







AN EVALUATION OF THE AHD PROJECT COMPONENT - HIV PROJECT BEIRA 2018-2021

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BACKGROUND

The MSF-OCB HIV project in Beira started in 2014 as a project for migrants and key populations. This led to insights into the magnitude of the Advanced HIV Disease (AHD) issue that needed to be addressed. In 2018, an AHD component was introduced in the Beira Central Hospital and in two health centres. It covered MSF-run laboratory diagnostics and in-facility case management circuits. This evaluation was aimed at assessing the relevance, appropriateness, effectiveness, efficiency, and connectedness of the project over the 2018-2021 period, as well as compiling lessons learnt that could facilitate future AHD projects.

METHODOLOGY

-  MIXED-METHODS APPROACH
-  DESK REVIEW
-  ROUTINELY COLLECTED MEDICAL
-  INDIVIDUAL INTERVIEWS (58)
-  FOCUS GROUP DISCUSSIONS (9)
-  DIRECT OBSERVATION

LESSONS LEARNED

While the establishment of parallel in-facility circuits focused on AHD provides a rapid response, a plan needs to be drafted on how to integrate AHD management into the existing health facility routines. | **Non-adherence** to treatment and lost to follow-up should be considered in the intervention design. | **Infection control** and antibiotics management should be integrated into the design of AHD intervention from the outset. | **MSF's AHD** experience may position it to provide stronger support to countries in the implementation of WHO's AHD recommendations and national AHD guidelines. | **Transferring routines**, functioning circuits and standards for institutional capacity reinforcement may be 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.

CONCLUSIONS

The project was highly relevant in meeting the needs of the population of Beira.

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, future transfer to the public health facility, post-discharge follow-up and remaining high mortality could have been better addressed.

Access for the general population was broad and KPs did seem not to have been hindered from accessing the AHD service.

The high HIV-related mortality rate in the BCH ER at baseline seems to have been reduced. At Munhava, mortality was not measured, and a significant number of patients became Lost-to-Follow-Up (LTFU).

Data were collected, but significant gaps were also noted.

The projects made good use of resources and staff, although high turnover of international staff and unexpected supply hurdles influenced the implementation.

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

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 was a major achievement for MSF OCB and MSF Beira.