. And for the people on the ground it was very important to understand what they are working towards, what are we trying to achieve. And for them to understand their contribution as an individual, what you are bringing to the table. So, for every person that you find, for every person that you test, for every person that you link to care, what does that mean in the overall goal of the organisation.”

- Ex-MSF Staff Member (#11)

After the SEU evaluation of the Community Health Agent programme, noted earlier, the involvement of CHAs in strategy discussion was detailed in their new strategies: *“Introduction of the evaluation followed by robust debates and dialogues of the evaluation with the CHAPs to get them involved and to probe into their thoughts of the programme and how to refocus the programme.”* (CHAP, New Strategies, 2016).

Again, we find the opportunities to share insights on the part of the CHAs as empowering and lending itself towards a more efficient and effective delivery of duties.

In trainings, particular focus was given to confidentiality, and it was relayed that understanding the damage that breaking confidentiality could have, and its ripple effects, as one respondent noted, *'would spill over to the whole programme, as people will talk'*. Another important aspect was the need to be transparent at all times, by not providing inaccurate information. If an Agent was unable to provide an answer to a question, they were to say so, and write it down and get back to that household with the answer. Such a strategy allowed the CHAs time to provide responses while helping to build trust within households.

Not directly mentioned in interviews, we could however ascertain from responses that a series of soft skills were developed, perhaps integrated in the training, and what we view as necessary to diplomatically negotiate with households. For community members to build trust and confidence in the programme required both strong professional skills with an ability to clearly articulate the benefits of testing and the problems of not being tested, as well as other positive health practices.

The role of the CHA involves balancing the need to get tested while clearly communicating that testing is voluntary⁵⁴. It appears that soft skills such as communication, negotiation, listening and much more, were entwined in the skill set of the CHAs.

HCT - ATTITUDES TOWARDS TESTING AND STIGMA

As previously relayed, the CHAP was integral to the success of the project overall and a necessary part in stigma reduction. We found that although stigma still exists and was reported as being already deeply rooted within the communities, many have said there is now a new openness to getting tested and to speak more openly about HIV and AIDS. The example of the HIV Ambassador speaking openly at churches, noted previously, and other examples as relayed below, are a tribute to the testing and education provided at the community level, including in schools, farms, and fixed sites.

A qualified DoH counsellor provided insights in the value of the CHAP in reducing stigma and changing attitudes:

“The CHAs were educating people, they went to their homes; they educated them about HIV, they got tested and come back with the stats. And also that program for the Traditional Healers did help a lot because you find that these traditional healers would refer their patients to go test in the community because ‘I can help you but what if it’s HIV, you need to know your status before I help you.’ I cannot say there is no stigma anymore but people understand HIV and know that they need to test.”

-Counsellor, DoH Sub-district (#40)

⁵⁴ HIV testing in the Facilities: HIV Testing is offered differently in Mbongolwane and Eshowe. In Mongolwane clinics, all patients are offered testing and the introduction of CHAPs to the facilities has increased the numbers tested. In Eshowe, testing is made on the patient demand and is “voluntary”: Quarterly Report 2016-Q4

Two ex-MSF staff gave recalled the significance of the community effort, which we view as contributing to a more positive outlook on testing, as follows:

“The most effective strategy, was getting the testing going through the community. The Community Health Agents, CHAPs, they did a range of stuff, testing but also speaking frankly about HIV, and also encouraging those who knew their status to get onto treatment, and those on treatment getting to being stable and adherent on treatment... that model of testing people in their own homes, it brings it down to that micro level...”

- Ex-MSF Staff Member (#13)

“Working in the community, the community component was big. To reach the first 90 is the most crucial if you don’t reach it, then second and third 90, the number will decrease... then we really enhanced the community activity especially testing in community that was one of the factors for success.”

- Ex-MSF Staff Member (#7)

“Absolutely, community’s reception of testing services improved a lot. Part of that is directly related to choice of community care givers that MSF, the calibre that MSF capacitated and assigned for certain areas of Umlalazi. For example, they ensured people had reputable character within the community they serve and they would be received well, had local leadership who has influence in the community they held them at high esteem, the leadership within these community lead some of the drive towards prevention, HIV testing, MMC. MSF had relationship or bond with these communities, they accept HIV not as a death sentence, but something you can manage even if you are positive- that encouraged testing, and the testing level in that district was above target.”

- Official 2, DoH Provincial (#4)

A traditional leader recalls changes within her community:

“I have seen the changes, before people did not like the testing, a person would say I will test only when they see that I am not ok. There was a time when the president had set a day that was set for testing all over, there is a hall on the other side here, I called imbizo, a big meeting, I had to inform people that today I think you have heard over the news that today is the testing date. I do request that after this short meeting that we are having all go out for testing, testing was done at the clinic, some of MSF people were here, I had to lead them I had to be the first one to go and test after MSF had explained, the numbers that they got that day were so high. Attitude is overall and not necessary on specific days.”

- Traditional Leader, Ntu (#44)

“There is no discrimination cause even if you have HIV or you don’t have it, they don’t discriminate anymore. Even if you want to check you know someone will come to check me at home and if she is not there you call her tell her, you have this problem like these, these people are people you can get advice from something like that.”

- CHAP Beneficiary 1, Eziq (#60)

“I was saying as there are people that are afraid to go to the clinic to fetch their medication as in the clinic they know that in that door it’s for those who are collecting their ARVs that as well have that discrimination, as you will be seen by people as they know you, if they can try to deliver our medication at home something like that.”

- CHAP Beneficiary 2, Eziq (#60)

In advancing HTC services and being aware of stigma, MSF overcame this by promoting the idea that they were not targeting specific households, as this excerpt highlights:

“...the message we are putting is that we are randomly going to households and are not going on the suspicion of someone being ill or has symptoms, so not to identify people as being sick amongst the community or village.”

- CHAP Coordinator (#11)

Planning and strategy development in how to access these communities and possible barriers to entry, needed to be comprehensive, which they were, with the inclusion of an extensive complement of stakeholders, and community members. These preliminary engagements conducted by the MSF team, noted under the communities at the centre section, provided the necessary groundwork for door-to-door testing and counselling, and was central to project success.

Furthermore, the professional outlook of the CHAs – equipped with both knowledge and tools – also contributed enormously in successfully reaching and accessing households. Trust was an essential part of the equation and the Agents were trained in this area, and in balancing the need to be tested with individual choice on the part of the community. CHAs being from the communities facilitated smoother access due to their knowledge of the various contexts of these environments.

While attitudes are changing towards testing and health education more broadly, stigma remains a challenge. MSF recognises that a soft approach combined with clear messaging delivered by community members and especially the community health agents but also traditional healers, PLHIV Ambassadors, and many others, in a variety of settings, assists greatly in overcoming this problem.

COMMUNITY MOBILISATION

Community mobilisation played an important part of the Eshowe HIV Project in informing and sensitising communities on specific campaigns and events. The method reinforced health messages and gave MSF wide visibility. MSF organised and supported community events organised by various stakeholders upon request, such as wellness events, events targeting young people, such as soccer tournaments, calendar events in the MSF supported clinics, etc. The Community Mobilisation Coordinator was the focal person compiling requests and organising other teams (M1SS, fixed sites, CHAP, and clinical unit) to participate in events.⁵⁵ Several respondents felt that one effective intervention among these was MMC mobilization among boys, which is highlighted below.

MMC MOBILISATION

Medical Male Circumcision (MMC) reduces the risk of female-to-male sexual transmission of HIV by approximately 60%.⁵⁶ Since 2007, WHO and UNAIDS have recommended voluntary MMC as an additional important strategy for HIV prevention, particularly in settings with high HIV prevalence and low levels of male circumcision, where the public health benefits will be maximised. MSF supported the DoH with recruitment of male learners who test HIV negative for MMC, as a lifelong partial prevention strategy, while the HIV positive learners were also supported with medical screening prior to circumcision. MMC was run by MSF's school management team, who were very supportive of this initiative and provided help in organising MMC camps in schools in Eshowe and Mbongolwane. Mobilisation and recruitment for MMC camps were conducted in 25 schools in Eshowe and 23 schools in Mbongolwane.⁵⁷

“MSF has MMC champs who were very trained about MMC, tell boys why you need MMC. They would explain to the boys during the school day, we use to go to schools and request permission from principals to give information on MMC, and the principals gave a date to come and sit with boys, and once we got permission from the principal we started to get there and with boys we got consent forms Those boys are younger than 18 years, so parents must give permission for MMC.”

-Official, DoH Sub-district (#85)

The collaboration between MSF and the DoE (including the schools) was seen positively, especially the ability to recruit boys from the various schools. The MMC component of MSF's work was described as an effective contribution to HIV prevention.

⁵⁵ Patient and Community Support Briefing Paper. June 2016

⁵⁶ MSF HIV Testing and Counselling in High Schools: Eshowe and Mbongolwane, uMlalazi, uThungulu District, KwaZulu-Natal. September 2015

⁵⁷ MSF HIV Testing and Counselling in High Schools Eshowe and Mbongolwane, uMlalazi, uThungulu District, KwaZulu-Natal 2015

“...schools we had a good collaboration with the DoE, we did testing in the school and it was really accepted by head masters, teachers and learners, and before testing we had education sessions, that was good because sexual debut in SA starts early, good to start sexual education at early stage, we had a component of MMC also related to collaboration with DoE. MMC was not done in schools, but recruitment for MMC was done in school with support of the Head Master, and this worked well for prevention, we saw effectiveness of school component, a very good investment for prevention component.”

-MSF Staff Member (#7)

MSF supported MMC camps, which were organised by DoH for mobilisation and transport of clients (young boys). In the MMC camps, only boys who were 12 years old or above with guardians' consent and birth certificates were circumcised. MMC camps took place usually every two weeks, and the DoH alternated between Eshowe and Mbongolwane for a camp venue. At the beginning of the week of a camp, MSF would visit schools to get permission from school principals to do a presentation about MMC to male students, this took place in the middle of the week. On the day of a camp, boys were picked up in the schools or close to where they lived, by the DoH car and/or MSF cars. The drivers would check if boys had consent and their birth certificates. The circumcisions took place at the Eshowe Hospital by a doctor, the boys were given food, and after circumcision, once the boys had recovered and were ready, they were driven home (only those with complications stayed overnight).⁵⁸ The circumcised boys were followed up by a nurse two weeks after the procedure to make sure the wound was healing well. The MMC intervention was handed over from MSF to the DoH in the fourth quarter of 2018.⁵⁹

The process as described above is clearly shared by one of the MMC beneficiaries.

“...on Friday they told us they will come tomorrow at 8 am in the morning then then I waited for them in bus stop, then I saw the car they came and pick me up so when you get in the hospital they told us to get our birth certificates and go to the receptionists to get registered they we joined the line so that I can get circumcised”

- Boy 1, MMC Beneficiary (#77)

⁵⁸ Patient and Community Support Briefing Paper. June 2016

⁵⁹ Project Document 2019

The collaboration between MSF and DoH to conduct MMC was seen very positively by respondents, especially the assistance provided by MSF. The biggest difference felt by the DoH were the resources and logistics provided by MSF to support MMC, which contributed to its effectiveness.

“...on Friday they told us they will come tomorrow at 8 am in the morning then then I waited for them in bus stop, then I saw the car they came and pick me up so when you get in the hospital they told us to get our birth certificates and go to the receptionists to get registered they we joined“Started MMC with MSF in 2013 then we worked with them - it was good to work with MSF their resources are very good, like transportation of clients and HR and things that we are lacking in the DoH, MSF have good cars, we are in deep rural areas- the Land Cruiser helped to collect the clients and take them back home safely after MMC - we take clients back to their homes directly, not a at stop point.”

-Official, DoH Sub-district (#85)

“The big difference before, MSF resources, MSF got lots of resource to make our work easier because of transportation, HR and lay counsellors and MMC champions, lady in office she supported us lots...we planned 50 clients for the day, boys came in numbers - we have problem with food, they didn't have food, MSF provided meals and transport and made it easier - if you need something from government, management will say you need approval and signatures, you just call MSF and the problem is solved””

-Official, DoH Sub-district (#85)

The MMC mobilisation was successful in not only educating the boys about the benefits of MMC (prevention), but also recruiting boys to undergo the procedure. The boys who took part in the MMC speak highly of MSF, from the way they were educated about the benefits of MMC, informed about the procedure, up until the way they were treated on the day of the procedure. Many felt that their decision to do MMC was a positive one, and all the boys clearly shared that they even encourage others boys (their peers) to do MMC.

“We do encourage them because we know it's going to help them after because as we are teenager's maybe we do something that might affect us and then so it's better to get circumcised for your future.”

- Boy 2, MMC Beneficiary (#77)

All the boys who took part in focus groups unanimously felt that MMC was a good thing, and that MSF was attentive and caring towards them.

“MMC it was voluntary and it was a good idea, what MSF told motivated us to do MMC...they told us that when you get circumcised you will get 60% protection from getting the AIDS”

- Boy 3, MMC Beneficiary (#77)

“the positive aspect is that they (MSF) were very caring and what they did, picking us up and providing accommodation for us to sleep, because we had to sleep at the hospital, because they had to check up on the morning that everything is functioning very well, and they gave us food medication to calm down the pain, and also they took us back home so it was really nice.”

- Boy 4, MMC Beneficiary (#77)

MSF’s activities undertaken for community mobilisation played an important role in the effectiveness of the project. None more than their MMC mobilisation activities, which were well planned with the DoE and schools, as well as with the parents and young boys themselves. The health education sessions prior to the procedure were key to recruiting boys and ensuring the process was successful.

The additional aspect such as providing logistics, picking up and dropping the boys and providing food, were seen as central contributing factors to the success and effectiveness of the MMC mobilisation.

Relayed earlier, the MMC component highlights the community engagement across constituent groups: parents, young males, teachers, leaders and officials. This remarkable collaborative effort is a testament to consistent and clear health messaging, coordination, and patient-centredness.

FACILITY INTERVENTION

“the positive aspect is that they (MSF) were very caring and what they did, picking us up and providing accommodation for us to sleep, because we had to sleep at the hospital, because they had to check up on the morning that everything is functioning very well, and they gave us food medication to calm down the pain, and also they took us back home so it was really nice.”

- Clinic Nurse

The facility component of the Eshowe HIV Project played a crucial role in addressing two important components of the project, especially linkage to care and ART initiation, as well as retention in care and adherence. The Project supported 10 DoH clinics in Eshowe (Eshowe Hospital, including Sinethemba Clinic, Eshowe Gateway Clinic, King Dinizulu Clinic, and Siphile Clinic) and in Mbongolwane (Mbongolwane Hospital, including Siyalulama Clinic, Samungu Clinic, Ngudwini Clinic, Mathungela Clinic, Osungulweni Clinic and Ntumeni Clinic). At least one MSF Counsellor was placed in each clinic (some counsellors worked in 2 small clinics). One intervention implemented by MSF in the health facilities were the community models of care, more specifically the youth/adult adherence clubs and Community ART Groups (CAGs).⁶⁰

⁶⁰ PCS Briefing Paper. June 2016

RELATIONSHIPS AND ENGAGEMENTS

Earlier we provided details on the relationships between MSF and the department, facility officials, and personnel. In interviews, we heard very positive feedback on the work of MSF at health facilities, their professionalism and efficient work practices, among other areas. One example from a clinic nurse exemplifies here once again that relationship:

“Yeah to work with MSF it is amazing, it was really amazing because when I came here there was a shortage of staff. Let me start by that, there was a shortage of staff and we were able to utilize the nurses from MSF in our facility, since we are a 24-hour services facility they helped us a lot you know, with some of the problems for the national, from the department of health, so we worked together same as we are working together now, by that time they had to go to the community out there to do tracings to call the patients back to care. They were very helpful on that.”

- Nurse, DoH Sub-district (#38)

While at district level strong relationships were found, the relationship with the Provincial DoH was noted as ‘a bit of a struggle’. We learned that MSF made some initial missteps with regards to engagements with the Provincial DoH, and these seemed to not have fully reconciled. Naturally, some interplay of personalities usually forms part of such relationships, and this may in some way count for some of the challenges between the parties. More specifically, and as noted previously under the Schools’ Programme, it again does not appear that MSF conducted a situational analysis or similar exercise, to understand the dynamics of the healthcare structure in the province. Presenting more efficient protocols and technical personnel does not translate into access and strong relationships, which are at the core of partnerships and joint approaches, and which in turn lead to mutual respect, and are the foundations to good working relationships.

Repercussions of poor relationships can lead to subtle and sometimes more obvious and serious challenges. One example of the latter was relayed in terms of the utilisation of HIV drugs held at MSF but were not given authorisation by the Province to transfer to a facility where they were needed. The reasons behind this may very well be reasonable, however, the lack of an open relationship gives rise to a lack of trust and understanding of issues, from both sides.

From the clinic position we heard that decisions are made at the higher level, and so that protocols must be followed. Therefore, for a clinic to make any changes, this must come from the DoH, and importantly that they *‘stay together with the DoH mandate, it’s not from them to us, it’s from seniors [at DoH]’*. This emphasis the need for good working relationships and underscores the idea that those in clinics or other such health facilities are employed by the DoH, and therefore must follow their rules and regulations. This point is made to highlight how DoH personnel are guided.

During the evaluation period (2013-2018) we were informed that some clinics were provided with support of up to 6 or 7 personnel that included data captures, counsellors, and nurses. With this sort of support already lacking we can understand the enormity of the challenge to reach the first 90 at the clinic level as was relayed by one staff clinic staff member:

“The first 90 is very difficult to get it at the clinic, with them [MSF] going to the homes, visiting everybody at their homes. That’s when we succeeded because it’s not very easy, you find that the clinic is very busy, you can’t test everybody who is coming to the clinic.”

- Nurse, DoH Sub-district (#53)

Meetings between all partners were reported as very important and regular. As per other instances, MSF were commended on their ability to provide regular feedback with evidence of progress and related challenges. For the clinic, the relationship provided access to more up to date information, which assisted them with a better flow of processes, and to be well-informed on new developments.

“we usually meet on a monthly basis and if it not on a 3-months for a quarter statistics, and their record [MSF] because they usually compile that, and they come back to show us and if there is a problem they show us how it can be ironed out...They supported us very well because in fact they usually get the information first then they bring it to us and when the government send theirs, it was very easy to start whatever we were have to start before and by that time they were still a lot of MSF staff assigned here... like the clubs we started before other areas...”

-Nurse, DoH Sub-district (#53)

LINKAGE TO CARE

There are several examples that highlight this component within the cascade that we believe have been effective including the CHAP, M1SS – TVET and Farms, and fixed sites. Indeed, the 2018 survey data shows, and as is explained further below, that a significant increase in linkage occurred over the lifetime of the Project. 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. At the TVET for instance, being able to get tested and link quickly, due to the availability of services on campus, and which also meant the reduction of logistical and financial obstacles, provided a relatively easy transition otherwise unavailable. Positives cases identified at households were underscored by counselling, support, and follow up that provided community members who may be reluctant to link, with previously unavailable confidants. Confidants, in the form of Community Health Agents, but also in the HIV Ambassadors and Nurses were themselves provided with the necessary training that enabled the provision of a patient-centred support perspective. Under *Effectiveness*, we have explained the importance of this support and follow up with one patient noting their reluctance of going to the clinic, and how MSF were supportive, encouraging and understanding of their situation. This one example, we believe, is an indication of the importance of ‘caring’ and was observed as being visible across each of the interventions under the Project.

It was also found that due to MSF’s data and patient management system, tracing patients who qualified for treatment under UTT and being able to get them onto treatment, provides for another example of effective practices of linking to care. This activity was also reported as being very successful and required, besides good patient information, a team with both technical and soft skills to

communicate with patients the need to get onto treatment. The examples below provide analysis of quantitative data surrounding this component.

The analysis of data from TIER.net is focused on linkage to care, being one of the focus areas of the evaluation. As outlined earlier, we operationalise linkage to care as the number of days between first visit date to a facility, and the date on which the patient started ART.

The median number of days to link to care overall is 14 days for the evaluation period. Average linkage time to care started at 34 days in 2013, already not far off the standard for linkage used in this report – ART start within 30 days of HIV diagnosis. Linkage came under the 30-day threshold in 2014, and improved markedly over the evaluation period, as Figure 1 shows.

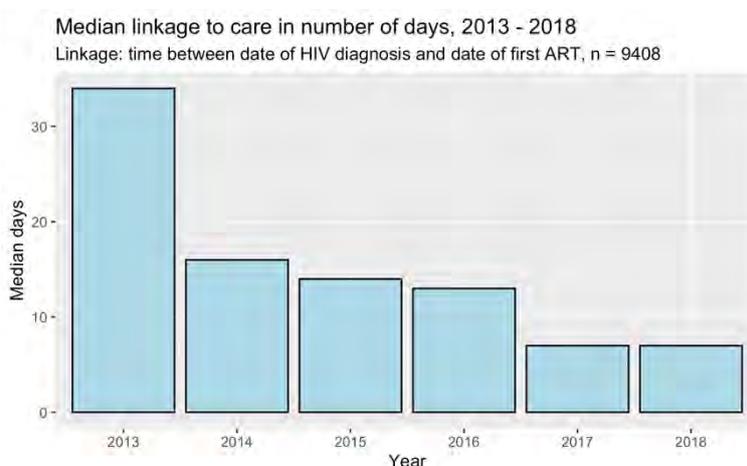


Figure 1. Median linkage to care in number of days, 2013-2018

From previous evaluations we know that gender is an important determinant of linkage to care, and men have been more difficult to reach with interventions than women. This has been a finding in the literature in Southern Africa, as well as in this project.^{61, 62} Hence, MSF introduced the Philandoda male wellness clinic at the Eshowe taxi rank in 2017. Outreach to the farms to reach farm workers, many of whom are men, had already been introduced in 2015. If we look at the trends of linkage to care by gender, we see that, except for 2013, initially linkage of men to care indeed is longer as expressed by a larger median linkage time (Figure 2). However, the last two years of the evaluation period show a roughly equal linkage time for women and men although in the last year men have (again) a slightly longer median linkage time. Because the eligibility criteria for ART based on CD4 count changed over the evaluation period, linkage time could be confounded by the introduction of Universal Test and Treat (UTT) in 2016. Therefore, a separate graph (Figure 2b) shows linkage time by gender for a group that remained eligible throughout the evaluation period: those with a pre-ART CD4 count of <350. Although in this subgroup the gender differences, and declining trend, are less steep than in the whole

⁶¹ 1. Maman D, Ben-Farhat J, Chilima B, Masiku C, Salumu L, Ford N, et al. Factors associated with HIV status awareness and Linkage to Care following home based testing in rural Malawi. *Trop Med Int Heal* [Internet]. 2016 Nov 1 [cited 2020 Mar 13];21(11):1442–51. Available from: <http://doi.wiley.com/10.1111/tmi.12772>

⁶² Lalonde C, van der Meer JBW. Optimizing HIV, TB & NCD Treatment in Five Sub-Saharan Africa Countries. Evaluation of DGD-Funded Projects: Guinea, Kenya, Mozambique, South Africa and Zimbabwe (2014-2016). MSF Stockholm Evaluation Unit, Stockholm, 2017

group, the conclusion remains that linkage to care decreases, and differences by gender have virtually disappeared by the end of the evaluation period – with men showing a slightly shorter median time to linkage than women. The aforementioned MSF interventions have likely contributed to the decreasing linkage time for men, notwithstanding the fact that the farm intervention was already ongoing for some time. Because we cannot determine how many men have accessed which type of service, and how this affected linkage time, the relationship between the intervention and the overall linkage trends cannot be ascertained. At the same time, it is reasonable to assume that it takes some time for an intervention to get established and show effects on linkage in the population overall.

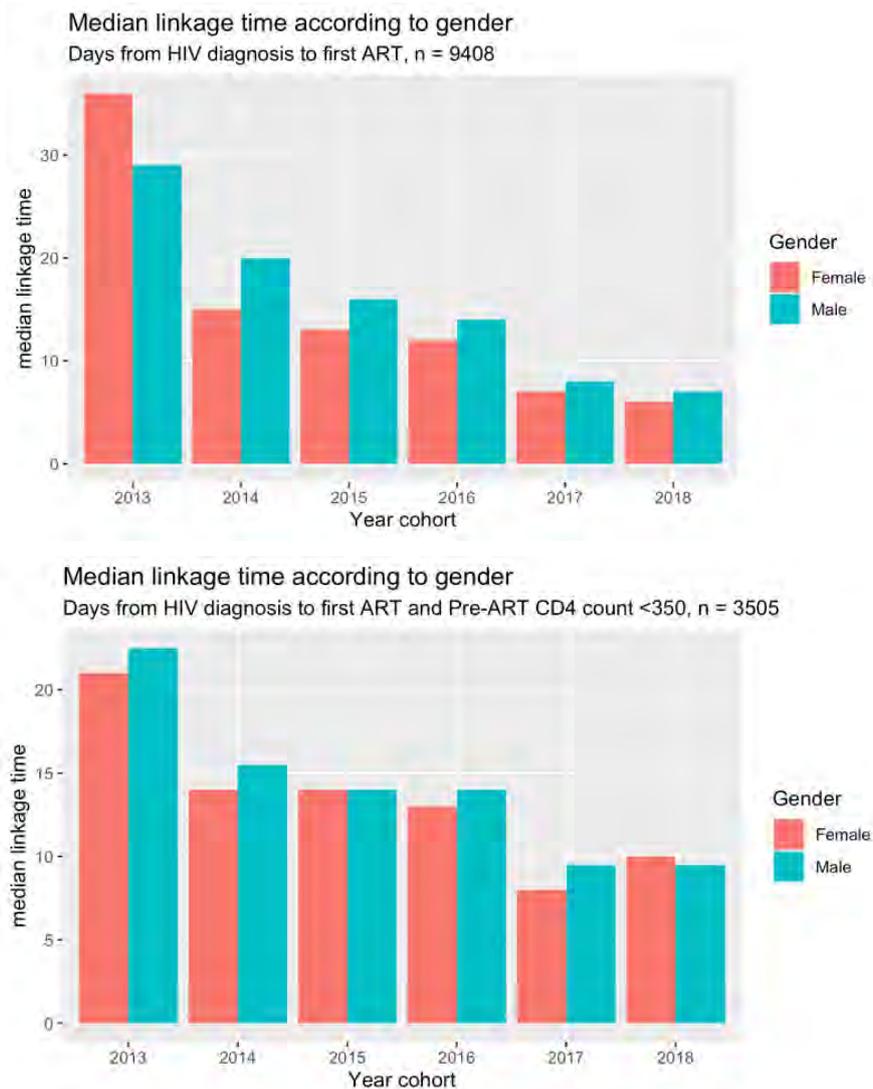


Figure 2a and b. Median linkage time according to gender

Data show that the relationship with age and linkage shows a clear pattern (Figure 3), although the development over time in each age group is less clear. There is a general declining trend in each age group but in 2016 linkage times increase in some each age groups, or stay the same, compared to the previous year. This might be due to the introduction in that year of Universal Test and Treat in South Africa, where all people living with HIV became eligible for ART independent of their CD4 count or clinical stage. This may have temporarily overwhelmed the health care system, resulting in longer linkage times. Also, phasing out of lay counsellors in 2015 may have played a role in the stagnation of

the trend in 2016. Lay counsellors are important in linkage to care, as lay counsellors do most of the HIV testing and counselling, as well as telephone tracing of loss to follow-up. The fact that the declining trend continues after 2016, may mean that the enhanced intervention package in Eshowe/Mbongolwane has mitigated the effect of the lay counsellor phase-out. Comparing trends over time between Eshowe/Mbongolwane and an area that only received the DOH standard of care is a way to further confirm this hypothesis.

Two age groups stand out: the oldest age group of people of 55 years and older has the longest median time to linkage of 62.5 days at the beginning in 2013 and improving over time. In 2018, this group still has the longest median linkage time (10 days) of that year. Also, children (0-14 years old) initially have relatively long median linkage times (38 days in 2013) but by the end of the evaluation period this situation has markedly improved, and with a median linkage time of 4 days in 2018, the linkage time in children is slightly shorter than the median of the other age groups.

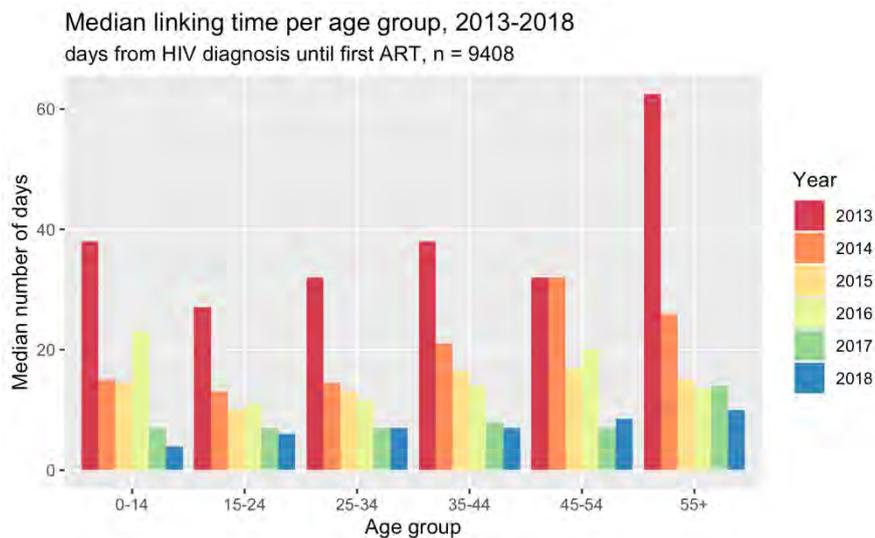


Figure 3. Median linking time per age group, 2013-2018

We have also looked at linkage time per facility. There is not a lot of difference in median time to linkage among facilities, except for the Eshowe Mobile clinics 1-3, which have markedly longer linkage times compared to the other facilities (Figure 4). This could be due to the purpose of these mobile clinics, which are meant to target hard-to-reach populations, where linkage can be expected to be more difficult than at the other, fixed, sites. Also, mobile clinics only visit certain locations once a month, so this means people who are not started on ART on the day of diagnosis may have to wait for a month or longer.

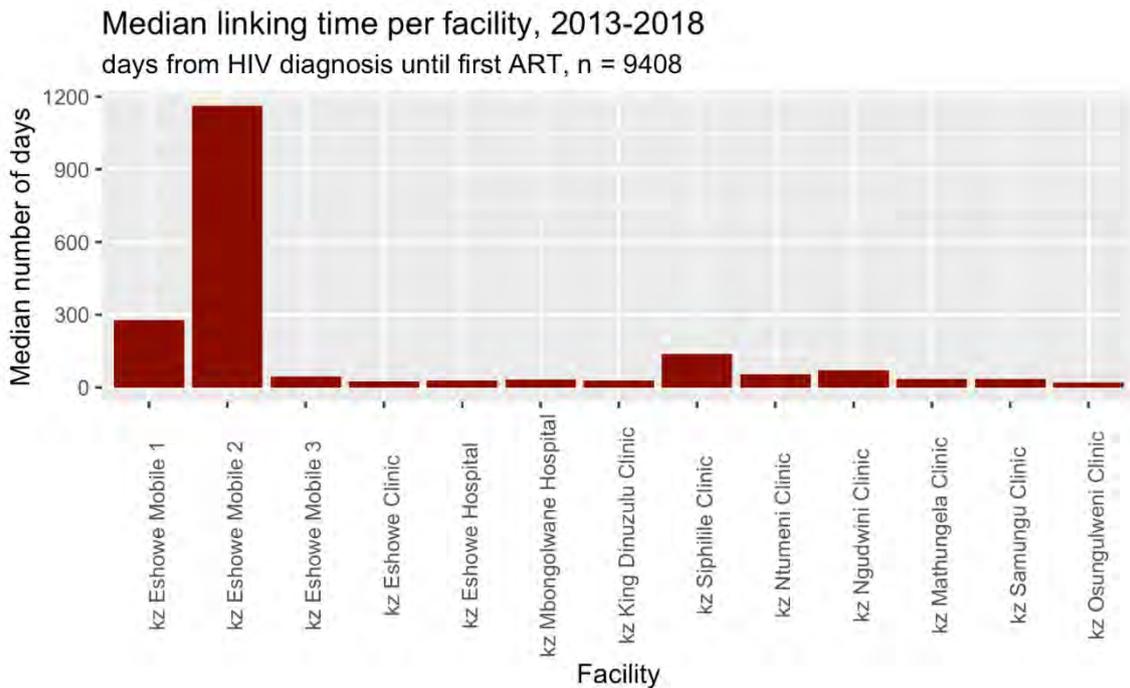


Figure 4. Median linking time per facility, 2013-2018

If we break the information in Figure 4 down in year cohorts over the evaluation period, we can see that median linkage time improves in each facility (Figure 5 - Mobile clinics have been left out to more clearly display the smaller differences in the fixed clinics)..A closer inspection of the data reveals that the high absolute values in median linkage time (between 200 and 400 days) in the first years of the mobile clinics, is due to small numbers of records in the database for that year, some of which show disproportionately high linkage times. We could not determine whether this is due to an artefact, e.g. mistakes in data entry, or that data represent real long linkage times for reasons explained in the previous paragraph.

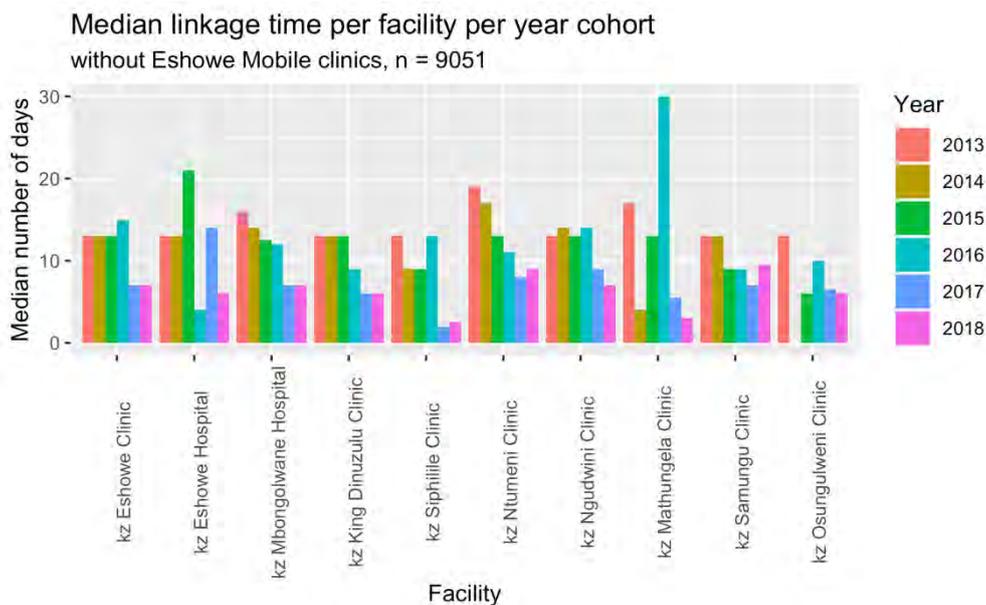


Figure 5. Median linkage time per facility per year cohort

Finally, we looked at clinical stage (according to WHO) as a determinant of linkage time. There is information about clinical stage in TIER.net, as well as on pre-ART CD4 counts. We choose to show CD4 counts here, as the data for this variable are more complete than the data about clinical stage. Figure 6 shows there is an association between median linkage time and CD4 count before ART. The higher the pre-ART CD4 count, the longer the linkage time, especially for CD4 > 500 cells/mm³. This likely reflects the treatment protocol at the beginning of the evaluation period, where people with such a high CD4 count were not eligible for treatment and thus only became eligible after a long time, when their CD4 came into the treatment range for the ART protocol at that time. To take away that effect, Figure 7 shows the linkage time over the evaluation period for the subgroup with a pre-ART CD4 count of <350 cells/mm³. Improvement in linkage time is most clear in the group with a CD4 count of 200-350 cells/mm³. The last two years of the evaluation period we observe a marked reduction in linkage to care for those who have a pre-ART CD4 count of > 500 cells/mm³, reflecting the introduction of UTT (data not shown).

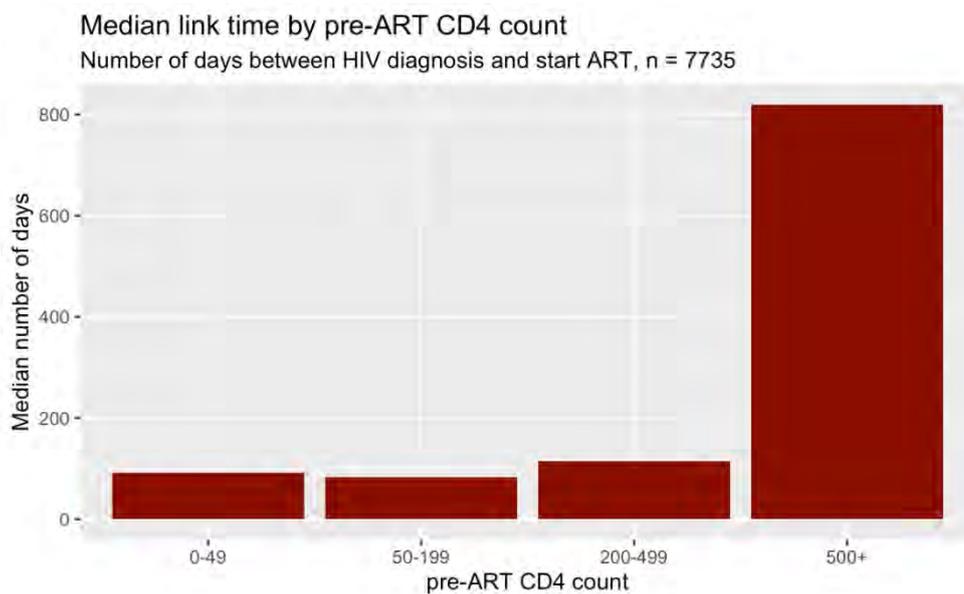


Figure 6. Median link time by pre-ART CD4 count

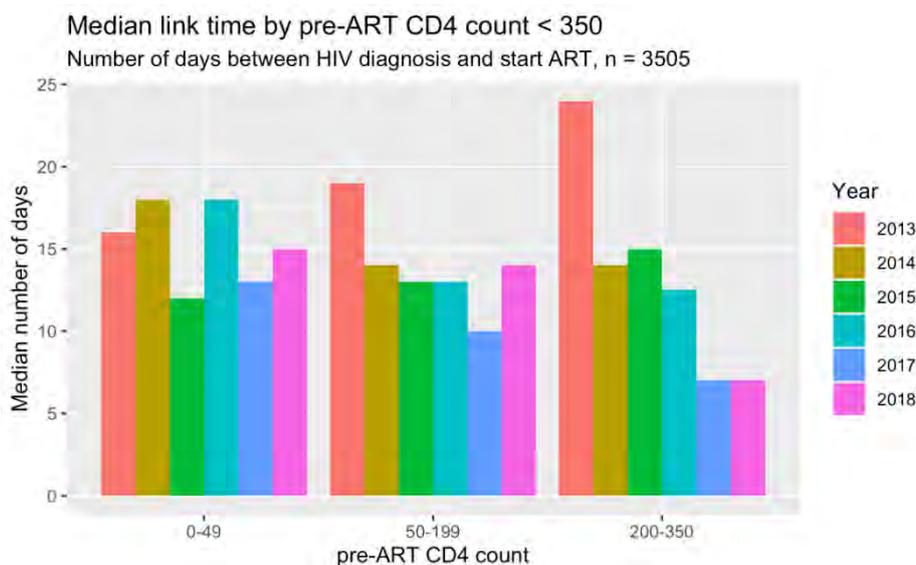


Figure 7. Median link time by pre-ART CD4 <350

Given the general nature of the data, and the relative absence of data that indicate if a particular patient has been subject to a particular intervention, these analyses can only give high level and general information. However, it 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. It also shows in a general sense that particular interventions, like the male wellness clinic or special efforts to link children to care, may have paid off. By the end of the evaluation period, men and women show largely equal linkage times, and children show shorter median linkage times compared to other age groups, whereas initially their linkage time was relatively long. The data do not prove a causal link between MSF interventions and linkage time, but show a marked improvement over the evaluation period, to which MSF interventions may have contributed. Without a control group, i.e. a comparison of a district without any special intervention, it is difficult to quantify MSF's contribution with certainty.

COMMUNITY MODELS OF CARE

The Community Models of Care programme started in 2012 with the King Dinizulu, Eshowe Gateway, Ntumeni and Siyalulama Clinics being the first where the programme was started. Patients were recruited into ART Adherence Clubs through education sessions that were done by counsellors within the clinics. Experienced patients were involved in the recruitment and facilitation of the ART Adherence Clubs with the help of the DoH and MSF Counsellor Mentors. The models that were initially implemented were: ART Adherence Clubs in King Dinizulu Clinic and Eshowe Gateway Clinic; and Community ART Groups (CAGs) in the rural areas of Mbongolwane. In 2013 and 2014 Club Summit gatherings were held in King Dinizulu and Siyalulama Clinic. The aim of the Club Summit was to conduct a means of a scaling up strategy in order to introduce these easy ART access models to the rest of the community members, as well as to encourage those patients who were already in ART Adherence Clubs and CAGs to continue taking responsibility of their treatment.⁶³

The CAGs are smaller 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. ART Adherence Clubs aim to enhance access to ART for patients who do not need close individual clinical monitoring. They are organised at facility level and create a fast-track for refilling with the possibility of two (possibly longer) monthly refilling. They also reinforce interaction between people living with HIV, build trust among patients, and enhance patient empowerment and education.

“The clubs played a pivotal role, it helps the clinic to have someone responsible for those people, it helped the clinic with decongestion when they were put in clubs because they would come on certain days, that alone also helped with removing stigma as people would associate with people in their club, emotionally it helped our community to see that I am not alone with the diseases, and it's like all other diseases”

-Nurse, DoH District (#52)

⁶³ Youth Adherence Clubs Concept Note 2016

“We are all peers, we help each other, there was no one that seemed to be better than the other. Not having a facilitator worked better for us, because we felt that were all equal. We saw no need for the adult person to sit in our group, we encourage each other to take our medication”

-Youth Adherence Group, Siy (#36)

Community models of care were developed and implemented through ART Adherence Clubs and CAGs, based on two existing MSF models: adherence clubs from Khayelitsha; and CAGs from Mozambique. Both are well established in their original settings and can coexist and be complementary. With the adoption of the National Adherence Guidelines, ART Adherence Clubs and CAGs have been absorbed into a programme of CHOICE for the patients and by December 2016 the community models/choices available included facility and ART Adherence Clubs, CAG’s, Fast Lane Pickup, Community pick up, and ‘normal’ clinical care at the facility.⁶⁴

The variety of models of care were well received within the project, across the various personnel at clinics, as well as for beneficiaries. Both clinic personnel and beneficiaries recognise the direct benefits which include reduced waiting times and ease of access, better quality of care, and more likely ensuring adherence for members, as those opening quotes suggest. As one ex-MSF Staff Member noted:

“In theory with SA guidelines, each health facility should have different models of care, each individual can choose the model that fits. It was not the case. For the Eshowe project we tried to make all the models of care available and we pushed health centres’ staff to give the opportunity to clients to choose the model of care, in health - we wanted clients to choose the model of care - then we had more people more enrolled in differentiated service delivery we wanted client to choose.”

-Ex-MSF Staff Member (#7)

Respondents provided details on topics, format of groups, and meeting arrangements. Overall, there appeared to be a high-level of satisfaction with all of the arrangements. Members could choose a topic and for youth and young groups, they were more interactive sessions. Topics and curriculum were delivered in a coordinated manner, while in some instances they could be decided by the group themselves. Topics in youth clubs or for younger groups, where they may not know their status and so education was steered to consider different levels of education and disclosure. MSF provided or funded transportation on specific occasions for day trips to sites and activities in Durban.

[Beneficiaries and Providers Perspectives on Adherence Clubs](#)

Detailed insights into activities and the value of the clubs are provided here by a qualified counsellor.

⁶⁴ MSF document. Community Models of Care, 2017.

“Adherence Clubs only recruit people who have been on treatment for more than a year, and who have the same regimen and who have suppressed. When they are in the Adherence Club we only spend an hour. The reason why we spend an hour is because we are doing the education; we weigh them and give the medication, so it takes an hour. So, the reason for the Adherence Club is not just to give the medication but also to give the information. Also, to remind them why they need to take their medication correctly and we also give them education on the treatment. What does the treatment do? How do you accept that you are living with HIV? And also, the importance of motivating other family members about knowing their status and coming to the clinic to test for HIV.”

- Counsellor, DoH Sub-district (#40)

The type of activity also depended on the group make up, as this clinic Nurse noted:

“We provide them with health education, medication, we talk to them, especially female group, looking at their age we try to find out if they are involving themselves in relationship, then if they are old enough we talk to them one by one if they also need family planning, if they need we provide them according their age, we provide medication as well, bloods in connection with their conditions.”

“Yes there is a schedule that shows what we are going to talk about according to the year calendar or year plan, there is a year plan which have family planning week and whatever and we work according to that plan”

- Nurse, DoH Sub-district, Ntu (#42)

Interviews from youth experiences, in groups and individually revealed the cohesion between members, as well as encouragement for self-development, which includes taking medication and focusing on oneself.

“During our meetings, sometimes we sang songs (those who can), do poems (those who can); They taught us how to prevent HIV from spreading, encouraged to keep time in taking our medication, we were taught the importance of taking and adhering to our medication and how it is going to help us. We were also taught how to behave since we know of their status. They also encouraged us to focus on ourselves and not to worry about the negativity from other people. We are receiving services here and still are receiving the service from hospital facilities. We also reminded of the group rules which included confidentiality. We all equally played different roles for example writing appointment dates on their cards, recording weight for each other. Supported each other.”

- Member, Youth Adherence Group (#36)

“They taught us how to take our medication, they encourage us to eat healthy, start our small garden; When we come here, they give us information first before they give us medication, you could only get away when you are in a hurry. They took bloods.”

- Member, Youth Adherence Group (#55A)

“Not to look down on ourselves because of our status. They were taught that they are not different from others, its only that they are HIV positive and that people cannot identify people from the street whether they are negative or positive, they all the same”.

“We also spoke about stigma. It was good to be in the group because we were all equal no one was better than the other and there was no discrimination because they were all the same.”

- Youth Adherence Group, Siy (#36)

A member also gave their perspective on the value of the club in terms of treatment adherence and the necessity in their view, of being together regularly, and not being provided with long term-medication.

“People are adhering to their treatment, but you would have those individuals that would be lazy to come and ask others to collect for them and come with excuses, but you can’t have excuses for two three months.”

“They are doing well, there is no need for them to give us 6 months’ supply, how they are giving us our treatment is good (two months three months) because if they are giving us for six months, even those who are tempted to default, if we don’t come to the group for a lot time, those who are defaulting might be terminally ill, so this short supply is good and able to pick up if there is anything wrong. They tell you if there is something that indicates that you are not taking your treatment accordingly.”

- Member, Youth Adherence Group (#55B)

The following excerpt puts into perspective the above point and the real value of a club and social interaction together with professional help provided.

“They were good, sometimes you find that some of the patients would come here looking very ill and depressed, they would make jokes which made us feel emotionally better, but if they see that the person is more ill, they would then call that person separately, and would take that person to the clinic to be treated there.”

- Member, Youth Adherence Group (#55B)

The importance of the community models of care can also be demonstrated using the TIER.net data, where we examined the odds to be lost to follow-up, and its possible determinants such as age and gender, the year (cohort) in which the patient was linked to care, and if the patient participated in any sort of community model of care. We did so by using a multivariate analysis that takes into account the effects of all these variables. An odds ratio of higher than one indicates a higher odds of being lost to follow-up. A p-value lower than 0.05 indicates that the results are statistically significant. We can see that the odds to be lost to follow-up if participating in any community model of care is 0.14 (95% CI: 0.13 – 0.16), which is roughly a factor 7 lower when compared to those not doing so (see Table 43).

This is a statistically significant result, and independent of age, gender, or the year of starting treatment as these variables have already been accounted for.

The result may indicate that participation in such a community model of care minimises the risk to be lost to follow-up. This is supported by another study in the same setting, where being in a form of differentiated model of care was associated with a significant reduction in the hazard of all-cause attrition compared to matched patients in standard clinic care.⁶⁵ On the other hand, the data shown in Table 4 may also be due to a selection effect. Generally, stable patients are eligible for these interventions. These patients are in better health and therefore they are less likely to be bed-ridden or otherwise have difficulties to make follow-up visits to a health care facility. Therefore, we did an additional analysis in which we added pre-ART CD4 count and pre-ART HIV clinical disease stage to the regression model. This did not markedly change the results shown in Table 4 (data not shown), lending some evidence to attribute the results to MSF's intervention, rather than to selection. Still, a selection effect cannot be fully excluded, because low CD4 count, and advanced disease stage may not fully describe the health of people living with HIV who are lost to follow-up.

Table 4. Odds Ratios to be lost to follow-up for participants in a community model of care, controlling for age, gender and cohort. Logistic regression results of TIER.net data, 2013-2018

LOST TO FOLLOW-UP				
VARIABLE	Odds Ratio	Lower 95% CI	Upper 95% CI	P value
Reference category: Age 0-14				
Age at ART Start 15-24	2.07	1.55	2.78	0.00
Age at ART Start 25-34	1.52	1.14	2.02	0.00
Age at ART Start 35-44	1.09	0.81	1.48	0.56
Age at ART Start 45-54	0.84	0.60	1.17	0.31
Age at ART Start 55+	0.93	0.64	1.36	0.71
Reference category: Female				
Gender: Male	1.18	1.06	1.32	0.00
Reference category: Cohort 2013				
Cohort 2014	1.20	1.06	1.37	0.01
Cohort 2015	1.05	0.91	1.20	0.50
Cohort 2016	0.88	0.75	1.02	0.09
Cohort 2017	0.56	0.46	0.68	0.00
Cohort 2018	0.30	0.23	0.41	0.00
Reference category: no participation				
Community Model of care participation	0.14	0.13	0.16	0.00

⁶⁵ Shigaeva A, Gcwensa N, Ndlovu C, Ntumase N, Sabela S, Ohler L, Trivino-Duran L, Ford Kamara E, Hlophe K, Van Cutsem G. Retention on ART and viral suppression among patients in alternative models of differentiated HIV service delivery in KwaZulu-Natal, South Africa (unpublished manuscript).

DoH and MSF Collaboration

As we saw the CCGs/CHWs working in the communities with CHAs, in clinics the counsellors, qualified and lay, worked together, and were supported through the programme. Collaboration with MSF is noted here by a DoH counsellor:

“We were working hand in hand with them [MSF] in running Clubs. There are adult clubs and also the youth, and the young ones. the children. So, what we do, we provide the support to the kids who are living with HIV. We are also providing educational facilities; we have got some sessions where we facilitate. We are giving them education in terms of ARVs, what does ARV do. We also help them compassion and fully disclosure depending on their years; depending on the year because we don't just do fully disclosure to any child, it depends how old is that child. So, working with MSF it has assisted us a lot because they have given us some training on how to disclose, we were trained by MSF how to render disclosure; how to assist the caregiver into disclosing the status to the child and the role of a Counsellor. So, we were working hand in hand with MSF and they were giving us a lot of information on how to assist these young ones...”

- Counsellor, DoH Sub-district (#40)

Teamwork, as the above shows was an important element in making the relationships work and in furthering better quality of service. Other important enabling factors are also relayed:

“In my opinion I think it is teamwork; education on the staff; training; taking the staff to training so that they will come back and provide the proper services to the clients. But basically, it's teamwork, working together with the staff and making sure that they reach the target and also in abiding with the guidelines on policies of the Department of Health. And also tracing and calling the patients to come. I think what helped us the most is for them to give us the training because when we get the proper training it's easy for us to motivate our clients, our patients, and to teach them to give them the proper education on what is happening if a person is HIV positive. How can you maintain your viral load to be suppressed? All those things.”

-Counsellor, DoH Sub-district (#40)

In relation to Clubs and CAGs, some of the challenges relayed may require another level of intervention, especially for younger children and youth, where they were sometimes not allowed to attend or must attend to house chores before they go to the clinic. Also, some do not stay with their biological parents so this would give rise to additional challenges. Food parcels for children was viewed as a motivation for families to keep attending sessions.

Within DoH it was found that certain programmes are managed by one individual, and so if they are unavailable, then there is really no one to take it over or provide cover, or colleagues may be reluctant to assist, for one reason or another. We learned that at the time of hand over from MSF, the manager was unavailable, and this resulted in adherence club members being stranded and having no-one assist them. In the end, they had no one to administer medication which caused viral loads to increase. This was relayed as the 'biggest challenge'.

This latter point should be a concern for all parties, but especially for DoH, who already understand the value of these interventions as they are provided for in national guidelines. For MSF, with the intention to remove some pressure from facilities through models of care with a focus on new and unstable patients, the gap in handover relating to human resource constraints and or a holistic facility buy-in, has the potential to render the intervention as uneven and below its true potential. That potential we heard, when functioning, was being realised and of great assistance across the different parties.

TRAINING AND MENTORING

Providing capacity building at facilities is central to skills transfer, and an area that South African government departments insist on. MSF, as part of their recognition of the realities on the ground and the need to up skill within facilities and especially in ART administration at clinics, as well as training of counsellors, conducted a series of activities to meet this need. However, as we see below, this need was not fully appreciated until around 2018.

Clinic staff relayed the methods and benefits of training and support, as the following show:

“They trained all our nurses even those that were not supported by MSF they were also training them but they did say they would not mentor them because they were out of the clinics, but they allowed them to attend the training; They would send a nurse mentoring to the clinic, that nurse would mentor those nurses that are allocated for that period and they would go through the programme when they see that they have achieved.”

- Nurse, DoH Sub-district (#52)

When asked if there was sufficient training, one respondent noted:

“As I mentioned that when we have workshops, we go somewhere else and come back, they come to mentor us on how to go about managing the patient or providing medication to them. Then they see that Mr Y is ready, they say it fine you can carry on. But they keep on visiting us in order to evaluate whether we are still doing ok, because guidelines are here and they come to check files.”

-Nurse, Ntu (#42)

An example of the process once a patient is received at the facility, by a trained nurse.

“Patients are tested, as soon as they are tested [positive] they are initiated on treatment they are given proper health education on how to go about on taking their treatment they are followed because if you tested today you are initiated today. Then you are given two weeks to come back for your blood results and for review how the treatment is treating you for that particular two weeks. If after two week we see the results are here, we need to initiate other treatment for, example codrimoxizole if the CD4 count is less than 200, and we have seen the results, if there is TB, two weeks after initiating ARV’s we initiate on TB treatment and we move on.”

-Nurse, Ntu (#42)

“For initiation they used to come here and it was not a problem because they give them the letter and the date than they come this side, sometimes they bring them. Before we were not starting at the same day, now there are sites that are in town so if there is somebody who is positives the NGO which is there now Broadreach [previously MSF], they go out and collect that person so that he or she can start the treatment on that day.”

- Nurse, Gat (#53)

The following are examples of the training provided that were shared during the interviews: training mentors on standard operating procedures to monitor retention and care and suppress viral load; training community health workers on the door-to-door (CHAP) programme and how they can work better in their communities; and the NIMART⁶⁶, training. The NIMART training was mentioned several times and was especially well received.

“We worked with health workers and doctors, we provided training for health workers for the Eshowe project, NIMART training it was well received, and the mentoring. MSF is big on the mentoring model, there are lectures and workshops and curriculum, but MSF clearly identifies that it’s when you are in the clinic seeing patients that you learn the skills you learn.”

-MSF Staff Member (#2)

“MSF in the clinics supported us with doctors, their doctors have advance HIV management, not like ours we don’t specialise in HIV- MSF they are specialised in HIV that helps us a lot with training, they organise training for nurses in clinics and the training helped us a lot. Only implementers nurses who implemented the NIMART, those are the nurses who go to the training and develop the skill.”

-Nurse, DoH Sub-district (#12)

⁶⁶ NIMART – Nurse Initiated Management of Anti-Retroviral Treatment. Providing this training to nurses at clinics meant closer services to communities, which was previously conducted at hospitals.

“What I can say is that we had meetings with MSF to introduce the program that they had to operate within the department, Initiation of ART (NIMART) they improved a lot in our clinics. They also supplied human resource to mentor our nurses, they also provided human resources to help because the doctors were visiting our clinics we had professional nurses, HIV Counsellors and peer educators, we improved a lot in initiating in the clinics.”

-Nurse, DoH Sub-District (#52)

The same sentiment was highlighted by an official from the DoH at District level, who also shared that the training provided by MSF for the clubs was very valuable, and much of what was learnt at the training was used to provide information for other health facilities in the district (even to some who were not part of the Project).

“Because MSF has been a champion of the clubs, when need the training for the clubs, we would ask them (MSF) to come and help us so that the other facilities which are in the district can get the information, so it will be a district training which is going to be cascaded by other people.”

- Official, DoH District (#49)

The training and mentoring were an effective tool in ensuring that doctors, nurses, counsellors and others were well informed and equipped to perform their work. In reflecting on what may have been better planned for within the project, it was recalled that given the workload at clinics, mentoring took somewhat of a backseat until around 2018. This was perhaps a blind spot for MSF due to the implementation focus on the one hand, and the workload on the other. Later, then when thinking about handover, mentorship became more at the forefront and a structured programme was rolled out.

“So, we are very, very hands on. So, if we could have started more structured mentorship programme for DoH staff probably could have been more effective or efficient. So, it was not really our intention to be very hands on, but MSF are helpful for health facility, so then we were counted as one of the staff, but it was not really our intention, but we were supposed to mentor the staff, then they should implement, at the end we were very hands on. In 2018 we started to have a more structured mentorship and looking at the project closure and hand over, and if we had pushed to start mentorship early it maybe could have been better.”

- Ex-MSF Staff Member (#7)

Multiple dynamics and considerations must be taken into account within facilities, and to be able to navigate these takes time, especially in trying to manage short and long terms goals. Two aspects are observed in the above, as elsewhere, in the work of MSF in the Eshowe Project context.

At one level we observe a ‘we can do it, so let us’ perspective, as also reported by MSF staff, and at another level, we observe that this approach can develop a level of dependency. Such a vision of implementation may have contributed to a level of short-sightedness in this regard, that may have negative knock-effects regarding sustainability. However, and within the moving parts of the project, we also learned that in mentoring sessions, MSF provided ‘substitute nurses’ to take over from those DoH staff that were to be mentored. This model then freed the mentee and afforded them the required space to learn. A careful balancing of these dynamics – long- and short-term objectives – by both parties, needs to be well understood, ahead of planned activities.

Health facilities, with trained and dedicated personnel in place, enabled a smooth process for testing (including verification testing) and played a crucial role in addressing two important components of the project, especially linkage to care and ART initiation, as well as retention in care and adherence. Importantly, and recognised by DoH and facilities, was the project’s ability to provide regular feedback with evidence of progress and related challenges. For the clinic, the relationship provided access to more up to date information, which assisted them with a better flow of processes, and to be well-informed on new developments. This is a significant departure from usual facility processes, where MSF installed personnel to manage these processes and trained DoH personnel.

The closeness of services for counselling and testing together with clinic capability, and dedicated personnel in place at clinics, which includes quality of services, stand out as being the drivers for linkage to care. As has been stated already, linkage to care was not only a capacity-visibility issue, which required great resources, it was also the person-centred approaches, messaging, seeking to understand the communities, and other ‘soft approaches’ within the project, that contributed towards an increase in linkage to care. Quantitative analysis of data from TIER.net shows this in more high-level and general terms; with increasing experience of the MSF team and increasing knowledge in the communities, linkage time improved over the evaluation period.

The variety of models of care were well received within the project especially the direct benefits which include reduced waiting times and ease of access, better quality of care, and more likely ensuring adherence for members. Limited quantitative data provides some indication that participation in community models of care minimises the risk to be lost to follow-up. Certainly, we see the motivational aspects from the mentors or counsellors as being very important in this regard, but also from peers, as the examples above have revealed. is a testament to consistent and clear health messaging, coordination, and patient-centredness.

EVALUATION QUESTIONS

As per the ToR the following evaluation questions were provided as part of the scope of this evaluation to assess the effectiveness of the Eshowe HIV Project. The following highlights how the project achieved all five specific evaluation questions.

1. TO WHAT EXTENT HAVE THE AGREED OBJECTIVES BEEN ACHIEVED?

The following were the initial seven expected project results:⁶⁷

ER 1: Uptake of HIV and TB testing and counselling and regular retesting increased. **YES**

- Evident in the work of the Community Health Agent Programme (CHAP), Farms and Schools Programme in particular, as well as clinical records:
 - CHAs understood the importance of their roles in getting defaulters back onto treatment through education, follow up, and regular engagement.
 - Community members understood the need for testing and counselling seen in a call for the CHAP work to continue, and in changes in attitudes towards testing.
 - Acceptance of the Schools Programme education and testing, especially when available on site (school grounds).
 - Availability of designated premises at TVET and Farms.
 - Buy-in and consent from school principals, teachers, parents and learners, especially for the MMC mobilisation.
 - Advocacy and mobilisation by traditional leadership.

ER 2: Community model of care developed and implemented through Facility Clubs and Community ART Groups (CAGs).⁶⁸ **YES**

- A high number of clubs and groups (23 clubs at one facility) were established to provide a variety of care models available to community members. One Nurse described the clubs as playing a pivotal role: *‘emotionally it helped our community to see that I am not alone with the disease, and it’s like all other diseases’*. There was an understanding of medication and social constructs around the disease, and confidence of youth club members to ‘focus on themselves’. Also noted, was the understanding in the efficacy of physically meeting regularly, and the relationship to adherence.

ER 3: Communities mobilised for testing, prevention and treatment, and to be accepting and supportive of those affected by and infected with HIV and TB. **YES**

- A multi-pronged approach, which included a variety of modalities for access within communities resulted in a high level of acceptance and support for those affected and infected by HIV. The hands-on participation of traditional leadership, support from government structures and strong communications between stakeholders, training and professionalism of CHAs all contributed to the success of this objective. Campaigns and events on specific occasions, underpinned by targeted messaging and condom distribution, programmes in

⁶⁷ Taken from the logical framework 2013; as the project went along the expected results changed, for instance by focusing more on prevention and high-risk populations.

⁶⁸ The evaluators are aware there are a variety of models of care that were part of this project (not only these two), and all of these will be included in evaluation.

schools and farms in deep rural areas, all contributed to this effort. This was further highlighted by many respondents indicating that people's attitudes towards testing had dramatically improved since the arrival of MSF and their interventions.

ER 4: Primary Health Care Centres and Mobile Clinics providing an enhanced and integrated package of HIV/TB treatment and prevention care services. **YES**

- Trained teams of lay counsellors and professionals (i.e., doctors and nurses) provided a variety of support at these facilities, which reduced waiting time, especially when linking to care. Mobile clinics informed communities through various means of their schedules to visit their areas (including to farms and schools). There was a notable uptake at clinics and a more streamlined and friendly process in place. This in turn encouraged users to continue to utilise these services. Two key fixed sites provided integrated services, the TVET College provided services on campus for young female and male adults (college students), and Philandoda to males.

ER 5: Mbongolwane Hospital providing effective referral service for HIV and TB complications.

- Evaluation could not obtain data.

ER 6: Monitoring and Evaluation and operational research systems provide useful and regular feedback on the medical and public health impact of the project interventions. **YES**

- MSF provided and trained data capturers at facilities to monitor patient data, and provide regular feedback on progress, as well as any obstacles, to DoH and relevant stakeholders. An example of quality data and follow up of patients is evident in the introduction of UTT, where MSF were able to access historical data and reach those infected (a calling project) and now eligible for linking to care.
- MSF also commissioned research which provided useful insight into the work being done in Eshowe and Mbongolwane. These include:
 - Eshowe Epicentre Surveys (2013 and 2018)
 - Optimizing HIV, TB & NCD Treatment in Five Sub-Saharan Africa Countries Evaluation of DGD-Funded Projects: Guinea, Kenya, Mozambique, South Africa and Zimbabwe (2014-2016). Catherine Lalonde and Joost van der Meer. December 2017.
 - Evaluation of Community HIV Testing Modalities MSF OCB in KwaZulu-Natal, South Africa. Richard Bedell. February 2016.
 - Bending the Curves of the HIV/TB Epidemic in KwaZulu-Natal. MSF. 2016

ER 7: Advocacy to promote activities of the project to the local community and to national and international communities is successful in promoting change in both policy and practice leading ultimately to achievement of project goals.⁶⁹

YES

Locally, provincially, and nationally, MSF's work has been promoted in newspapers, radio and TV, and local MSF personnel were provided the opportunity to speak of the programme and their experiences.

⁶⁹ In 2015 the Expected Results were changed to follow the cascade of care and 90-90-90 (prevention, testing, linkage, treatment, adherence, VL suppression) more closely – please refer to any log frame from 2015 – 2019.

- Nationally, MSF provided technical expertise (part of the technical working group) on the Adherence Guidelines for HIV, TB and NCDs (February 2016). Within the guidelines under 'Youth-focused strategies' MSF's work is mentioned.
- Internationally, and in light of the Eshowe HIV Project exceeding the 90-90-90 UNAIDS targets meant detailed information on, and promotion of the project, was now available via the multilateral platforms that UNAIDS utilises, among others. The community-based approach is part of a new direction for primary health care and MSF's work is recognised in this regard. The project has also participated in numerous conferences including the International Aids Society (IAS) Annual Conference.
- The project has also developed posters, fact sheets and tools kits in the promotion of the project. The CHAPs Tool Kit in particular could be adapted to upskill CHWs in other sectors in South Africa and elsewhere. The organisations website also acts as a conduit for information, and on the project specifically.

2. WHAT WERE THE MAIN BARRIERS AND ENABLING FACTORS FOR ACHIEVEMENT OR NON-ACHIEVEMENT OF OBJECTIVES?

Barriers:

- Notable barriers relayed within the main report pertain to access and working within government frameworks and guidelines. Treatment guidelines did change quite a bit over the period of time, and these were observed during the initial phases. Our evaluation found that MSF had overcome these issues for the most part, and certainly they were able to find workable solutions until the present day.
- The lack of understanding or comprehensive analysis (situational, landscape, and such like) were notable in accessing schools and in continuous involvement and deliberations with farm owners.
- At the community level, buy-in was slow initially due to stigma and discrimination against PLHIV, and parents are still reluctant for their children to be provided with condoms and sexual and reproductive health education, as relayed by learners.

Enablers:

- Working directly with and respecting local structures, political, traditional, community-based and faith-based organisations afforded access at the household and homestead level.
- CHAs from the communities in which they serve, the promotion and messages from trusted traditional leadership (gatekeepers) served as important enablers for project achievement.
- At clinics, well resourced (human resources with specialized training), patient-friendly, with systems and protocols for follow up also contributed towards achieving project success.
- Additional factors included HIV Ambassadors deployed in certain circumstances, the training to LSAs and LO teachers in schools, and Traditional Health Practitioners further complemented these efforts.

- Soft skills, professionalism (training and mentoring) and preparedness, consistent and uniform messaging and feedback sessions were among factors that contributed to project success, especially visible in the work of community health agents.
3. WHAT ARE THE SPECIFIC ELEMENTS OF THE MSF ESHOWE INTERVENTION THAT HAVE PLAYED THE MOST SIGNIFICANT ROLE IN PROJECT EFFECTIVENESS? (OVERALL AND ESPECIALLY ON LINKAGE TO CARE AND ENROLLMENT INTO ART).
- The ability of MSF to deploy resources ‘the power and machinery’ behind the MSF teams, as the project aimed for coverage and thus required a lot of people on the ground.
 - Community engagements, and buy-in, especially with local leadership (traditional, political, religious, and civil society), and patient-centred approaches were all central to project success, and contributed towards a more educated and thus willing population in accepting the intervention.
 - Leadership, management, coordination and logistics, and most apparent through a fleet of appropriate vehicles with team of drivers and management, provided the backbone to the various activities.
 - A high level of knowledge on the project’s activities and objectives throughout the project team, led to a coordinated implementation of activities.
 - Capacity has been built within the health facilities and communities, for example, traditional healers now have the knowledge and ability to test and recognise potential cases, school Learner Support Agents offer assistance to learners, and clinic staff have increased their expertise.
 - Flexibility in the disbursement of resources: key personnel, vehicles, tents, and such like, translated into proactive measures that was well received by the community.
 - The active participation of non-MSF staff, including HIV Ambassadors played an important role in education dissemination, and the inclusion of reluctant groups, including church leaders and their congregation.
 - Several of the interventions implemented by MSF played an important role in effectiveness, for example the CHAP was effective in getting the community tested, and then providing linkage to care (if required); Philandoda was effective in bringing health services closer to men, as group who often don’t access health services; the Schools Programme and TVET College were both effective in allowing adolescents, young people and young adults to access services at school/college in a location where they spend most of their time; the Farms Programme was effective in bringing services closer to a group of individuals seen as at higher-risk of HIV; the MMC mobilization was effective in educating and recruiting boys for MMC in a safe and well organized manner; and the Community Models of Care were effective in recruiting and encouraging patients to join ART Adherence Clubs and CAGs so that they continue to take responsibility for their treatment. No specific intervention is highlighted as the most significant due to the variety and nature of each of these interventions.
 - In terms of linkage to care, the closeness of services for counselling and testing together with clinic capability, dedicated personnel in place at clinics,

and patient-centredness stand out as being the drivers for linkage to care. The importance of support and follow up, and encouraging patients to go onto treatment while also understanding individuals' situations was observed as being critical across each of the intervention areas.

4. TO WHAT EXTENT DID THE INTERVENTION OPTIMALLY APPROACH POPULATION AT HIGHER RISK OF HIV? (I.E., YOUNG MEN AND WOMEN, SEX WORKERS, MEN WHO HAVE SEX WITH MEN).

- The overall focus of the project was on the entire population due to the high incidence of HIV in the catchment area. Also, from the first survey conducted by MSF in 2013, it was clear that the target population should be young women aged up to 30 years, as well as young men. Therefore, unlike other interpretations of Key Populations in other HIV projects, MSF didn't specifically target key populations such as sex workers, MSM, etc. Different interpretations were provided in the targeting of populations at higher risk, with some overlaps with key populations. Reference was made to a very small sex worker activity within the intervention, but this was short-lived. We observed a sense that this population could have been explored more, by some, while others relayed quite extensive efforts had been made.
- Young boys and girls were reached via the Schools Programme, and those on treatment, via the community models of care (youth adherence clubs). A total of 34 schools (14 in Eshowe and 20 in Mbongolwane) were included in the project, and many from in deep rural areas.
- On farms, males especially, but also female farm workers reported to being less likely to accessing services if they were not made available by MSF.
- Young adults (male and female) were targeted at the TVET College and men were specifically targeted at the Philandoda clinic, both populations at higher risk were offered a variety of services, including health education.

5. WHAT COULD HAVE BEEN DONE TO MAKE THE INTERVENTION MORE EFFECTIVE?

- Earlier recognition and understanding of the stakeholders that would be directly involved in the project.
- More comprehensive planning on the structures required to implement the project
- Earlier considerations regarding sustainability of the project once MSF has left the project area. There was a sense of dependency among CBOs who lacked skills and knowledge to continue to implement the activities once MSF has left.
- Access learnings from other organisations from other sectors who work with traditional communities and are familiar with local structures.⁷⁰
- More robust internal process, especially with documentation and handover to incoming staff members.

⁷⁰ South Africa has many examples of programmes where multiple learnings could be garnered. One example that engages with traditional leadership (albeit in a different sector) is the Thohoyandou Victim Empowerment Programme, based in Limpopo.

REPLICABILITY

Replicability refers to *‘what activities/processes are necessary for transferring the project to other geographical and functional areas’*.⁷¹ In line with this definition, and as outlined in our methodology section, we sought to understand this criterion from the perspectives of a variety of respondents. Two aspects, somewhat polar, were commonly relayed in terms of replicability: that MSF’s work is already being replicated, and the challenge of replication on government due to financial and human limitations. Sometimes both of these ideas were collapsed where details of how specific aspects of the project could be replicated, and the challenge of resources would be included.

In some instances, respondents (mis)understood the question, or indeed provided responses first in terms of sustainability, and then replicability. As evaluators we understand the clear differences, and overlaps, between the two, yet, as we seek comprehensive insights into the project, we feel it is also important to leave room for respondents’ interpretations.

The following sections address the three evaluation questions in terms of replicability, as per the TOR.

REPLICABLE ASPECTS FROM THE ESHOWE PROJECT

In light of the success and effectiveness of the Eshowe Project, the following interventions were highlighted by key informants as replicable and/or scalable, and many of these or aspects of these, can be incorporated into South Africa’s National HIV programme. It is also important to pay some attention to the context in which these approaches can be replicated, many can be replicated outside of South Africa, and in rural and urban contexts. In fact, many of the interventions have already been handed over to the DoH as mentioned in the previous section on effectiveness, these include the CHAP, M1SS, Schools Programme, Philandoda, MMC mobilisation, community adherence groups, and training and mentoring, and some already being done in other countries.

“MSF has a life span in a certain areas, we know this and we ask, is the programme or activity sustainable, can another departments continue with these activities? Like the schools programme with HCT, we collaborated with the DOE school health team, when we leave, would the schools programme be sustainable, can the DOH or other partners continue with those programmes, like the schools, the farms, HCT at the community level – so far, we know that we have handed over certain aspects over to the DOH, and they are continuing with these.”

-MSF Staff Member (#19)

This is an important reflection and speaks to engagement and planning process from project inception, through to maturity, and project end, and handover. We have learned and noted earlier that project handover was not at the forefront of the MSF strategy.

⁷¹MSF Inception Report Template

CHAP - DOOR-TO-DOOR TESTING

The CHAP was an intervention that was noted by several key informants as scalable, both internal and external to the organisation. Key elements to replicability include having an existing cadre or a CBO that potentially has that cadre; a reasonable level of education to allow people the CHAs to be trained, and the financial resources to pay CHAs. Offering HIV testing services in the comfort of one's own home allows for privacy, as many people do not want to be seen going into a health facility, where stigma is still a problem, while this type of intervention can help reduce stigma in communities. Although it was clear that door-to-door testing does not need to be constant, HIV testing campaigns should take place every three or four years (as highlighted in the CHAPs Toolkit), and community caregivers would still be employed to take on this task as it is important to continue with HCT, TB screening, tracing loss to follow-up, and tracing those who test, as these elements are all essential for linkage to care.

As the Luyanda sites have taken the place of the CHAP, these are also viewed as replicable, and less costly. It is important to not completely let go of the door-to-door testing as they are complementary to the Luyanda sites. As one MSF staff member shared, what should remain key is the role of the DoH in supporting the Luyanda sites, which are key for linkage to care:

“I would say the Luyanda site concept can easily be replicable, because DOH has community health workers as well, and the linking to care to the next level is also one thing, what has been happening the working together that we have done with the DOH in Eshowe and Mbongolwane has helped to see what has been lacking implementation, if the DOH had to take over what we have been implementing what can be taken over, so this linking is to ensure that there is point of referral at the facility can be easily replicable elsewhere.”

- MSF Staff Member (#26)

In terms of the human resources required to support or replicate the CHAP one key informant (MSF Staff, #2) felt that it was easy enough to train the community healthcare workers or community health agents already in the employ of the DoH or indeed follow the MSF model and utilise an intermediary such as a local CBO, and that it is good approach to use this cadre of healthcare workers, where there are not enough doctors or nurses. One MSF staff member felt that the CHAP was replicable because of the level of community health worker or caregiver that have already been trained or can be trained to provide the services required for the CHAP.

“...the reason why I say it can be done is because the community health agents are in a level of community health workers which were previously known as caregivers, so if Department of Health or any other NGO can hire those caregivers to provide all the services that were provided by CHAPs, that can be done and it can really help those communities...the community health workers or caregivers already go to the houses, it's part of their scope, so it's just a matter of integrating it to HIV testing and TB screening and STI and provide pregnancy testing in the services that they provide.”

-MSF Staff Member (#25)

MSF developed a detailed yet accessible CHAP Toolkit, replete with the ‘MSF Experience’, insights we view as being extremely useful. This is a valuable tool, and in our estimation a wide dissemination of this material should be embarked upon.

M1SS: BRINGING THE SERVICES TO PEOPLE

The M1SS (Mobile-One-Stop-Shop) where MSF was bringing services to communities, from going to schools, visiting High Transmission Areas (HTAs) like farms and the TVET College, and taxi ranks, was seen by many as an intervention that was scalable or replicable. As one MSF staff member shared the DOH has already adopted a similar intervention with mobile clinics, and it needs to be presented in a way that community members will want to access the services, as relayed here:

“What also can be done, the Mobile-One-Stop-Shop it can be done, and I think Department of Health already is having what they call mobile clinic...it is there the way its presented to the community, it’s like people they need to go to mobile clinic to collect medication only, and only if they are sick maybe, if they can increase the mobilisation to say people can they come and be tested therein the mobile clinic, and maybe add a little bit of lay counsellor who will provide counselling”

- MSF Staff Member (#25)

In the HTAs, MSF via the mobile clinic, provided testing and a comprehensive package of services, and they even cater for minor ailments or any other needs that were presented, and they provided chronic treatment and ART to clients. As one Official from the District DOH highlighted, this is something that the DOH is not doing in their current set up on high transmission areas, which is mostly focused on condom distribution and testing, and is an intervention that can be scaled up and adopted by the DOH.

“I think as DOH we can learn something on how to best run high transmission areas as how MSF has done it. [M1SS] could work for all of us, their focus on high transmission areas, I think as a department we need to take that one and move with it, yes we have something like that but not a way MSF was driving it in that area I think we can learn on how they did it in that area and try and replicate”

- Official, DoH District (#31)

Furthermore, having dedicated drivers, as per the MSF model, who double-up as community mobilizers and security, in some instances, was deemed as advantageous. This helped with the maintenance of vehicles and controlling costs in this regard.

SCHOOLS PROGRAMME

The Schools Programme was described by many key informants as giving adolescents and young people the option of accessing services at school, a location where they spend most of their time. Therefore, this programme was seen not only as scalable, but also as providing a positive change to lives of adolescents and young people.

In essence the Schools Programme provided an opportunity to instil a testing culture among young people, and with the collaboration of the DoE and school principals, this intervention is easily replicable as was highlighted by an MSF staff member:

“HIV testing programme in schools, first go inside schools educate and get permission and test learners, now DOE have HIV and TB policy for the schools, they need to roll out everything in South Africa, if you are able to instill testing culture when they are still in school, when they reach university and they see the tents there, and they might get an HIV test, they will go get a test, they will know if they expose themselves they might test positive, at high school education is very important. DOE can replicate what MSF did in Eshowe and this could have a huge impact on young people. Learners can learn about HIV at early age, and instill culture of testing.”

- MSF Staff Member (#20)

The point of close collaboration to ensure successful replicability was also mentioned by an official from the DoE, as well as ensuring that there is proper consultation and training for all those involved in the programme.

“I think that is the key that you involve those who are working, who have many years in the environment, change them first, you then move to the next one. Then you arrive to the learners when everyone is on board. Principals must be involved so that they support the programme in terms of schools, involve everyone that is supposed to be involved, just train the circuit managers so that they can support the programme those that are in charge of the schools, with us it works so well that you start with the management, they are the ones that are senior, expose them to the programme, then it will be easy to go down because the big guys are fully aware of what is going happening. I think proper consultation and proper trainings”

- Official, DoE District (#33)

Another element of ensuring that the Schools Programme can be replicated is to link it with the schools’ health team, this is key because these teams already exist in the DOH. The services that are provided by the school health teams can include what was provided by MSF in their programme, including the LSA programme. One MSF staff member felt confident that:

“...perhaps they can do this in other areas were MSF is not working, really implement those things and see, we have LSA school health team who visit schools now and again we have local community health workers who are working within the area who can cover those things and even we were discussing with the curriculum department to say can they add HIV and TB in their curriculum, so that the LO teachers can touch on it when they are educating”

- MSF Staff Member (#19)

PHILANDODA: THE MALE CLINIC

The establishment of Philandoda, the male wellness clinic, focusing on men was seen as an intervention that is replicable. Philandoda was mentioned by one key informant as one of MSF's best innovative interventions, because often men complain that there are no programmes focusing on men's health. The clinic was established right in town, near the taxi rank, and taxi drivers embraced the idea because it was one of a kind, and there were no other clinics specifically focusing on male clients. As an official from the District DOH shared, this is an intervention that should be taken up and incorporated by the DOH (Philandoda was handed over to the DOH in 2019).

“Also the male wellness clinic I think with that one as DoH we should be learning best practice out of it and try to incorporate it in our DOH service delivery approach so that it is best suited for that gender, because that's the main major that we are complaining about that they are not accessible and they are not presenting themselves even when they are sick”.

- Official, DoH District (#31)

MMC: COMMUNITY MOBILISATION

MSF's community mobilisation campaigns, in particular MMC, was also seen as replicable. Of particular interest is the MMC youth camps and health education provided to the young males and high school learners, which was seen as replicable in other settings. The MMC component of the MSF project was handed over to the DOH in October 2018, and many of the activities implemented by MSF are being done by the department.

COMMUNITY ADHERENCE GROUPS: RETENTION IN CARE

Retention in care and adherence related activities such as the community adherence groups and the patient support system, where efforts are made to bring a patient into care, was highlighted as a successful element of the project. The clubs' system, and the delivery of HIV medicines was seen by some key informants as easily replicated in almost any context, and in fact CAGs have already been replicated by MSF in other contexts in Southern Africa (i.e., Zimbabwe and Mozambique).⁷²

TRAINING AND MENTORING

MSF invested considerably in training and mentoring, in Eshowe and in other HIV projects in Southern Africa. Many respondents felt strongly that this component of the project is replicable. The training provided to healthcare workers (i.e., NIMART) was mentioned as key, along with the mentoring model used by MSF such as lectures, workshops, and curriculum, all were mentioned by several respondents as replicable and easily adaptable to different contexts and in different ways in South Africa and elsewhere. One former MSF staff member shared how she benefited from the training and mentoring:

⁷² Optimizing HIV, TB & NCD Treatment in Five Sub-Saharan Africa Countries Evaluation of DGD-Funded Projects: Guinea, Kenya, Mozambique, South Africa and Zimbabwe (2014-2016).

“I’m a beneficiary of the MSF and Broadreach NIMART training strategy. So MSF and Broadreach collaborated in providing NIMART training to nurses in the supported facilities - used in three districts - I was trained and mentored with a doctor and mentored for a period of 14 weeks, and then I became a NIMART practitioner (certified), and then I went on to become a mentor and a trainer at MSF. For me, I am not doing too badly, I am now with the National Department of Health, I am an MSF product. With regards to training, MSF provided a lot of training in Adolescent and Paediatric HIV management and TB management training - A great collaboration with the DOH in the area, in these trainings...very successful.”

- Ex-MSF Staff Member (#8)

In summary, with reference to each of the interventions mentioned above, there are several elements of the Eshowe HIV Project that are replicable and in fact have already been handed over to the DoH. However, one should also note that these elements and components of MSF’s interventions, as was shared by one MSF staff member, are replicable to different levels or degrees. It should also be noted that all these interventions were done in collaboration with the DoH, and not in parallel. Everything can be replicated, the question of scaling-up is related to sustainability, and the need for continuous resources, which means that for government, you can only scale it to a level that you can manage, and so a sustainable approach needs to be developed in this vein. MSF implemented these interventions at a scale to saturation, in order to bend the curve. The willingness, coordination, capacitation, supervision, monitoring and troubleshooting approach will determine how much these components can be scaled and the resources that are required.

Finally, the issue of contextualisation was shared by a former MSF staff member, highlighting and summarises well the importance of replicating interventions and models in other contexts.

“I also learned the importance that whatever you learn, you must be able to contextualise it, to understand the local communities and what works in this environment...just as one place has beautiful models, it doesn’t mean it will work in your new place, then you have to re-strategise and plan how you can adapt to the local context. You cannot assume that if it works in one place it will work in another, and you must engage with the locals to adapt those models and this means buy-in and you, can help them understand how it relates to their context. What is important for using models elsewhere is not to duplicate everything that is there, but come up with new strategies and innovations so that people can access care. You can see we (MSF) had different models of care and programmes like CHAPs and access to ARVs, the first programme that brought testing door-to-door, while the DoH was a bit hesitant. It was a new strategy and we tried it out and learned from it. The variety and options we gave to people (via M1SS), the more options people have the easier for them, they can access if they don’t like one. A large variety is key to cover types and tastes of the community.”

- Ex-MSF Staff Member (#11)

ESHOWE PROJECT: CONTRIBUTION TO THE SOUTH AFRICAN NATIONAL STRATEGIC PLAN (NSP)

The South African National Strategic Plan for HIV, TB and STIs 2017 - 2022 (NSP) serves as a roadmap and a plan that sets out the goals and objectives to enable the many thousands of organisations and individuals who drive the response to HIV, TB and STIs to act as a concerted force, moving in the same direction. This NSP aims to achieve its ambitious targets by intensifying the focus on geographic areas and populations most severely affected by the epidemics; using a combination of interventions that have proved to deliver high impact; and strengthening systems and initiating processes to provide the foundation necessary for higher performances. The NSP has eight goals including Goal 1: *Accelerate prevention to reduce new HIV and TB infections and STIs*; Goal 2: *Reduce morbidity and mortality by providing HIV, TB and STI treatment, care and adherence support for all*; Goal 3: *Reach all key and vulnerable populations with customised and targeted interventions*; Goal 4: *Address the social and structural drivers of HIV, TB and STIs, and link these efforts to the National Development Plan-Vision 2030 - aims to eliminate poverty and reduce inequality by 2030*; Goal 5: *Ground the response to HIV, TB and STIs in human rights principles and approaches*; Goal 6: *Promote leadership and shared accountability for a sustainable response to HIV, TB and STIs*; Goal 7: *Mobilise resources and maximise efficiencies to support the achievement of NSP goals and ensure a sustainable response*; and Goal 8 *Strengthen strategic information to drive progress towards achievement of NSP Goals*.⁷³

MSF's work has definitely contributed to the NSP, as Eshowe was among the first sub-districts to bend the curve on HIV and reach the 90-90-90 targets. The work of MSF has contributed significantly to the NSP, because it was not only looking at clinical management, including health services, but it was also looking at having an impact at the community level, issues that are covered by the NSP.

The various interventions implemented by MSF through the Eshowe HIV Project directly complimented the South African National Strategic Plan, with many of the NSP goals being enhanced or improved, in particular in Eshowe and Mbongolwane. MSF's work in both these areas was able to achieve what the NSP sets out to target and achieve, as is highlighted by an Official from the Provincial DoH:

“... yes on all of the goals...with HIV and AIDS, all the goals are interlinked there are key areas that MSF focused on that had a ripple effect on all other interlinked deliverables around that, so it definitely impacted on all of the goals and that can be quantified by MSF and by the district”

- Official, DoH Provincial 1 (#4)

An MSF staff member felt that the biggest difference and contribution of MSF's work to the NSP was linkage to care and offering differentiated service delivery.

⁷³ National Strategic Plan for HIV, TB and STIs 2017-2022. National Department of Health. Retrieved from https://sanac.org.za/wp-content/uploads/2017/06/NSP_FullDocument_FINAL.pdf

“...has it contributed to NSP? - YES it has definitely in terms of differentiated service delivery, Eshowe has contributed quite a bit into piloting different types of differentiated services delivery and demonstrating that it is feasible. I do hope that current research that is being done on advanced HIV and on detection of TB will also be incorporated into new policies.”

- MSF Staff Member (#83)

The Eshowe HIV Project has also given hope that the 90-90-90 targets are achievable in other areas, and in Eshowe the key factors were more attention towards patient-centredness, mentoring and training, and more broadly, health promotion. From a community perspective, there has been more attention towards ensuring the different parts of the health system talk to each other, and that those working at community level are linking patients with clinics, and that there is a clear referral communication system between clinics and hospitals. Joint planning is important and ensuring that from time to time people sit together to look at emerging data, and as one key informant highlighted, this is something that has been more cohesive in Eshowe than it is generally.

Furthermore, it is possible to incorporate MSF’s strategies, good practices and lessons learned into the NSP to make sure that HIV programmes and interventions are reaching target populations and attaining good outcomes.

MSF’s work has contributed to the NSP, as Eshowe was among the first sub-districts to reach the UNAIDS 90-90-90 targets. MSF’s work has significantly contributed to the NSP, as it looked at clinical management, and implemented interventions which had an impact at the community level. These various interventions directly complimented, enhanced or improved many of the NSP goals. 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. A significant difference and contribution of MSF’s work to the NSP was linkage to care and offering differentiated service delivery.

LESSONS LEARNED

The following are lessons learned from the Eshowe HIV Project which facilitate HIV management in South Africa and for other MSF HIV projects in similar contexts, these include strategy, investment in relationships, collaboration with CBOs, policy and guideline development, research and MSF’s leadership and teamwork. As we have seen with the communities at the centre, this approach can be replicable anywhere, but it warrants deep engagement in the political, social and cultural relationships, including with traditional leadership. In terms of relationships MSF needs to invest in personnel who can understand those sensitive dynamics.

STRATEGY

It is crucial to have a strong strategy (including exit strategy) in place right from the start, as this is directly related to planning and implementation. At the beginning of the project, MSF did not have an

agreement with government, which meant there was not much buy-in from government, facilities, and the community. As one former MSF staff member (#13) shared, *“If we had secured agreement and understanding with authorities earlier, we potential would have had the better potential for uptake into the local district and provincial and national implementation of HIV programme around the country”*. They also emphasised that if you have people on your side, and they feel like they are part of the whole project, they have a stake in what you are doing, there is more motivation or interest in how that is successful or not, and then that will lead to that desire to replicate it in other places.

INVESTMENT IN RELATIONSHIPS

Through this project, MSF was able to invest in several different relationships, all of which have been key to its success, and are also suggested by key informants as crucial for replicability. These include the community, traditional leadership, government, clinics/hospitals, TVET College, farm owners, and CSOs.

The community: The relationship with the community is key as they are the beneficiaries and participants. Further, they know what challenges they are experiencing and can ultimately help you in what together you are trying to achieve. One MSF Staff Member highlights this succinctly:

“...if you are going to the community, never forget the community, they have answers to their problems, you come in with expertise, how to implement ideas they have, but most of the time the challenges they know what can be done in order to resolve the issues – this will help to work with community.”

- MSF Staff Member (#20)

Traditional Leadership: The relationship with traditional leaders, and in particular the engagement with the Amakosi right from the start, is very important because they are the gatekeepers and have direct access to the local community and are listened to. It is crucial to foster this relationship from the start as it will strengthen community buy-in. MSF was successful in investing in this relationship, and in terms of replicability, it is suggested as an important first step in getting community buy-in and participation.

Government (Departments of Health/Education): Where there are relatively strong government structures (such as in South Africa), building a good relationship with government is important, again, right from the start. It is crucial to share with them the programmes or interventions you will implement, receive their feedback and move forward together, which will reinforce a good working relationship. The relationship between government and MSF has always been very positive, mainly as it was a data driven approach, so it is key to share data, as highlighted by an MSF Staff Member:

“...stakeholder consultation worked well because whenever they are having those consultation meetings with stakeholders, they will like explain exactly what will happen, and get the feel of stakeholders to see if it worked well or not.”

- CBO Partner 4 (#22)

Clinics/Hospitals: Investing heavily in the relationship with districts and clinics is also key, as well as fostering joint planning together with all partners. This approach worked well for MSF as the team was able to build close relationships with the district and clinics, which meant that they were never perceived as intruders, but rather as partners. As detailed earlier, the ultimate approach by MSF was both bottom up and top down.

TVET College: Engaging with college management and building that relationship is important, because they allow MSF to come into the campus to provide not only health education (via events), but also health services (including HIV, STIs and SRHR) to young adults who are a key target population. The Eshowe campus management team was very supportive of MSF’s work with their students, which then resulted in the creation of a clinic on campus, which was a new idea for them. This concept can also be easily replicated in other TVET College campuses in the province and country.

Farm Owners and workers: Building a relationship with the farm owners, via the Eshowe Farmers Association was a successful strategy to ensure that services were taken to the farm workers, where they worked. Through this relationship, the farm owners provided a space and access for their workers, allowing MSF to provide much needed services to a group of people who otherwise might not be able to seek services at clinics. Once again, this model can be easily replicated to other farms once you have informed, involved and built a relationship with the farm owners. Separate meetings with all farm workers are also important to understand their needs and any possible challenges that may arise.

Partners/CSOs: Building relationships with CSOs was critical to the success of the project, and MSF was able to build strong partnerships with these organisations (SHINE and Child Care South Africa). In South Africa, CBOs play an essential role in service delivery and are often included in community projects under various government departments.

An MSF staff member shared that regular meetings took place with partners to look at data together, and by doing this MSF and the partners were able to make conclusions which helped the district learn how to better implement programmes and interventions. MSF’s involvement in the Umlalazi Coalition is an excellent example of the importance of investing in partners. MSF’s consultation with partners and stakeholders was evident by their contribution to this Coalition, as noted by a coalition partner,

Another area that worked well with partners, as noted by a partner, was to share the workplan to understand expectations, and to have an open-door policy to provide feedback:

“Whenever you worked together you need to share the workplan to understand expectations and identify areas where we have similarities, and find a way of working together, to show clearly lines of demarcation. We also had open door policies, we don’t wait for those big issues, but we call each other and sort them out and address any challenges. Give each other feedback quite often at monthly meetings to discuss progress, challenges and on how we can support each other.”

- CBO Partner 3 (#82)

COLLABORATION WITH CBOs (SHINE AND CHILD CARE SOUTH AFRICA)

MSF’s collaboration with local CBOs, in particular SHINE and Child Care South Africa, revealed several lessons learned, which are key to replicability.

What worked well with CBOs

Strategy for working with local partners:

When working with local partners, collaboration is crucial, but even more so is having a strong and comprehensive strategy focusing on what you want to achieve, and how you will achieve it.

Local ownership:

MSF was able to successfully assist CBOs it worked with to contribute to local ownership, by working in collaboration with them, which is an important lesson moving forward with projects having a similar focus. This was noted by an MSF Staff Member:

“In terms of NGOs they contribute to local ownership that’s important a relationship that is important to maintain. Trying to give local ownership is important, NGOs are the way to do that. Not trying to take NGOs over, we should participate and collaborate with them we should not raise expectations or not create unsustainable relationships, expectation of MSF for funding depends. Trying to identify governance issue that can help the NGO when we are gone, we are too focused on operational issues, like SHINE had a fraud, mismanagement, these things cripple the organisation, it’s not MSF role to get into the engine room – like if we are learning budgets - ask them would you like to join, use soft approaches this might help achieve success.”

- MSF Staff Member (#80)

What didn’t work well with CBOs

Investing and strengthening local partners:

- MSF struggled with very weak CBOs and they struggled to adequately create capacity among them. The lesson is to adequately invest and strengthen in local partners from the start, especially in the areas of governance and financial management, as one MSF Staff Member noted:

“We didn’t reach a level where we could trust that they could do it without us.”

- MSF Staff Member (#83)

A former MSF Staff Member suggests that taking a community development approach might have been better:

“We wanted them to be independent, but also, wanted to control them... so the speed with which we tried to do things, was important, but also a real weakness in other ways – you would want to take a more community development approach, but we didn’t have time to do that.”

- Ex-MSF Staff Member (#13)

Focus solely on local partners:

- MSF only focused on local organisations (in Eshowe and Mbongolwane) to assist with implementation, they were unable to expand the net and look further to identify other organisations that could have the capacity to assist. As one former MSF Staff Member (#11) shared, *“we don’t only look at if the organisation’s needs are local. What we need to replicate or make sure is that the project is sustainable. Yes, you might be local, but if you don’t have the resources, people or knowledge to replicate it, so you have to enhance it and adapt it to the evolving needs of the community – a visionary organisation can push the boundaries.”* The lesson is to widen the criteria for engaging partners, therefore to not only bring in local partners, because skills, knowledge and a shared vision are all very important.

Capacity building among partners:

- Capacity building remains a grey area in all aspects, MSF arrived with expertise in various areas and worked to capacitate partners to be able to implement activities and ensure that they have expertise once they leave. One partner felt that there should have been transfer of skills on issues such as logistics and M&E, CSOs could have benefited more from being capacitated in these areas, including sustainability, *“they need to do more in the capacity building and do a sustainability plan after they leave. For Child Care South Africa what did they leave after they left, nothing – but we gained a lot of knowledge”* (CBO Partner 2, #17)

POLICY AND GUIDELINE DEVELOPMENT

MSF through the Eshowe HIV Project was able to have an enormous impact on the development of the *South African Adherence Guidelines on HIV, TB and NCDs*. MSF staff members were directly involved in writing the guidelines, and in many aspects what MSF was implementing in Eshowe forms part of the guidelines.

“In the adherence guidelines, it is now called a different name, but it is exactly what we were doing at MSF, where we have the facility pick up points, external pick up points, the adherence clubs, and built onto our strategy. But all the things that we were doing at MSF, the DOH learned from MSF, they have integrated into the adherence guidelines. Also the consolidated ART guidelines, revised last year around June/July, they now include an enhanced adherence form, which was a tool that MSF used for adherence...a lot of things that MSF have made their way into various guidelines of the country.”

- Ex-MSF Staff Member (#8)

In terms of replicability, one key informant felt that seeing as South Africa was able to develop good adherence guidelines with assistance from MSF, that this can be used to help other countries in Africa.

“...I think once you get national guidelines, especially in South Africa, other countries in Southern Africa kind of look at what is happening in South Africa, okay look what they are doing in South Africa, maybe we should try these here, in that sense I think having the impact at national level in South Africa might make it other countries will also take of that and try to implement it in their countries as well.”

- MSF Staff Member (#24)

RESEARCH

Another important element was having an operational research aspect to the project, and therefore being able to document MSF’s work and turn that experience into evidence that others can learn about and replicate.

“...and that aspect of communicating our findings which is important for the possibility of replicability, and documenting things down into guidelines that you can refine and then share, so people are able to process that work, also talk to people on the ground about what is going to work for the local situation, and the experience levels of the staff that you have...”

- Ex-MSF Staff Member (#13)

This sentiment was also shared by an official from the District DoH, emphasizing that practical implementation research assists the government, tell them how they are doing things at the local level, “*how are we implementing the guidelines, how are we implementing the standard operating procedures so that we will be able to improve.*” (#32). Government and hospital officials also indicated that research assists them in making decisions on where to direct their efforts.

MSF'S LEADERSHIP AND TEAMWORK

Central leadership together with having an enthusiastic team who is supportive of what is happening in the field was key to MSF's success, and an important lesson learned. It is important to have a team that is proud of their work and can work together to achieve their goals and objectives, especially those working directly with the community.

“this was felt at all levels, people were very proud of the job they were doing and excited about the job they were doing. It's important to see how one could capitalise on that, there was a sense of ‘we are in all in this together’ and the community fronting people were the most important, all team members were involved in decision making, there was good energy, cheerleading that happened for that project. When the results came out it wasn't the project leads that were congratulated it was everyone on the ground and they knew it was their work, this was an important factor in keeping that project as vibrant and alive as it was.”

- MSF Staff Member (#2)

Several key informants shared that MSF was very dedicated and always willing to assist and provide support to the district, while learning from the way they implemented their interventions.

“I would advocate that you give them space to implement their capabilities, because you could learn a lot from what they are doing. I think the system that there were using by moving in experienced doctors or project leaders then change every two to three years, I think it was beneficial because each time they bring a new team we learnt something new, and every time it was like we are building up as a district...”

- Official, DoH District (#31)

“With the other organisations they are there, but perish very soon, but since MSF arrived they have been working tirelessly, there is no time when you could say the work is not being done or the funds are not there...the employment that they have assisted our people, they employed many people, some you see that their homes are surviving because their children are employed at MSF, so MSF has just brought change in to many families.”

- Traditional Leader (#44)

The lessons learned from MSF's Eshowe intervention to facilitate HIV management include having a strong strategy in place right from the start of the project, which is directly related to planning and implementation, as this facilitates buy-in from government, facilities, and the community.

Investing in relationships with the following key stakeholders is also key, especially with the community, traditional leadership, government (Departments of Health/Education), clinics/hospitals, TVET College, farm owners and workers, and partners/CSOs. Collaboration with CBOs was also a lesson learnt, for example developing a strategy for working with local partners and ensuring that collaboration is central worked very well in this project. On the other hand, MSF struggled with adequately creating capacity among CBOs, and there is therefore a need to invest and strengthen local partners from the start of the project, particularly in governance and financial management.

Other important lessons learned include policy and guideline development such as MSF's contribution to the development of the South African Adherence Guidelines on HIV, TB and NCDs, ensuring that operational research is an aspect of the project and being able to document the work being done, as well as good leadership and an enthusiastic team who are supportive about project.

EVALUATION QUESTIONS

As per the TOR the following evaluation questions were provided as part of the scope of this evaluation to assess the replicability of the Eshowe HIV Project. The following highlights how the project achieved all three specific evaluation questions.

1. WHAT ARE THE ELEMENTS OF THE MSF INTERVENTION IN ESHOWE THAT ARE SCALABLE, AND COULD BE INCORPORATED INTO SA'S NATIONAL HIV PROGRAM?
 - **Community Health Agents Programme (CHAP):** Key elements to replicability include having an existing cadre or a CBO that potentially has that cadre; a reasonable level of education to allow people the CHAs to be trained, and the financial resources to pay CHAs. Luyanda sites (which have currently taken the place of the CHAP) are replicable and less costly, although door-to-door testing should complement the Luyanda sites every few years. In terms of the human resources, community healthcare workers or community health agents can be easily trained and are already employed by the DoH.
 - **M1SS:** Bringing services to communities is seen as easily replicable, from going to schools, visiting high transmission areas (HTAs) like farms and the TVET College, and taxi ranks, which is an intervention already adopted by the DoH (mobile clinics).
 - **Schools Programme:** The programme offers health services to adolescents and young people in a setting where they spend most of their time, and already has some structure (LO lessons) which can easily be scaled up to other schools. Close collaboration between the implementing organisation and the DoE (including schools and principals) is also key for successful replicability. Linking with the schools' health team, who already exist in the DoH was also highlighted as assisting with replicability.
 - **Philandoda:** Having a male wellness clinic in a location where men can easily access health services is important, and easy to replicate especially in town or near the taxi rank.
 - **MMC:** Organising community mobilisation campaigns around MMC was seen as replicable, especially because of the link to schools, where it is easy to educate and recruit young male learners.
 - **Community Adherence Groups (CAGs):** Creating these groups at the facility level and the clubs' system, and the delivery of HIV medicines was seen as easily replicated in almost any context, with these already being replicated by MSF in other contexts in Southern Africa (i.e., Zimbabwe and Mozambique).
 - **Training and Mentoring:** The training and mentoring provided by MSF can easily be replicated, especially the training provided to healthcare workers (i.e., NIMART).

2. HOW DOES THE MSF INTERVENTION IN ESHOWE COMPARE WITH SA NATIONAL PLAN? WHAT DID MSF DO IN ESHOWE THAT WAS IDENTIFIABLY DIFFERENT?
 - MSF's work has contributed to the NSP. Eshowe was among the first sub-districts to reach the 90-90-90 targets, and MSF's work has significantly contributed significantly to the NSP, as it looked at clinical management

(including health services) and implemented interventions which had an impact at the community level, which are all issues covered by the NSP.

- The various interventions highlighted in this report directly complimented, enhanced or improved many of the NSP goals, therefore MSF was able to achieve what the NSP sets out to target and achieve.
- 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.
- Some respondent felt that the biggest difference and contribution of MSF's work to the NSP was linkage to care and offering differentiated service delivery.
- It was also felt that it is possible to incorporate the strategies used by MSF, as well as the good practices and lessons learned from the Eshowe HIV Project into the NSP to make sure that HIV programmes and interventions are reaching target populations and attaining good outcomes.

3. WHAT ARE THE LESSONS LEARNED FROM MSF'S ESHOWE INTERVENTION TO FACILITATE HIV MANAGEMENT (WITH SPECIAL ATTENTION TO LINKAGE TO CARE) IN SOUTH AFRICA'S OR OTHER MSF HIV PROJECTS IN SIMILAR CONTEXTS?

- **Strategy:** Having a strong strategy in place right from the start of the project, which is directly related to planning and implementation, this also facilitates buy-in from government, facilities, and the community.
- **Investment in relationships:** Investing in relationships with the following key stakeholders is crucial.
 - **The community:** The relationship with the community is key as they are the beneficiaries and participants, and they know what challenges they are experiencing and help with what you are trying to achieve.
 - **Traditional Leadership:** The relationship with traditional leaders (Amakosi) from the start of the project is important as they are the gatekeepers and have direct access to the local community, which will ensure and strengthen community buy-in.
 - **Government (Departments of Health/Education):** It is key to build good relationships with government structures right from the start, and to inform them of the programmes and/or interventions to be implemented, receiving their feedback is key to moving forward together,
 - **Clinics/Hospitals:** Investing in the relationship with districts and clinics will help foster joint planning with all partners, which worked well for MSF as they were able to build close relationships with the district and clinics.
 - **TVET College:** Building a relationship and engaging with college management is important to allow health education and health services to be provided on campus, close to where the students are on a daily basis.
 - **Farm Owners and workers:** Building a relationship with the farm owners, who are the main access point to the farm workers is important as they

- are those who offer a space and access for their workers to access much needed health services.
- **Partners/CSOs:** Building and fostering relationships with CSOs is key to building strong partnerships, as in many cases these organisations play an essential role in service delivery
 - **Collaboration with CBOs (SHINE and Child Care South Africa):**
 - **What worked well with CBOs:** Developing a strategy for working with local partners, and ensuring that collaboration is central, as well as having a strong and comprehensive strategy focusing on what you want to achieve, and how you will achieve it. Ensuring local ownership and being able to successfully assist and collaborate with CBOs contributes to local ownership.
 - **What didn't work well with CBOs:** Investing and strengthening local partners was a challenge, and MSF struggled with adequately creating capacity among CBOs. There is a need to invest and strengthen local partners from the start of the project, particularly in governance and financial management. Focusing solely on local partners also presented some challenges, since MSF only focused on local organisations (in Eshowe and Mbongolwane) to assist with implementation, they were unable seek the assistance of other organisation who may have had more knowledge, experience and capacity. Capacity building among partners seemed to also present challenges, although MSF arrived in Eshowe and Mbongolwane with expertise, and they worked to capacitate partners the transfer of skills was not as apparent.
 - **Policy and Guideline Development:** MSF's contribution to the development of the South African Adherence Guidelines on HIV, TB and NCDs, and especially having staff members directly involved in writing the guidelines is an important lesson and contribution, which can be replicated in other countries.
 - **Research:** Having operational research as an aspect of the project and being able to document the work being done and turning that experience into evidence is very important. This type of research also assists key stakeholders, such as government, to ensure practical implementation and assists with decision making.
 - **MSF's Leadership and Teamwork:** Having an enthusiastic team, who provide leadership and are supportive about project is crucial, and this was reflected as key to MSF's success. Having a team that works together and is proud of their work makes an immense difference in the quality of work that is provided at the community level.

CONCLUSIONS

The Eshowe HIV Project achieved the agreed objectives set out at the initial stages of project implementation. More specifically, the following initial seven expected project results were achieved: the uptake of HIV and TB testing and counselling and regular retesting increased, which was evident in the work of the Community Health Agent Programme (CHAP), Farms and Schools Programme, and in clinical records; a Community Model of Care (CMOC) was developed and implemented through Facility Clubs and Community ART Groups (CAGs) with a high number of clubs and groups established to provide a variety of care models available to community members; communities were mobilised for testing, prevention and treatment, and were accepting and supportive of those affected by, and infected with, HIV and TB, which was done with a multi-pronged approach, including a variety of modalities for access within communities; Primary Health Care centres and mobile clinics provided an enhanced and integrated package of HIV/TB treatment and prevention care services, with trained teams of lay counsellors and professionals which reduced waiting time, especially when linking to care; mobile clinics informed communities through various means of their schedules to visit their areas (including to farms and schools); 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 medical and public health impact of project interventions, and insight into the work being done in Eshowe and Mbongolwane; and advocacy to promote project activities to the local community, and to national and international communities were successful in promoting change in both policy and practice, leading ultimately to achievement of project goals.

The main barriers faced in the project relate to access and working within government frameworks and guidelines, which was observed during the initial phases. This evaluation found that MSF had overcome these issues and found workable solutions. The lack of understanding or comprehensive analysis (situational, landscape, etc.) were notable in accessing schools, and in continuous involvement and deliberations with farm owners. While at community level, buy-in was slow initially due to stigma and discrimination against PLHIV, and parents were reluctant for their children to be provided with condoms and sexual and reproductive health education.

The main enablers for achievement of project objectives were working directly with, and respecting, local structures, political, traditional, community-based and faith-based organisations, which afforded access at the household and homestead levels. Other enabling factors include: CHAs originating from the communities in which they serve; the promotion and messages from trusted traditional leadership (gatekeepers); clinics were well resourced (human resources with specialized training), patient-friendly, with systems and protocols for follow up; HIV Ambassadors deployed in certain circumstances to assist with advocacy; training provided to LSAs and LO teachers in schools, and Traditional Health Practitioners; soft skills, professionalism (training and mentoring) and preparedness from MSF; and consistent and uniform messaging and feedback sessions, especially visible in the work of CHAs.

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, 'the power and machinery', behind the MSF teams, as the project aimed for coverage and thus required a lot of people on the ground.

Community engagements and buy-in, especially with local leadership (traditional, political, religious, and civil society), were all central to project success, and contributed towards a more educated and thus willing population in accepting the intervention. Leadership, management, coordination and logistics, which was most apparent through a fleet of appropriate vehicles with team of drivers and management providing support to the various activities. Capacity has been built within the health facilities and communities, for example, traditional healers now have the knowledge and ability to test and recognise potential cases, school LSAs offer assistance to learners, and clinic staff have increased their expertise. Flexibility in the disbursement of resources (key personnel, vehicles, tents, etc.) translated into proactive measures that was well received by the community. The active participation of non-MSF staff, including HIV Ambassadors played an important role in advocacy and education dissemination, and the inclusion of reluctant groups, including church leaders and their congregation.

The following interventions implemented by MSF played an important role in effectiveness: *Community Health Agents Programme (CHAP)* was effective in getting the community tested and then providing linkage to care (if required); *Philandoda* was effective in bringing health services closer to men, a group who often does not access health services; the *Schools Programme* and *TVET College* were both effective in allowing adolescents, young people and young adults to access services at school/college in a location where they spend most of their time; the *Farms Programme* was effective in bringing services closer to a group of individuals seen as at higher-risk of HIV; *MMC* mobilization was effective in educating and recruiting boys for MMC in a safe and well organized manner; and the *Community Models of Care* were effective in recruiting and encouraging patients to join ART Adherence Clubs and CAGs so that they continue to take responsibility for their treatment. It should be noted that no specific intervention is highlighted as the most significant due to the variety and nature of each of these interventions.

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 importance of support and follow-up, and encouraging patients to go onto treatment while also understanding individuals' situations was observed as being critical across each of the intervention areas.

The project was able to approach population at higher risk of HIV as young boys and girls were reached via the Schools Programme, and those on treatment, via the Community Models of Care (youth adherence clubs). On farms, males especially, but also female farm workers were reached as they reported to being less likely to access services if they were not made available by MSF. Young adults (male and female) were targeted at the TVET College, and men were specifically targeted at the Philandoda clinic. All populations at higher risk of HIV were offered a variety of services, including health education.

In order to make the intervention more effective, the following could have been done: earlier recognition and understanding of the stakeholders that would be directly involved in the project; more comprehensive planning on the structures required to implement the project; earlier considerations

regarding sustainability of the project once MSF has left the project area, as there was a sense of dependency among CBOs who lacked skills and knowledge to continue to implement the activities once MSF leaves; and more robust internal process, especially with documentation and handover to incoming staff members.

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) which are less costly, although door-to-door testing should complement the Luyanda sites every few years, and because healthcare workers or Community Health Agents (CHAs) can be easily trained and are already employed by the DoH; the *M1SS* which brings services to communities from going to schools and visiting high transmission areas (like farms, TVET College, and taxi ranks) is an intervention already adopted by the DoH (via mobile clinics); the Schools Programme as it offers health services to adolescents and young people in a setting where they spend most of their time, and which already has some structure (LO lessons); *Philandoda*, the male wellness clinic, can be established in a location where men can easily access health services, which can be replicated in town or near the taxi rank; organising community mobilisation campaigns around *MMC*, especially because of the link to schools, where it is easier to educate and recruit young male learners; creating *Community Adherence Groups (CAGs)* at the facility level and the clubs system, as well as the delivery of HIV medicines was seen as easily replicated in almost any context; and the *training and mentoring* provided by MSF to healthcare workers can easily be replicated, especially the training on NIMART.

Everything can be replicated, the question of scaling-up is related to sustainability, and the need for continuous resources, which means that for government you can only scale it to a level that you can manage and so a sustainable approach needs to be developed in this vein. MSF implemented these interventions at a scale to saturation, in order to bend the curve. The willingness, coordination, capacitation, supervision, monitoring and troubleshooting approach will determine how much these components can be scaled and the resources that are required.

The MSF intervention in Eshowe has contributed to the South African National Strategic Plan (NSP), as Eshowe was among the first sub-districts to reach the UNAIDS 90-90-90 targets. MSF's work has contributed significantly to the NSP, as it looked at clinical management (including health services) and implemented interventions which had an impact at the community level, which are all issues covered by the NSP. The various interventions highlighted in this report directly complimented, enhanced, or improved many of the NSP goals, therefore MSF was able to achieve what the NSP sets out to target and achieve. 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. MSF was successful in investing in relationships with the following key stakeholders: the **community** as they are the beneficiaries and participants, and they know what challenges they are experiencing and can help achieve results; **traditional leaders** (Amakosi) who need to be engaged from

the start of the project as they are the gatekeepers and have direct access to the local community, which will ensure and strengthen community buy-in; **government structures** should be involved right from the start, by informing them of the programme and/or interventions to be implemented, and receiving their feedback is key to moving forward together; personnel from **districts** and **clinics** as they will help foster joint planning with all partners; **TVET College management** to allow health education and health services to be provided on campus, close to where the students are on a daily basis; **farm owners** who are the main access point to the farm workers, and offer a space for their workers to access much needed health services; and **CSOs** as in many cases these organisations play an essential role in service delivery at community level.

Collaboration with CBOs (SHINE and Child Care South Africa) during the project also provided some lessons. Aspects that worked well with CBOs include ensuring that collaboration is central, as well as having a strong and comprehensive strategy focusing on what you want to achieve, and how you will achieve it. Ensuring local ownership and being able to successfully assist and collaborate with CBOs contributes to local ownership. On the other hand, what did not work well with CBOs was that MSF struggled with adequately creating capacity among CBOs, particularly in governance and financial management. Focusing solely on local partners in Eshowe and Mbongolwane also presented some challenges in implementation, with MSF unable to seek the assistance of other organisations who may have had more knowledge, experience, and capacity.

Other lessons learned included having a strong planning and implementation strategy in place right from the start of the project, which facilitates buy-in from government, health facilities, and the community; MSF's contribution to the development of the South African Adherence Guidelines on HIV, TB and NCDs; conducting operational research as an aspect of the project, and being able to document the work being done, and turning that experience into evidence, which assists key stakeholder (i.e., government) to ensure practical implementation and decision making; and MSF's leadership and teamwork was exemplary, it is crucial to have an enthusiastic team who provide leadership and are supportive of the project.

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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Médecins Sans Frontières

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