STOCKHOLM EVALUATION UNIT

EVALUATION OF

THE AHD PROJECT COMPONENT

HIV PROJECT BEIRA 2018-2021

EXECUTIVE SUMMARY

FEBRUARY 2023
This publication was produced at the request of Médecins Sans Frontières (MSF) – Operational Centre Brussels (OCB) under the management of the Stockholm Evaluation Unit.

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EXECUTIVE SUMMARY

BACKGROUND

Mozambique is one of the most severely affected countries by the HIV pandemic. The Médecins Sans Frontières (MSF) – Operational Centre Brussels (OCB) HIV project in Beira started in 2014 as a project for migrants and key populations (KPs). This led to insights into the magnitude of the Advanced HIV Disease (AHD) issue that needed to be addressed. In 2018, MSF introduced an AHD component in the Beira Central Hospital (BCH) and in two health centres (Munhava and to a lesser extent, Ponta Gea). The AHD component covered MSF-run laboratory diagnostics and in-facility case management circuits. During the evaluation period, Cyclone Idai and COVID-19 restrictions were important external factors.

METHODOLOGY

The evaluation was aimed at assessing the relevance, appropriateness, effectiveness, efficiency, and connectedness (reduced set of Evaluation of Humanitarian Action criteria) of the project over the 2018-2021 period, as well as compiling lessons learnt that could facilitate future AHD projects.

The evaluation included a desktop review, and a visit to all three project sites in Beira. A mixed-method approach was used. Key informant and patient interviews provided mainly qualitative information, while document review and study of MSF patient databases were used to explore quantitative information. From the outset, the evaluation was conducted in participatory manner with MSF Beira managers. An on-site debriefing session was held and later with the Consultative Group.

FINDINGS & CONCLUSIONS

RELEVANCE

The project was highly relevant in meeting the needs of the population of Beira. At that time, there was no similar project in the Sofala Province, while at the Munhava health facility, over 20% of HIV patients tested were diagnosed with AHD.

APPROPRIATENESS

The project was appropriate to quickly address the lack of AHD diagnostics and management in emergency and primary healthcare settings. In later phases of the project, issues such as the future transfer of the case management to the public health facility, post-discharge follow-up and remaining high mortality at the BCH Emergency Room (ER) could have been better addressed.

EFFICIENCY

At the operational level, MSF responded with flexibility to changing needs for human resources and medical supplies. The evaluators found that the projects made good use of resources and staff,

although high turnover of international staff and unexpected supply hurdles during one year which influenced the implementation. The project received the financial resources it identified as needed. The project did not set efficiency criteria or measure value for money.

EFFECTIVENESS

The AHD management service was established as planned in both BCH ER and Munhava, and support was provided to Ponta Gea outside the original scope. Access for the general population was broad and KPs did not seem to have been hindered from accessing the AHD service. Both men and women used the services equally.

The high HIV-related mortality rate in the BCH ER at baseline seems to have been reduced. During the evaluation period, the mortality measured at BCH ER remained stable at 20% of patients with AHD. At Munhava, mortality was not measured and a significant number of patients became Lost-to-Follow-Up (LTFU). Verifiable indicators for patient diagnostic testing were better achieved in BCH than at Munhava.

No mortality study took place. Data were collected, but significant gaps were also noted.

CONNECTEDNESS

The project was created in a relative vacuum, with no other organisations working directly on AHD management. However, over the evaluation period, MSF could have created more connections with partners to work on adherence, post-discharge follow-up or facility circuits.

Towards the end of the evaluation period, the project started to build individual professional competencies of future implementers through the mentoring approach. However, there was a lack of an exit strategy to transfer standards and routines to institutions.

Supporting the Minister of Health (MoH) to draft national AHD guidelines in a country with 1.7 million Antiretroviral (ARV) patients was a major achievement for MSF OCB and MSF Beira, beyond the scope of the targeted results.

LESSONS LEARNED

- An MSF intervention focused on AHD can reduce in-facility mortality related to AHD in a relatively short period of time.
- While the establishment of parallel in-facility circuits focused on AHD and run by MSF resources provides a rapid AHD response, a plan needs to be drafted on how to integrate AHD management into the existing health facility routines at a later stage.
- AHD management needs to be supported by a reliable flow of information on crucial indicators. This includes laboratory information, supply information, and post-discharge mortality information. Internal dashboards and monitoring sheets with reliable, information on crucial indicators make changes over time visible and provide a basis for management decisions.
- The root causes of AHD such as non-adherence to treatment and lost to follow-up should be considered in the overall intervention design, even if they will be eventually addressed by other partners.
- Infection control and antibiotics management should be integrated into the design of facility-based AHD intervention from the outset.
- Early identification of Patients with AHD with CD4 at primary health facilities contributes to reducing AHD costs to the public health system, limiting the need for specialised medical expertise, and reducing AHD mortality.
- MSF's clinical and programmatic AHD experience may position it to provide stronger support to Mozambique and other countries in the implementation of WHO's AHD recommendations and national AHD guidelines.
- Transferring routines, methods, functioning circuits and standards for institutional capacity reinforcement may be just as important as the development of individual skills.
- A handover plan to the future implementer and handover standards needs to be designed early in the project.
- Clear, frequent, and consistent messages are important in advocacy, to be disseminated across all levels of the hierarchy of national stakeholders. Advocacy with key health partners such as PEPFAR or WHO can play a key role in supporting MSF´s work.

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(February 2023)