

EVALUATION OF THE

**PMTCT COMPONENT OF
MSF'S HIV PROJECT
IN CONAKRY, GUINEA**

AUGUST 2022

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The views of the authors expressed in this publication do not necessarily reflect the views of Médecins Sans Frontières and the Stockholm Evaluation Unit.

This report was written in French and translated to English. This English version may not reflect all the nuances of the original version.

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral/antiretroviral
DAC	Development Assistance Committee
MSF	Médecins Sans Frontières
MTCT	Mother to Child Transmission
OCB	Operational Center of Brussels
OECD	Organisation for Economic Co-operation and Development
PCR	Polymerase Chain Reaction
PEC	Care provision (<i>prise en charge</i> in French)
PLHIV	People living with HIV (<i>PVVIH</i> in French)
PLNSH	National Programme for the Fight against AIDS and Hepatitis (Plan national de lutte contre le sida et les hépatites)
PMTCT	Prevention of Mother to Child Transmission of HIV
PNC	Prenatal Consultation
SEU	Stockholm Evaluation Unit
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
VIH	Human Immunodeficiency Virus
WHO	World Health Organization

EXECUTIVE SUMMARY

In 2003, the described situation of Human Immunodeficiency Virus (HIV) infection showed devastating effects of the virus on the health of populations around the world, but these effects were not uniformly felt and were often concentrated in places where treatments were least likely to be available. Overall, screening and coverage with antiretroviral (ARV) drugs was extremely low¹. In the same year 2003, UNAIDS declared a "generalized epidemic" of HIV in Guinea. According to the 2005 Guinea Demographic and Health Survey, 1.5% of adults aged 15-49 were infected with HIV, with the regions most affected by HIV infection being Conakry (2.1%), Labé (1.8%), N'Zérékoré (1.7%) and Faranah (1.6%)². In Guinea, lack of access to antiretroviral (ARV) treatment was a major concern at the time, with coverage rates estimating that only 20% of the population living with HIV were receiving ARV treatment³. Until 2018, the challenges remained as great as at the beginning of the epidemic, when of the estimated 120,000 people living with HIV, only one in three (32%) were receiving treatment.⁴

In response to the HIV epidemic in Guinea, Médecins Sans Frontières – Operational Center of Brussels (MSF-OCB) launched an HIV project in Guinea in 2003, in Matam (Conakry) and Guéckédou (Nzérékoré). The overall objective of the HIV project has been from the beginning and continues to be to reduce HIV-related morbidity and mortality rates in Guinea. In the years following its launch, the HIV project disengaged in Guéckédou and increased its reach in the country, establishing a presence in Wanindara, Gbessia, Flamboyants, Tombolia, Coléah, Minière, and Dabompa. In 2011, the Prevention of Mother-to-Child Transmission of HIV (PMTCT) component was introduced as one of the main objectives of the project in the structures supported as part of its decentralization from the main structure of the Matam Communal Medical Center.

In 2020, despite the various challenges observed in Guinea, it should be noted that significant progress had been made in the field of PMTCT where 94% of pregnant HIV-positive women had access to treatment compared to 20% in 2010 at the national level. In the same year, the rate of mother-to-child transmission of HIV (including transmission during breastfeeding) decreased to 16.6%, from 35.9% in 2010. Early diagnosis of infants was improved with a screening rate of 43.2% compared to 5.3% in 2010.⁵

In 2021, MSF commissioned an external evaluation of this project to assess its performance on the PMTCT component. An evaluation of the decentralization component carried out in 2016 had already identified a major bottleneck on PMTCT activities, with a low retention rate of patients (mothers and children) and difficulties in mobilizing financial resources at the national level. The evaluation of the PMTCT component presented in this report used a mixed quantitative and qualitative method with a case study.

¹ <https://apps.who.int/iris/bitstream/handle/10665/42891/924156265X.pdf>

² https://www.dhsprogram.com/pubs/pdf/HF4/Guinea_HIV_factsheet_french.pdf

³ Terms of reference for the evaluation of the PMTCT component of MSF OCB's HIV project in Guinea

⁴ <http://cnls-guineeconakry.org/wp-content/uploads/2019/09/Cadre-Strat%C3%A9gique-National-de-lutte-contre-le-Sida-2018-2022.pdf>

⁵ <https://www.aidsdatahub.org/sites/default/files/resource/unaid-aid-data-book-2021.pdf>

A field mission made it possible to carry out observations in the health structures supported by the project on the PMTCT component and to carry out interviews with key actors and beneficiaries of the project.

MSF's response to the HIV project in general and more specifically to the PMTCT component was relevant and in line with the needs of the country and the population in the fight against HIV. The effectiveness of the project was demonstrated by the number of women treated with PMTCT, the technical platform installed to make available the viral load test, support for the supply of drugs, as well as the reduction of the rate of transmission of HIV from mother to child. Indeed, in the health facilities supported by MSF's HIV project, the rate of mother-to-child transmission of HIV was reduced to a rate of 12% [7 – 12]⁶ between the years 2020 and 2021 compared to the rate of 35.9% in 2010. Although the project's target to reduce this rate to less than 5% was not met at the time of the evaluation, this rate remains lower than the rate of 16.6% observed at the national level in 2020, proving the performance of the sites supported by MSF's HIV project compared to the rest of the health facilities in Guinea. Difficulties in monitoring activities were noted, including reporting, with several missing documents and a Tier.net database that did not allow the encoding of all data relevant to the monitoring of PMTCT activities. This could explain the accuracy rate of the data in this database, which remained at 87% for a target of 95% set by the project. The main bottlenecks identified for the achievement of the project's objectives with regards to PMTCT project include the lack of ownership of laboratory solutions and supply chain management of ARVs and other inputs by the Ministry of Health, causing stock-outs, the delay in screening some women with late screening during breastfeeding, the delay in the implementation of new prophylaxis protocols in exposed newborns (many newborns still benefiting from prophylaxis using a single ARV molecule), and the low retention rate of women in PMTCT.

It was not possible to assess efficiency in all its dimensions, particularly on the financial side because the financial information was not received by the evaluators. It should be mentioned, however, that the time resource does not seem to have been used efficiently: after more than 10 years of intervention on PMTCT, the rate of MTCT could not fall below the 5% target set by the project.

The impact of the project is perceptible both in terms of coverage (number of women who have benefited from PMTCT in MSF-supported sites, compared to all PMTCT sites in the country) and in terms of the feelings of beneficiaries. Indeed, the project has enabled HIV-positive women, beyond obtaining PMTCT care, to feel greater confidence and social inclusion in a country marked by high HIV-related stigma. The technical and economic sustainability of the project seems unlikely as appropriate measures including an exit plan and transfer of responsibility have not been taken. Funding for HIV in general and PMTCT remains largely dependent on Global Fund and the premature withdrawal of MSF funding through PMTCT disengagement could lead to a setback in efforts and progress on PMTCT in Guinea.

The findings of the evaluation allowed the evaluators to make some recommendations for the project in Guinea, and potentially for the PMTCT component more generally. These are presented in detail at the end of the report. For all work on the PMTCT component during the implementation of an HIV project, and with a view to scaling up in other contexts or on larger areas of intervention, MSF should

⁶ The rate of mother-to-child transmission of HIV remained variable between 7 and 12% over the period from 2020 to 2021.

carry out a review of its PMTCT strategy, in particular by appropriately detailing the PMTCT component implemented and ensuring the relevance of the indicators monitored and the quality of the data, which form the basis of any decision.

GENERAL RECOMMENDATION

MSF needs to review its PMTCT strategy to increase its effectiveness and achieve the main objective of the project in this regard, which is to reduce the rate of mother-to-child transmission of HIV to less than 5% at the end of the project. It is therefore necessary to adapt and update the protocols applied in PMTCT according to new knowledge in PMTCT but also taking into account the local context of the area or country of intervention. Action plans for HIV projects should also include an exit strategy developed at the start of the intervention, and with concrete actions and stages of MSF's disengagement. These strategies are to be developed by involving all the actors concerned by the PMTCT theme or any other project component where MSF is considering a transfer of responsibility to another actor. This would not only ensure the commitment and buy-in of the key players in the process, but also identify the actors who could take over in the future, and ensure the sustainability of the results and good practices acquired.

SPECIFIC RECOMMENDATIONS

RECOMMENDATION 1: Improve the management of project data and information through better reporting and archiving. Specifically:

- Create a system for archiving project reports by outcome within the SharePoint platform that is already used by MSF and synchronize these files on the computers of the Project Coordinator, the Medical Coordinator, the Medical Referent of the project, and the Technical Referents of the Headquarters;
- Review the configuration of the Tier.net database to include the possibilities of entering all the data useful for monitoring the project and especially the PMTCT ones;
- Provide ongoing refresher training for Tier.net database users to minimize encoding errors that were identified during the evaluation.

RECOMMENDATION 2: Update the 2021-2025 project roadmap by clearly highlighting PMTCT activities. Specifically:

- Define the PMTCT strategy over the period 2021 – 2025 including the exit strategy / process of a possible transfer of responsibility regarding PMTCT to another actor;
- Present the capitalization aspects of Guinea's different experiences on PMTCT as one of the priorities for the period 2021 – 2025;
- Insert an exit strategy over 2 to 3 years in the roadmap by specifying the ideal profile of the actor who could take over all PMTCT activities after MSF's disengagement (It should ideally be a local actor to strengthen in terms of capacity over time and make the disengagement process gradual by

delegating activities one after the other – it does not seem appropriate to transfer the PMTCT responsibility to an international actor whose PMTCT funding cannot be guaranteed thereafter over time).

RECOMMENDATION 3: Accelerate the decentralization of PMTCT to other structures prior to MSF's disengagement from PMTCT in Guinea. Specifically:

- Keep the monitoring of PMTCT under the responsibility of MSF over the period 2021 – 2025 while preparing its disengagement and transfer to another partner;
- Increase actions that allow the sustainability of PMTCT activities in decentralized structures, in particular by advocating for greater state involvement in PMTCT funding and the participation of funding institutions other than the Global Fund;
- Decentralize PMTCT in structures outside Conakry over the period 2021 – 2025 to increase equity in access to health care.

RECOMMENDATION 4: Strengthen PMTCT action across all four pillars over the transition period, before the transfer of responsibility to another actor. Indeed, it would be wiser to transfer responsibility on a complete package. Specifically:

- Increase HIV testing among women in childbearing age and explore the appropriateness of introducing community-based testing;
- Strengthen family planning activities with the prevention of unwanted pregnancies among HIV-positive women;
- To the extent possible, involve family members of HIV-positive women (if they agree to share status and this does not result in exclusion) in supporting them in their living environment, to increase the retention of women in care, and that of their children if they are infected.

RECOMMENDATION 5: Initiate reflections on updating MSF protocols and on the application of the new recommendations in relation to the period of discharge of children from PMTCT and the prophylaxis regimen to be established. Specifically:

- Ensure that all babies receive PCR at 6 weeks and 9 months and initiate a reflection on how to ensure that PCR is extended outside of MSF programs (or even on optimizing the use of GenXpert);
- Develop specific strategies to improve access to HIV testing and PMTCT care for women who do not have access to antenatal care;
- Strengthen HIV self-testing programs in husbands of women with PMTCT (polygamy being prevalent, this could reduce the risk of transmission among co-wives of women in PMTCT);
- Perform viral load testing for all women on ARVs in the third trimester of pregnancy;

- Integrate pre-exposure prophylaxis (PrEP) into the PMTCT (primary HIV prevention) strategy, particularly among groups of women at high risk of HIV infection (Sero-different couples, sex workers, etc.);
- Accelerate the integration of family planning (contraception / prevention of unwanted pregnancies) among HIV-positive women;
- Review, in conjunction with nutrition experts, the possibility of taking children out at the age of 18 months after a negative rapid test and a negative PCR and consider weaning from breast milk if the woman has the opportunity to feed the child without the risk of incurring malnutrition during this crucial period for the growth of the child (Several children remained in PMTCT with breastfeeding which puts them at risk of transmission from mother to child, yet preventable by getting these children out);
- Accelerate the implementation of protocols for initiating AZT+NVP prophylaxis in all exposed children (not just high-risk children), whether their mothers have entered PMTCT via prenatal consultation or later in the third trimester of pregnancy or upon delivery.
- Adopt a prophylaxis combining AZT+3TC+LPV/r or ABC+3TC+LPV/r for children seen too late, after delivery or at the time of breastfeeding, since these children are then considered at very high risk;
- Establish emergency PCR as soon as possible for adequate decision-making on care in special situations, especially for the children of women who test positive for HIV during breastfeeding;
- For newborns and infants with presumptive clinical signs of HIV infection, promptly initiate triple antiretroviral therapy including Dolutegravir (DTG), which can be initiated from the fourth week of life.

RECOMMENDATION 6: Review the standard OCB indicators on PMTCT as most appear to be indicators to measure the risks of mother-to-child transmission of HIV but much less the performance or changes generated by PMTCT projects. Specifically:

- Revise some indicators to make them more operational, some being adapted to inform the development of PMTCT strategies but less to monitor the PMTCT activities of an HIV project;
- Refer to the four pillars of PMTCT to define the specific activities of PMTCT and thus the indicators to be monitored on the project;
- Adapt the PMTCT indicators of each MSF project according to the package of activities deployed, assuming the expansion of the standard OCB list of indicators but also the removal of less relevant indicators, such as that of children born alive to HIV-positive mothers.⁷

⁷ PMTCT is not aimed at preventing mortality in utero or during childbirth, but at preventing mother-to-child transmission of HIV. This indicator is likely to be tracked on projects when it will not be used to inform the project's PMTCT performance. This is an example here of an indicator to be removed, according to the evaluation team.

1. INTRODUCTION

1.1. GEOGRAPHICAL AND HEALTH CONTEXT OF GUINEA AND THE SITUATION OF HIV INFECTION

Guinea is a West African country covering an area of 245,857 km² with a population of 13.2 million (2022 estimate). Guinea is subdivided into 4 natural regions which are Upper Guinea, Forest Guinea, Middle Guinea, and Lower Guinea. Administratively, it is subdivided into 8 administrative regions, 33 prefectures, and 5 urban communes of the city of Conakry. Population growth was estimated at 2.9% in 2014. The total fertility rate for 2018 is 4.3 children per woman, the crude birth rate is 33.6‰, and the infant mortality rate is 66‰ for the same year. Life expectancy at birth was estimated at 59 years in 2014. With a Human Development Index (HDI, 2017) of 0.459, Guinea is one of the least developed countries in the world (175 out of 189)⁸. A Guinean household comprises, on average, 7.1 people with little variation between urban (7.2) and rural (7.1) environments. On the other hand, there was a significant variation depending on the gender of the head of household: 7.6 for households headed by men and 5.1 for those headed by women⁹. Overall, 19% of households are headed by women. Almost half of the household population (48%) are children under the age of 15. Nearly 7 in 10 women aged 15-49 (69%) have no level of education, compared to 45% of men. Only 4 per cent of women and 11 per cent of men have a higher level of education. Overall, 24 per cent of women and 53 per cent of men are literate. In Guinea, women have their first sexual intercourse 3.9 years earlier than men. The median age at first sexual intercourse is 16.6 years among women aged 25-49, compared with 20.5 years among men aged 25-49. The proportion of women who had their first sexual intercourse before the age of 18 is three times higher (66%) than the proportion of men (22%). Overall, 11% of women aged 15-49 in union use some method of FP—11% use a modern method and less than 1% use a traditional method. The most frequently used methods are the breastfeeding and amenorrhea method (MAMA) (4%), injectables (2%), implants (2%) and the pill (2%)¹⁰. *Women represent 51.6% of Guinea's population (2020 estimates)*.¹¹

In 2003, UNAIDS declared a "generalized epidemic" of HIV in Guinea. During the 2005 Guinea Demographic and Health Survey, 6,836 people were tested for HIV. According to the survey, 1.5% of adults aged 15-49 were infected with HIV. The regions most affected by HIV infection were Conakry (2.1%), Labé (1.8%), N'Zérékoré (1.7%) and Faranah (1.6%). The **prevalence rate among women was 1.9%** compared to 0.9% among men, more than double¹². At the beginning of the epidemic, low testing and lack of access to antiretroviral (ARV) treatment were the major concerns for the HIV response. Today, the challenges remain as great as at the beginning of the epidemic: in 2018, of the 120,000 people living with HIV, only one of four received treatment. People living with HIV in Guinea face strong

⁸ <https://www.stat-guinee.org/>

⁹ https://www.stat-guinee.org/images/Documents/Publications/INS/rapports_enquetes/RGPH3/RGPH3_caracteristiques_des_menages.pdf

¹⁰ <https://www.dhsprogram.com/pubs/pdf/SR262/SR262.pdf>

¹¹ <https://donnees.banquemondiale.org/indicateur/SP.POP.TOTL.FE.ZS?locations=GN>

¹² https://www.dhsprogram.com/pubs/pdf/HF4/Guinea_HIV_factsheet_french.pdf

stigma, additional medical costs and frequent stock-outs of essential medicines. Without treatment, people living with HIV can easily develop AIDS.¹³

Globally, 45% of HIV-infected children are born in West and Central African countries where the effectiveness of programmes for the prevention of mother-to-child transmission (PMTCT) is still limited¹⁴. In general, this region has received little attention in the response to HIV for several years because it is outside the area of high HIV prevalence in Africa (Areas with high prevalence are those with a prevalence above 5%). Based on data from 52 countries, it was noted that antiretroviral (ARV) treatment coverage among adults, pregnant women and children was significantly lower in low-prevalence countries, while half of all people living with HIV (PLHIV) live in these countries. In **2015, PMTCT coverage in Guinea was 83%, placing Guinea in second place after Togo out of 20 countries in West and Central Africa**. The average PMTCT coverage for the entire region is 42%.¹⁵

With a high level of poverty, weak infrastructure and an unstable political regime, the country has for decades faced complex public health challenges, such as Ebola outbreaks, which have compounded pre-existing difficulties in providing quality basic care to patients in need of medical treatment and assistance.

1.2. DESCRIPTION OF MSF HIV PROJECT IN GUINEA

MSF-OCB took the decision to launch an HIV project in Guinea at the beginning of the epidemic in 2003, in Matam (Conakry) and Guéckédou (Nzérékoré), focusing on the prevention and treatment of HIV and HIV/TB co-infection. In the years that followed, the HIV project increased its reach in the country, establishing a presence in Wanindara, Gbessia, Flamboyants, Tombolia, Coleah, Minière, Dabompa, and Matam.

The overall objective of the HIV project has been from the beginning and continues to be to reduce HIV-related morbidity and mortality rates in Guinea and its project activities revolve around four areas:

1. **Quality and free integrated care** in MSF supported facilities;
2. Implementation of a comprehensive package of **psycho-social support** in the structures supported by MSF;
3. **Advocacy** and **activism** to improve patient care;
4. Support to the National Program for the Fight against AIDS and Hepatitis (PNLSH) in the **quantification of drugs** as part of the improvement of the supply chain.

The project supports eight centers in Conakry in 2022: Matam, Gbessia, Flamboyants, Wanindara, Tombolia, Colèah, Minière, and Dabompa. MSF-OCB supports these centres in terms of strengthening the clinical skills of staff involved in the provision of care (prise en charge, PEC) of People living with HIV (PLHIV) and TB, the supply of medicines and other medical consumables, logistical and financial support including the granting of performance bonuses, data management (data collection and

¹³ Treating AIDS in Guinea. (2018). Retrieved 15 March 2022, from <https://msfaccess.org/treating-aids-guinea>

¹⁴ Joint United Nations Programme on HIV/AIDS. UNAIDS Data 2017.

¹⁵ https://www.msf.org/sites/msf.org/files/2016_04_hiv_report_fr.pdf

analysis, monitoring and evaluation of HIV/TB activities) and infection prevention and control (environmental health).

In 2011, prevention of mother-to-child transmission (PMTCT) activities were added to the HIV project's portfolio of activities in Gbessia and Flamboyants, in addition to the Matam Communal Medical Centre (CMC), the largest structure supported. PMTCT remains a key component of MSF's HIV project in the country. At the beginning of 2022, the PMTCT component was implemented in all the structures supported by the MSF HIV project.

Between 2012 and 2017, the number of PMTCT sites in Guinea increased from 89 to 394 functional sites showing the guinean Government's attention to PMTCT. Despite this attention, some PMTCT sites remained non-operational in 2017 (14% of sites in the city of Conakry, 53% of sites in Kankan and 44% of sites in Nzérékoré).¹⁶

It is worth recalling the four pillars of PMTCT in order to understand the intervention of the project on the different pillars. These pillars are:¹⁷

Pillar 1: *Primary prevention* consisting of the prevention of new HIV infections among women of reproductive age; This prevention is based on HIV-related testing and counselling, the involvement of men in the process leading to structural and behavioural changes.

Pillar 2: *Preventing unwanted pregnancies for women living with HIV* through the integration of family planning services into HIV services.

Pillar 3: *PMTCT itself* consists of the prevention of vertical transmission of HIV and includes access to high-quality prophylactic regimens, integration of services and strengthening of links and referrals between services, support for improved retention in care (psychosocial and community support).

Pillar 4: *The care of women in the family environment* consisting of providing appropriate support, care and treatment to HIV+ mothers, their children and their families. This includes providing care and follow-up to HIV-exposed infants, including support for appropriate infant feeding.

The specific activities deployed on the PMTCT component by MSF's HIV project in Guinea are:

- HIV testing for pregnant women, women in labour and breastfeeding women;
- Provision of ARV and prophylactic treatment for HIV-positive mothers;
- Monitoring and provision of prophylactic treatment to newborns of HIV+ mothers;
- HIV testing in babies (virological PCR test: 6 weeks and 9 months) and infants (serological RDT, 18 to 24 months);
- Placing HIV-positive children on ARVs and following up the cohort.

¹⁶ <http://cnls-guineeconakry.org/wp-content/uploads/2019/09/Cadre-Strat%C3%A9gique-National-de-lutte-contre-le-Sida-2018-2022.pdf>

¹⁷ https://www.pedaids.org/wp-content/uploads/2017/11/PMTCT2015FR_Oct3.pdf

Table1. Summary of the main moments of the project's history¹⁸

YEAR	EVENT
2003	Opening of the HIV project at CMC Matam (Conakry) and Guéckedou
2007	Beginning of decentralization (Wanidara, Bernay Fotoba, FMG, Madina and Koulewondy)
2011	Beginning of PMTCT activities and support for Gbéssia and Flamboyants. Closure Guéckedou
2012	1st round table. Project end foreseen in 2017
2014	Ebola epidemic. Start R6M
2015	Beginning support to CMC Coléah, CMC Minière and CdS Tombolia
2016	Beginning of USFR Donka hospitalization support and community screening
2017	Beginning of support for the hospitalization of the CMC Matam and the horizontalization of the CTA
2018	2nd round table. Project end foreseen 2020. Start support to CS Dabompa and performance-based evaluation system
2020	Opening of the first PODI. Implementation of palliative care, nutrition and antibiotic resistance at USFR Donka. Beginning of support for cervical cancer and FP screening.
2021	3rd round table and development of the roadmap 2021-2025: focus on 4 pillars (tuberculosis, pediatrics, advanced HIV and sexual and reproductive health) Opening of the second PODI.

1.3. EVALUATION CONTEXT, OBJECTIVES, AND SCOPE

1.3.1. EVALUATION CONTEXT

Nineteen years after the start of the MSF-OCB HIV project in Guinea and ten years after the introduction of PMTCT activities on the project, MSF OCB wanted to carry out an evaluation of the PMTCT component. It was a formative evaluation with the aim of highlighting the challenges, the lessons learned from the implementation of the project, the results obtained, and their sustainability on the PMTCT component, while orienting the analysis towards a perspective of transferring

¹⁸ Source: Roadmap HIV/TB Conakry Project 2021-2025

responsibility to another actor at the time of MSF's disengagement. Indeed, MSF's wish to identify a partner to take over the PMTCT component was clearly expressed in the terms of reference of the evaluation. This evaluation should bring its conclusions on the practical modalities of this transfer or its relevance in the current context of the fight against HIV in Guinea and according to the specificities of the MSF-OCB HIV project.

MSF OCB in a document entitled "The Price of Oblivion" published in 2016 exposes the problem of HIV care in West and Central Africa, ranging from the inadequacy of testing services to the lack of ARV drugs. This evaluation of the PMTCT component carried out in Guinea is therefore part of a broader perspective to use lessons learned in order to capitalize on experiences throughout the West and Central Africa region. The results of the evaluation will therefore be used for MSF's institutional learning and will strengthen its accountability in Guinea and throughout the region on the PMTCT component of HIV care.

1.3.2. EVALUATION OBJECTIVE

The objective of the evaluation of the PMTCT component of the project is to:

- Contribute to MSF's internal discussions on improving the PMTCT component of the HIV project in Guinea;
- Contribute to internal and external discussions on programmatic approaches to PMTCT in the context of West and Central Africa but also in a broader context (organizational interest and need for capitalization);
- Identify weaknesses and strengths, then list recommendations to improve MSF's intervention on PMTCT.

1.3.3. EVALUATION SCOPE

1.3.3.1. Evaluation Coverage

The evaluation covered the 6 OECD DAC criteria of the evaluation which are ¹⁹**relevance, coherence, effectiveness, efficiency, impact, and sustainability**. Over time, the evaluation covered the period from 2011 to the first quarter of 2022.

The 8 health structures supported by MSF in the framework of PMTCT in Conakry were all included (Matam, Wanindara, Gbessia, Flamboyants, Tombolia, Coleah, Minière, and Dabompa) as well as the other actors and partners working on PMTCT (PNLSH, CNLS, UNAIDS, Jhpiego, DREAM, Solthis, etc.). Beneficiaries (patients, representatives of patient associations, and caregivers) were also taken into account in order to assess the impact of the project as perceived by the beneficiaries of the PMTCT component.

¹⁹ Development Assistance Committee, organisation for Co-operation and Development in Europe (OECD)

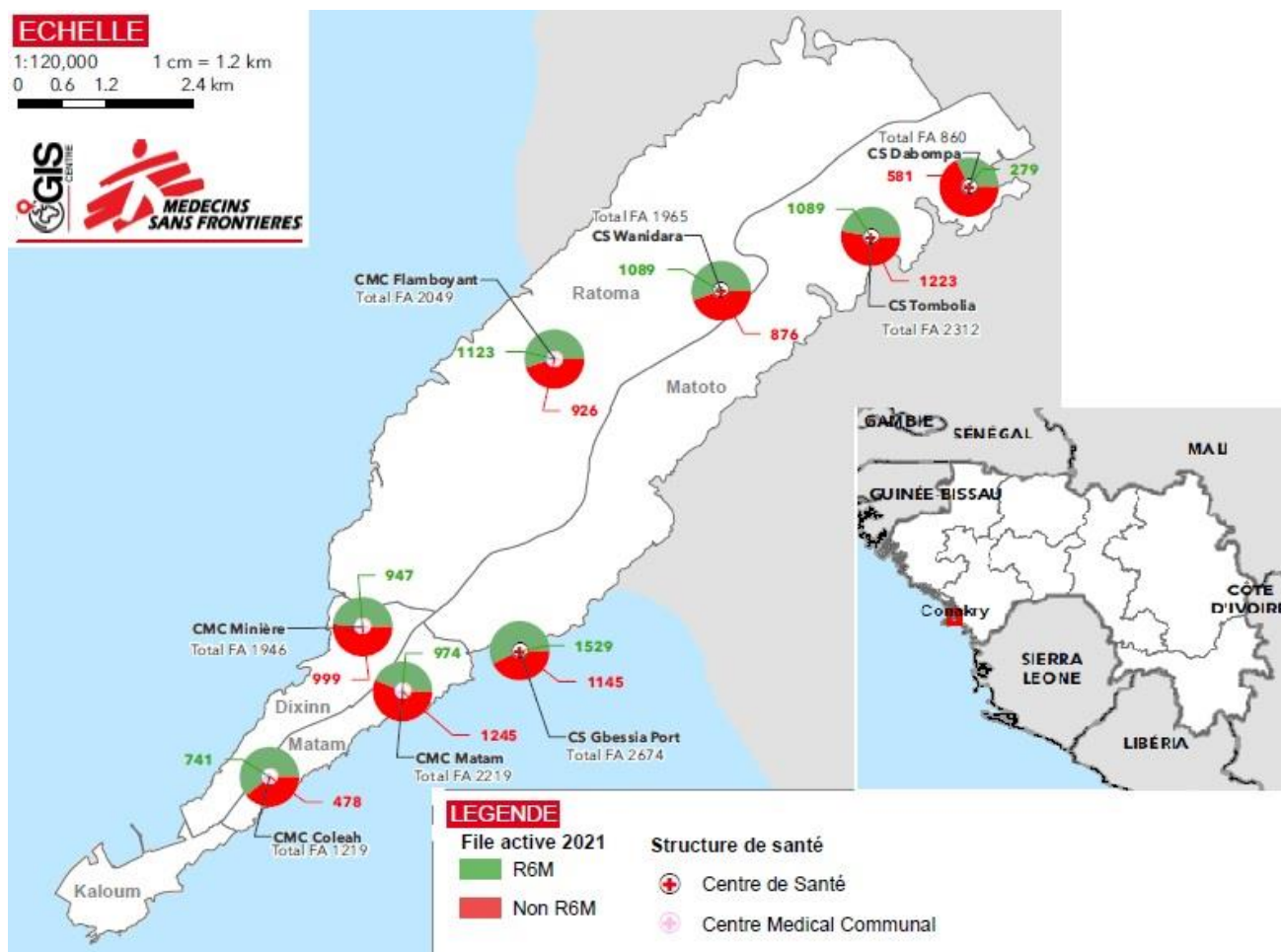


Figure 1. Map of MSF's HIV project intervention areas in Conakry and the structures covered by the evaluation²⁰

1.3.3.2. Priority areas assessed

The terms of reference of the evaluation specify the expectations of MSF on this evaluation. Initial interviews with members of the consultation group and other key stakeholders for the project provided clarification on the key areas that were explored during this evaluation.

It is specifically a question of analyzing:

- MSF's intervention strategy on the 4 pillars of PMTCT in Guinea (**What does MSF do and how on the following 4 pillars?**) :
 - ✓ *Primary HIV prevention among women of childbearing age;*
 - ✓ *Prevention of unwanted pregnancies for HIV+ women;*
 - ✓ *Prevention of HIV transmission from women living with HIV to their children*
 - ✓ *Provision of appropriate treatment, care and support to mothers living with HIV, their children and their families.*

²⁰ Project document (general layout of the card modified for inclusion in this report)

- The overall success of the HIV project in Guinea (PMTCT Component) on the following components (**Which activities were developed by MSF and what are the results**):
 - ✓ *Support to maternity wards for the screening of pregnant women (in first Pre Natal Consultation -PNC - or at childbirth);*
 - ✓ *Support to maternity wards for the implementation of NVP/AZT prophylaxis in children exposed to HIV;*
 - ✓ *Early detection (6 to 10 weeks) and rapid testing (18 to 24 months) for children exposed to HIV;*
 - ✓ *Initiation of ARV treatment for children tested HIV-positive;*
 - ✓ *Strengthening retention in care for women initiated in PMTCT option B+.*

- Bottlenecks identified during the project evaluation in 2016 (**What response did MSF provide?**) :
 - ✓ *Work done to reduce long waiting times for test results from external laboratories;*
 - ✓ *Work to increase the retention rate of patients (mothers and children) who are HIV-positive.*

- Good PMTCT practices in the HIV project in Guinea and the possibility of capitalizing on them in a broader context covering West and Central Africa (**What worked, what didn't, and how to leverage lessons learned to improve practices in the project and other projects?**) ;

- The possibilities of transferring the project to a partner in 2 to 4 years (**What is the process of this transfer?**) :
 - ✓ *To what type of partner the PMTCT component could be transmitted (local or international partner) and what would be the stakes of this transfer;*
 - ✓ *What plan could MSF put in place to transfer skills and ensure sustainability after transfer?*

- Other cross-cutting activities that do not fall directly under the PMTCT umbrella:
 - ✓ *Organization and performance of psychosocial care in general;*
 - ✓ *Organization and performance of laboratory activities (screening test, viral load examination, etc.) and pharmacy (dispensing of ARV drugs).*

1.4. CONCEPTUAL MODEL OF THE EVALUATION

1.4.1. DEFINITION OF THE CONCEPTUAL MODEL OF THE EVALUATION

The following conceptual model guided the entire evaluation process. It highlights and develops the evaluation priorities and put them in relation to the different criteria evaluated through the evaluation questions.

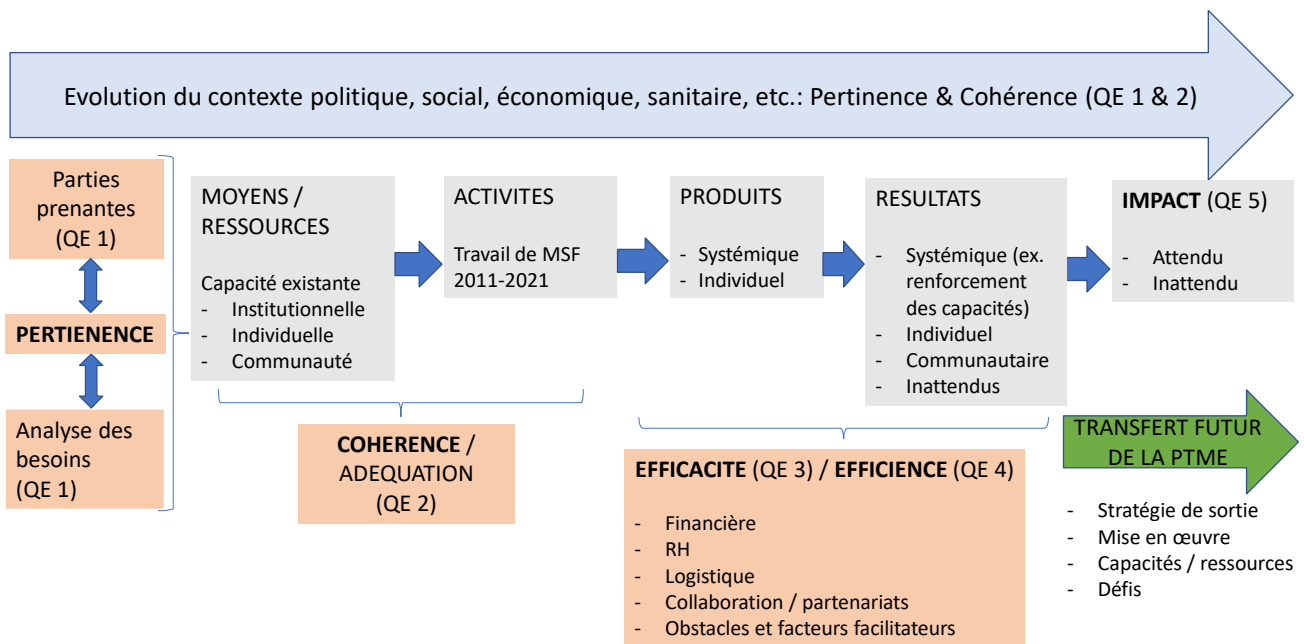


Figure 2. Conceptual model for the evaluation of the PMTCT component of the MSF HIV project in Guinea

The figure above is a simplified logic model that links the five evaluation questions (EQ 1 - EQ 5). It begins with a needs assessment (EQ 1) and a stakeholders' assessment that leads to certain inputs and MSF activities (2011 - 2022) that are needs-based and context-appropriate (EQ 2). These activities result in outputs and outcomes that are achieved effectively (EQ 3) and efficiently (EQ 4). The longer-term impacts (EQ 5) are also assessed, as well as the proposed transfer to another actor for the continuation of the project on its PMTCT component.

1.4.2. EXPLANATION OF EVALUATION CRITERIA AND CORRESPONDING QUESTIONS

The objective of the evaluation was to address the following key evaluation questions presented in the Terms of Reference, according to the evaluation criteria defined in the following table.

Table2. Evaluation criteria with their definitions

EVALUATION CRITERIA	CORRESPONDING EVALUATION QUESTION	DEFINITION OF THE EVALUATION CRITERION
Relevance	Is the PMTCT component of the HIV project aligned with the priorities and needs of stakeholders?	Extent to which objectives are aligned with beneficiaries' expectations, country needs, overall priorities, and partner and donor policies. Note: In retrospect, the question of relevance often involves whether the objectives of the action or its design are still appropriate in light of the changing context.

EVALUATION CRITERIA	CORRESPONDING EVALUATION QUESTION	DEFINITION OF THE EVALUATION CRITERION
Coherence	Is the PMTCT component well designed to meet the priorities and needs of stakeholders?	<p>Extent to which the intervention is consistent with other interventions within a country, sector or institution.</p> <p>Note: The criterion seeks to examine how other interventions (particularly policies) support or weaken the evaluated intervention, and vice versa.</p>
Effectiveness	Is the PMTCT component achieving the predefined objectives and expected results?	<p>Extent to which the objectives and outcomes of the intervention have been or are in the process of being achieved, including differentiated outcomes across populations.</p> <p>Note: Effectiveness analysis involves taking into account the relative importance of objectives or results.</p>
Efficiency	To what extent are resources (HR, financial, etc.) well used to implement the PMTCT component of the HIV project?	<p>Extent to which the intervention is producing, or is likely to produce, results in an economical and timely manner.</p> <p>Note: The term "economical" refers to the conversion of inputs (funds, expertise, natural resources, time, etc.) into outputs, outputs and impacts in the most economically advantageous way possible, compared to the options available in the context. The term "timely" refers to meeting deadlines or deadlines reasonably adapted to the requirements of the changing context. This may include assessing operational efficiency (the extent to which the response has been well managed).</p>
Impact	What is the impact of the PMTCT component on stakeholders (patients, Ministry of Health midwives receiving peer support, community, etc.)?	<p>Extent to which the intervention has produced, or is expected to produce, significant and far-reaching effects, positive or negative, intentional or not.</p> <p>Note: The impact criterion focuses on the ultimate importance and potentially transformative effects of the intervention. It aims to determine what its social, environmental and economic effects are in the longer term or on a larger scale than those already assessed under the effectiveness criterion.</p>

The evaluation matrix (Appendix 1) elaborates the evaluation questions in more detail.

2. EVALUATION METHODOLOGY

2.1. METHODOLOGY

A case study approach was used and allowed for an in-depth exploration of the PMTCT component in the project, including understanding the questions of how and why. This has been particularly applied to the analysis of data from the Tier.net database.

Case studies have been successfully used in evaluations of health programmes, including in developing countries, and have shown their effectiveness in the processes that have led to the results achieved.²¹

Mixed methods for data collection and analysis were preferred to cover all aspects related to a PMTCT intervention. Indeed, mixed methods have demonstrated added value in the analysis of health interventions that include important social aspects.²²

2.2. SOURCE OF INFORMATION

Data were collected from five sources below:

- a) **Document review** – a document library has been created and contains the various documents shared by MSF and other general documents useful for the evaluation collected by the evaluators. These include project documents: concept note, logical framework, project reports (annual reports), etc.
- b) **Key informant interviews** – a list of key informants was developed by mutual agreement between the Evaluation Focal Point and the evaluation team (project team members, care providers, state and civil society institutional partners/NGOs/patient associations, women living with HIV beneficiaries of the project). A snowball approach was used by adding additional stakeholders as the evaluators went along, until the theoretical saturation of the information was obtained. Interviews were conducted face-to-face in the field in Conakry and remotely via Skype/Zoom/Teams as appropriate. A total of 40 individual interviews were conducted.
- c) **Focus group discussions** with patients and some key informants of project coordination. Eight (8) group discussions were organized with patients, staff of supported health facilities, and MSF teams in Conakry with 4 to 6 participants depending on the availability of respondents.
- d) **Observation during field visits** – an evaluator conducted field visits to supported structures or partners for observation and key informant interviews in Conakry.

²¹ Crowe, S., Cresswell, K., Robertson, A., Huby, G., Avery, A., & Sheikh, A. (2011). The case study approach. *BMC medical research methodology*, 11(1), 1-9.

²² Tashakkori, A., Johnson, R. B., & Teddlie, C. (2020). *Foundations of mixed methods research: Integrating quantitative and qualitative approaches in the social and behavioral sciences*. Sage publications.

- e) **Secondary data encoded** in the database Tier.net – from the primary data collected by the project team members in the health facilities. This secondary data was cross-referenced with data from operational monitoring tools for project indicators (monitoring sheets).

2.3. DATA COLLECTION TOOLS

To guide data collection and explore in depth the different areas/axes of the evaluation, *an evaluation matrix* was developed by the evaluators (Appendix 1). This matrix includes the evaluative questions as formulated in the TOR of the evaluation, supplemented by the proposals of the evaluation team around the main questions mentioned in the terms of reference and included in Tableau 2 of this report under section 1.4.2 "Explanation of the evaluation criteria and corresponding questions". To conduct interviews and focus groups, *an interview guide* has been developed for this purpose (Appendix 2). Interviews were not recorded and no images were taken.

2.4. DATA ANALYSIS

2.4.1. THEMATIC CODING

The data collected were coded by theme to allow for categorization and analysis to draw substantial conclusions. Encoding was performed for the following categories of data:

- Project management data, strategy, and intervention system ;
- Data on medical activities related to PMTCT in health facilities supported in Conakry.

2.4.2. TRIANGULATION & ANALYSE COMPARATIVE

Data were analysed by **triangulation and benchmarking**. To ensure internal validity, triangulation and comparison was made between methodologies (qualitative and quantitative), data collection tools (document review, key informant interviews, care services/PMTCT data – psychosocial support, and field observations) and stakeholder groups/types (project coordination, implementing partners, beneficiaries, other PMTCT stakeholders in the area of intervention, etc.). It should be noted, however, that the triangulation of the data suffered from a lack of documents shared with the evaluators because the majority of the requested documents were not obtained, or too late.

Quantitative data were subjected to frequency analysis, including for the number of women in PMTCT care, the number of infants who received prophylactic treatment according to established protocols, the rate of mother-to-child transmission of HIV, etc. These analyses were then compared with the data reported in the project's operational monitoring tools (Monitool).

2.5. ETHICAL CONSIDERATIONS

The evaluators committed to fully comply with MSF's ethical guidelines, including the SEU guidelines at this level, and to inform the accompanying SEU Evaluation manager as soon as a conflict of interest or non-compliance issue arises. No such situations were identified during the evaluation process. Despite the precautions taken by the evaluation team, it should nevertheless be noted that direct contact between the evaluators and the different respondents, including patients, could be considered

as prejudice to their freedom of participation or lead to selection bias by choosing respondents who will not provide enough information or quality information. This is a lesson learned that will be used to improve future evaluations.

2.5.1. EQUITABLE REPRESENTATION AND RESPECT FOR DIGNITY AND DIVERSITY

To provide broad inclusion of various groups, the evaluators contacted different stakeholder groups. The evaluators sought to interview in a balanced way the different MSF staff members (by profile, experience, geographical location, position) and representatives (both at the operational level and at the coordination/managerial level) of all the health structures partners of the project on the PMTCT component. A random sample of patients (HIV+ women) to be interviewed was selected and representatives of the patient associations that are partners of the project were met at a meeting of the REGAP+ association.

2.5.2. TRANSPARENCY

All evaluation findings were supported by credible evidence and the evaluation team conducted a regular peer-to-peer review of its work to guard against unintentional personal bias and possible misinterpretation. Quality control was carried out through daily points between the lead evaluator and the evaluator who carried out the field visits and any difficulties encountered were escalated to the SEU and the Evaluation Consultation Group to find an appropriate solution.

2.5.3. CONFIDENTIALITY AND DAMAGE PREVENTION

The names of the patients are not mentioned in the evaluation documents and, as a rule, the sources of information remain all anonymous. All information collected is considered confidential and shared only with MSF, unless otherwise specified by MSF. The information collected will not be used for any purpose other than the evaluation itself. The evaluators avoided any politically or culturally sensitive interview content.

Young women under the age of 18 living with HIV (minors) were not included as respondents in the assessment for confidentiality reasons. Indeed, in Guinea, the sharing of HIV status is not common due to a high stigma related to HIV and interviewing a woman under the age of 18 would require the consent of an adult guardian who is not always informed of her HIV-positive status, which could harm the woman by unintentional disclosure of her HIV+ status.

2.6. EVALUATION CHALLENGES AND LIMITATIONS

In general, there were no major difficulties in conducting the evaluation with the exception of obtaining certain key project documents. It should be noted here that several reports were missing and that no financial data of the project was shared with the evaluators for them to assess the efficiency on the PMTCT component, despite several reminders from the evaluation team.

The limitations of the evaluation are as follows:

1. **Recall bias** - Interviews with informants are sensitive to the degree of memory retention. Some respondents may remember specific events in more detail than others. In addition, the staff changes frequently and not everyone could be contacted or wanted to participate in the

interviews. This can lead to potential knowledge gaps, but this has been mitigated by triangulation with other lines of evidence (other respondents, published documents, etc.).

2. **Data quality and/or insufficiency** - Quantitative data (Database Tier.net and Monitoring sheets) depend on the quality of the primary data since their production, correct input, and proper processing. Indeed, several shortcomings were noted at the level of the databases (discordant data, absence of certain data, etc.) and at the level of the interpretation of the analyses. Discussions with project management identified some causes, some of which may be related to human error when entering data, and others to the design of the database tier.net which is not adapted to integrate all the data useful to monitor the project, especially on the PMTCT component. Thus, some essential data such as the number of children put on AZT/3TC/NVP triple therapy cannot be extracted from the database because the design of the database does not allow their encoding. This is an important limitation in terms of appropriateness and use of the database. It should be noted that these data are essential in the quantification of drug needs and that a loss of data could be the cause of inadequate quantifications (underestimation of needs for example) and cause stock-outs. The absence or non-access of evaluators to some key data over part of the 2011-2021/22 period covered by the evaluation, with off-peak periods without any data analyzable by the evaluation team, especially for the first years of PMTCT implementation, did not allow an analysis of the evolution of PMTCT in general and its performance over the entire period. There is indeed a major problem of completeness of the project data, in particular related to a change of databases.²³
3. **Possibilities for generalizing the results of the evaluation:** - The results of this evaluation, particularly regarding the quality of the databases, can be generalized to the entire HIV project in Guinea and to other MSF projects in other countries using the same database. However, the findings concerning the State's commitment to the financing of PMTCT, the possibilities of transferring responsibility from PMTCT to another actor, or the strategy and process of decentralization are context dependent and cannot be extended or duplicated as such to other countries, particularly in West and Central Africa. A multi-country evaluation (meta-evaluation) of MSF's projects with a PMTCT component would be needed to better explore the possibilities of capitalising on the different experiences on PMTCT or to carry out a scoping review of PMTCT implementation in the region before any extension or duplication of MSF's actions.

²³ A paediatric fixed-dose combination of AZT/3TC/NVP has some advantages from a postnatal prophylaxis perspective as it is widely available and well established and is a form that is suitable for the child : <https://apps.who.int/iris/bitstream/handle/10665/329296/WHO-CDS-HIV-18.17-fre.pdf?ua=1>

3. EVALUATION FINDINGS

The evaluation findings presented by evaluation criterion of the OECD Development Assistance Committee (DAC) in this report are the result of a participatory process between the evaluation team and the Consultation Group, and especially the HIV project team in Guinea which has gradually taken ownership of the evaluation, in particular by making some corrections to the data in the database Tier.net in real time before the end of the evaluation process.²⁴

3.1. RELEVANCE

The relevance analysis answers the following evaluation question:

- **QE 1: Is the PMTCT component of the HIV project aligned with the priorities and needs of stakeholders?**

3.1.1. SYNTHESIS OF KEY FINDINGS ON RELEVANCE

3.1.1.1. Pre-intervention needs assessment

In 2003, based on monitoring data, UNAIDS declared the HIV epidemic in Guinea widespread. Based on this data, MSF launched an HIV response intervention in Guinea the same year. This shows MSF's responsiveness to responding to a need for health care during a far-reaching humanitarian or health crisis.

A situational analysis was reportedly conducted prior to enrolling PMTCT structures in 2011 but the evaluators did not have access to the analysis report. MSF is currently working in 8 so-called priority sites (all located in Conakry) in Guinea, among the 66 priority sites as defined by the PNLISH. According to the information gathered during interviews, this priority would be set on the basis of the size of the active queue of patients (large cohort site) and the technical and reception capacities more or less advanced compared to other sites. Most of the priority sites with a PMTCT package have become so through MSF's support in terms of capacity building and by decentralizing CMC services from Matam (objective to relieve congestion in Matam). Indeed, there is the question of the progress of the decentralization of quality care in PMTCT in rural prefectures to the extent that some patients make trips to Conakry in search of quality HIV care and especially to test the viral load. It should be noted that health facilities in the interior of the country are also experiencing a human resources crisis because most caregivers prefer to focus on Conakry.

A reassessment of needs by MSF at the time of the start of PMTCT (including also the analysis of needs in terms of human resources, material, etc.) as well as before considering the transfer of responsibility to another actor would help to better respond to the particularities of the context and increase equity for universal health coverage.

²⁴ <https://www.oecd.org/fr/cad/evaluation/criteres-cad-evaluation.htm>

3.1.1.2. Addressing a significant need for an unprepared health system in 2003

MSF has been one of the first partners to respond to the HIV epidemic since 2003. The PMTCT component introduced in 2011 is relevant as the epidemic saw a prevalence of 2.1% for women compared to 1.4% for the general adult population (15-49 years) and 1.2% for men.²⁵

The intervention was focused on areas with higher prevalence in Guinea with the start of the HIV project in Nzérékoré and then in Conakry, which had prevalences of 1.7% and 2.1% respectively. Guinea's health system, which is already struggling to meet people's needs, was further weakened by the 2014-2015 Ebola epidemic, which made it even more difficult for people living with HIV to access health services. This has resulted in decreased utilization and availability of HIV care facilities, reduced HIV testing, and decreased adherence or retention of patients in care²⁶. Meanwhile, Médecins Sans Frontières (MSF) was implementing a half-yearly appointment spacing approach, locally adapted as the Six Month Appointment (R6M), with the aim of improving retention in care. The proportion of people remaining in care after 18 months and beyond was 90% in the R6M group. However, no data could show how this approach could have been adapted to pregnant women with PMTCT in a specific way during the Ebola outbreak.²⁷ The need for regular monitoring of women with PMTCT, particularly for prenatal consultations and vaccines indicated during pregnancy, does not allow the deployment of the R6M strategy for **pregnant women** with PMTCT. Nevertheless, for women in post-natal follow-up or during breastfeeding, appointment spacing strategies modelled on the vaccination schedule could be considered to match the child's vaccination visits with the mother's follow-up visits for her HIV infection.

In Guinea, in general, and beyond the sites supported by MSF, screening for Syphilis in pregnant women remains very low, at around 21.4% with a positivity rate of 6.6%. This shows the importance of stepping up MSF's efforts on PMTCT by systematically integrating syphilis testing into the PMTCT package with the already available Duosyphilis test (HIV and Syphilis screening).²⁸

In general, the HIV project has therefore provided support for the reorganization of care for HIV patients, especially by ensuring continuity of care in particular contexts such as Ebola where the health system was overwhelmed with a reduction in services and the mobilization of caregivers on the fight against Ebola.

3.1.1.3. Project contribution to the response to the HIV epidemic and the reduction of MTCT

Since the beginning of the HIV epidemic in Guinea, difficulties in accessing testing and low coverage of ARV treatment have been the major problems encountered. The package of free HIV care is limited, including the treatment of opportunistic infections that remains largely paid for, outside the structures

²⁵ <https://dhsprogram.com/pubs/pdf/FR280/FR280.pdf>

²⁶ Ndawinz, J. D., Cissé, M., Diallo, M. S., Sidibé, C. T., & D'Ortenzio, E. (2015). Prevention of HIV spread during the Ebola outbreak in Guinea. *The Lancet*, 385(9976), 1393.

²⁷ Bekolo, C. E., Diallo, A., Philips, M., Yuma, J. D., Di Stefano, L., Drèze, S., & Tiomtore, O. W. (2017). Six-monthly appointment spacing for clinical visits as a model for retention in HIV Care in Conakry-Guinea: a cohort study. *BMC Infectious Diseases*, 17(1), 1-10.

²⁸ https://www.unaids.org/sites/default/files/country/documents/GIN_2020_countryreport.pdf

supported by MSF which continues to offer care with a complete free package. MSF's support helped increase PMTCT coverage with intervention in 8 priority HIV care sites in Conakry.

The evaluation demonstrated recognition of MSF by national and international actors and partners in Guinea as a key partner at the forefront of the care of people living with HIV in Guinea, and more specifically on the PMTCT component. This recognition is linked to MSF's intervention in the following areas:

- Support on the screening and follow-up of pregnant women with psychosocial support;
- Organization of the Paediatric HIV PEC;
- Supply of ARV and IO drugs;
- Intervention in the continuous training of nursing staff;
- Technical support to the Ministry of Health, particularly in the development of normative documents and various patient care guides/protocols;
- Reinforcement of technical platforms for carrying out laboratory examinations (CD4, Viral load, PCR screening, etc.) with equipment and supply of inputs;
- Payment of incentives to HIV care staff, such as performance bonus.

3.1.2. ANALYSIS AND CONCLUSION ON THE RELEVANCE OF THE PMTCT PROJECT COMPONENT

Mother-to-child transmission of HIV is a major cause of childhood AIDS in Africa. Its prevention requires in the first place to encourage future mothers to be tested, but it also requires that screening tests are made available and accessible. The mother's treatment then aims to prevent HIV infection in the child and organize his follow-up after birth. In the absence of adequate care services, more than half of infected children die before the age of 2 and only 10% reach that age²⁹. In the absence of treatment, the combined risk of MTCT/HIV in utero and intrapartum is 15-30% and this risk is increased in breast-fed children by 20-45%. Antiretroviral therapy applied to an HIV-positive woman in early pregnancy can significantly reduce the risk of mother-to-child transmission of infection and can contribute to reducing the rate of HIV transmission. The number of infected children per year continued to increase until 2002, when it reached its peak of about 590,000. In 2010, it was 350,000 according to WHO estimates.³⁰

With a female-dominated epidemic and the challenges of accessing testing and treatment in Guinea at the beginning of the HIV epidemic and long after, the introduction of the PMTCT component to MSF's HIV project in Guinea was relevant. While progress has been made in the area of PMTCT with a reduction of mother-to-child transmission (MTCT) to 16% in Guinea, there is still work to be done to

²⁹ http://www.sfls.aei.fr/userfiles/Prise_en_charge_globale_du_VIH_Guide_formation_paramedical.pdf

³⁰ Soubeiga, S. T., Compaore, R., Djigma, F., Zagre, N., Assengone, E., Traore, L., & Simpore, J. (2015). Evaluation of antiretroviral treatment in HIV-1 positive pregnant women, on mother-to-child transmission of infection: case of the Saint Camille Medical Center in Ouagadougou, Burkina Faso. *The Pan African Medical Journal*, 20.

achieve the reduction (<7% in 2019) and elimination (<5% in 2023) targets of Guinea's national MTCT elimination plan. In PMTCT sites supported by MSF's HIV project, MTCT in 2021 was at 12% for a target of reducing this transmission to less than 5%, which justifies the relevance of maintaining the PMTCT intervention in Guinea. Nevertheless, it should be remembered that the 2021-2025 project roadmap does not specifically mention PMTCT actions as a priority component and even less catch-up actions to achieve the main objective of PMTCT on the project.

The weakness of the system to meet all the needs of the fight against HIV, a weakness aggravated by the Ebola epidemic in 2014 and the Covid-19 pandemic since 2020, proves the need to invest in strengthening the health system with a project catalyst for change on PMTCT. Indeed, the HIV project has not developed a theory of change specific to the PMTCT component.

3.2. COHERENCE

The analysis on coherence answers the following evaluation question:

EQ 2: Is the PMTCT component well designed to meet the priorities and needs of stakeholders?

3.2.1. SYNTHESIS OF KEY FINDINGS ON COHERENCE

3.2.1.1. Intervention on a national HIV priority

Guinea has developed a national plan for the elimination of mother-to-child transmission and has identified PMTCT as a priority in the fight against HIV. This plan set the following PMTCT objectives:³¹

- Reduce the TMTC to 7% in 2019 (Reduction target);
- Reduce the TMTC to 5% by 2023 (Elimination target).

This is consistent with MSF's target on the PMTCT component of the HIV project with a target for reducing TMTC in children exposed to HIV set at less than 5%, indicating MSF's alignment with national priorities.

It should therefore be noted that reducing TMTC in MSF sites to less than 5% before 2023 could demonstrate the importance and effectiveness of the approaches deployed. The effectiveness section of this report examines the contribution of the MSF project to the achievement of national targets for progress towards the elimination of TMTC in 2021 in MSF-supported sites .

3.2.1.2. Adaptation of the project to the changing context and needs

With the increase in the number of PLHIV in general and those on ARV treatment in Guinea, MSF has gradually expanded its activities and strengthened its action over the years, particularly with the renovation of health facilities and the training of staff.

The project has gradually adjusted its strategy on PMTCT in particular with the update of treatment protocols (Integration of dual AZT/NVP therapy for prophylaxis in children at risk of HIV TMTC) but this

³¹ https://www.unaids.org/sites/default/files/country/documents/GIN_2020_countryreport.pdf

update was late in 2020-2021 with many infants having continued to receive a single molecule in prophylaxis (i.e. AZT or NVP).³²

For the implementation of PMTCT activities funded by the Global Fund, the NGO Jhpiego was selected as a sub-recipient, adding another key player on the PMTCT component in Guinea. This NGO carries out activities in MSF-supported sites but only on the infection prevention support components (non-duplication). The evaluation did not note a framework for harmonizing practices between the different stakeholders on PMTCT and some actors interviewed believe that although MSF's work on PMTCT is significant, MSF does not sufficiently involve other actors in decision-making and often deploys its own protocols without always consulting with other actors.

It should be noted that with the presence of other actors and funding from the Global Fund, MSF has begun a gradual withdrawal/disengagement of support on the supply of front-line ARV drugs and in managing access to viral load tests. Indeed, viral load reagents on open platforms (OPP) and closed platforms (Abbott) will now be purchased with funding from the Global Fund and the State. It should be noted, however, that the Global Fund pays only 40% of the amount budgeted for PMTCT (and HIV) and that the remaining 60% is to be covered by the national side, which is not always able to meet its commitments.

The MSF project's halt to the payment of front-line ARVs and its disengagement therefore risks jeopardising the progress made. The NGO Jhpiego is dependent on funding from the Global Fund as a sub-recipient (the PNLSH is the main recipient), therefore unable to compensate alone for the 60% without contribution from the State or other actors including MSF.

With the difficulties faced by the health system, aggravated by the weight of the Covid-19 pandemic, it seems that it was premature to transfer responsibility to other actors, particularly on the supply management of the HIV viral load test. It should be noted that at the time of the evaluation, interviews reported several blood samples awaiting viral load testing for approximately 7 months due to a stock-out in inputs. However, patients at MSF sites continue to benefit from viral load testing for advanced HIV and PMTCT cases on GeneXpert devices. This is indeed an experience that can be capitalized at the level of Guinea by optimizing the use of GeneXpert devices available in hospitals. There are geneXpert devices in all prefectural hospitals in Guinea, purchased as part of the fight against Ebola in 2014-2015 and others purchased for the diagnosis of tuberculosis, which would allow a decentralization of HIV viral load examination. The decentralization of viral load testing (on GeneXpert and other platforms) could contribute to improving the follow-up of women with PMTCT, which can be used as an objective marker of the adherence of these women, predictive of the risk of transmission of HIV from mother to child (it is accepted that with a viral load <1000 copies of virus/ml of blood, the risk of HIV transmission tends to disappear). Access to PCR would also help with HIV diagnosis for babies exposed at 6 weeks and 9 months. It remains important to clarify that we must not advocate only for the use of GeneXpert but rather the different platforms. In terms of efficacy, several studies confirm the effectiveness of both platforms and that quantitative and qualitative tests on GeneXpert are also promising tools for monitoring treatment effectiveness in HIV patients on treatment and for early diagnosis of HIV-exposed infants. GeneXpert devices are true bedside diagnostic tools that do not require sophisticated

³² AZT : Zidovudine ; NVP : Névirapine

laboratory infrastructure, expensive reagents or qualified personnel to provide test results and they eliminate the logistical challenge of transporting samples to central laboratories.³³

With the decentralization of PMTCT, according to the evaluation made in 2016, there is a difference in the quality of comprehensive HIV care between the Matam CMC (larger structure) and the decentralized structures. Indeed, at that time, psychosocial support was more reinforced in Matam than in peripheral structures and access to ARVs, medicines and examinations also showed differences between these structures. It should be noted that a work on harmonization of quality has been carried out since this evaluation to take into account the specificities of peripheral structures, in particular with the establishment of psychosocial counsellors in the other structures (in addition to Matam). PMTCT needs have also been met by setting up a PMTCT package in decentralised structures. Indeed, the quality of care in decentralized structures should be close(r) to that established in Matam, as far as possible.

The project roadmap for the period 2021-2025 does not sufficiently and clearly integrate MSF's strategic direction on PMTCT during this period, suggesting that reflections on a possible transfer of responsibility to another actor would have taken over. However, even considering this transfer, it remains relevant and important to highlight the modalities of this transfer in the roadmap as well as MSF's positioning in relation to PMTCT thereafter.

3.2.2. ANALYSIS AND CONCLUSION ON PROJECT COHERENCE

The objectives of the PMTCT project were consistent with the objectives of Guinea's National Plan for the Elimination of Mother-to-Child Transmission of HIV. The project has gradually adjusted its strategy on PMTCT, notably with the updating of treatment protocols despite the delay in the application of these new protocols with many infants who have continued to receive a single molecule in prophylaxis.

3.3. EFFECTIVENESS

The effectiveness analysis on the PMTCT component sought to answer the following evaluation question:

- **EQ 3: Does the PMTCT component achieve the predefined objectives and expected results?**

3.3.1. SUMMARY OF KEY FINDINGS

3.3.1.1. Screening women

The first 90%³⁴ was achieved for pregnant women. Field visits noted a proposal for HIV testing during the first PNC, during childbirth, but also during visits to vaccination and nutrition units. It should be noted, however, that this data is reported only for women screened in prenatal consultation or during childbirth. The indicator does not take into account the number of women screened during breastfeeding while the PMTCT guidelines recommend testing women until the end of breastfeeding.

³³ Ceffa, S., Luhanga, R., Andreotti, M., Brambilla, D., Erba, F., Jere, H., ... & Marazzi, M. C. (2016). Comparison of the Cepheid GeneXpert and Abbott M2000 HIV-1 real time molecular assays for monitoring HIV-1 viral load and detecting HIV-1 infection. *Journal of virological methods*, 229, 35-39.

³⁴ From the 90-90-90 strategy in relation to PMTCT: 90% of women living with HIV are screened and know their status – 90% of women screened are put on ARV treatment – 90% of HIV-positive women on ARVs have an undetectable viral load.

It should be noted that PNC coverage is low in Guinea (67% in 2017), which means that 1/3 of women not screened during pregnancy are not counted. The performance assessed by this indicator therefore involves an interpretation bias because it does not take into account the entire cohort of women eligible for screening under PMTCT.

Indeed, this is an aspect of PMTCT to be reinforced with repeated screening until the end of the breastfeeding period. It is known that in the event of primary infection (first contact with the virus), the HIV viral load increases rapidly and thus the risk of mother-to-child transmission of HIV is very high. The proportion of breastfeeding women who received a screening test did not appear in the project reports because this data is not tracked in a specific way in the project.

3.3.1.2. Follow-up of HIV+ women

More than 1,000 HIV-positive pregnant women were followed in PMTCT in MSF-supported sites out of 6,000 followed in PMTCT for all of Guinea in 2020, and thus benefited from the PMTCT component, demonstrating the contribution of these structures to the management of PMTCT.

Services provided to women in addition to HIV testing include:

- **ARV treatment for all pregnant and/or lactating women tested for HIV+.** A stock of ARVs was made available to midwives to allow this immediate initiation of treatment and a daily inventory was carried out;
- **Screening for tuberculosis,** with preventive treatment with isoniazid if the screening is negative for a period of 6 months;
- **Viral load examination for all pregnant HIV+ women** and newly diagnosed women (including breastfeeding women);
- **Psychosocial support** for newly diagnosed and late patients and follow-up consultations;
- **Offer of family planning services** including implants and intrauterine devices, etc. provided by the Ministry of Health. It is a specific pillar of the PMTCT with very few women reported having benefited from this service (20 women).

It should be noted that screening for cervical cancer for HIV+ women as well as for syphilis is not systematic in the health facilities visited. As these activities were not included in the project as PMTCT activities, although they do not fall directly under the PMTCT umbrella, it appears that little attention has been paid to them (these activities are not tracked or reported). However, the role of sexually transmitted infections in mother-to-child transmission of HIV is well known, with an increased risk in case of maternal genital lesions.

3.3.1.3. PEC of children exposed to HIV

Based on the data available on the project, 2371 exposed children were followed in MSF-supported health facilities in Conakry from 2016 to 2021.

Reports on the application of the PMTCT cascade over the period 2018 to 2021 show that only children exposed during pregnancy (women who entered PMTCT through PNC) and childbirth (women who

entered PMTCT at childbirth) were tested. Testing for children exposed during breastfeeding did not start until 2020 (see Figure 3 on the next page).

The percentage of HIV-positive infants is very high, between 12% and 7% respectively in the first and second quarters of 2021. It should be noted, however, that these are mostly children whose mothers were enrolled late in PMTCT (parturient and breastfeeding) and not the general population of HIV-positive women (those who started PMTCT in PNC). It is important to note that it is not possible to conclude with certainty on the quality of PMTCT care although the factors of poor performance of PMTCT indicators can be multiple, some depending on causes that the project can not control. While an overall performance level of 92% is reported for health structures supported in the project indicator monitoring tool (Monitool), failure to meet the PMTCT target may also raise questions about the reliability of this performance. Improved data monitoring by detailing testing trends in children followed in PMTCT, with mothers who enrolled late with negative tests would allow a better appreciation of the quality of follow-up for this group of women.

The following graph shows the variability of mother to child transmission rate in MSF-supported centres according to the period of entry into PMTCT. It confirms the need to strengthen PMTCT actions during the pregnancy period and in particular to increase HIV testing in pregnant women, in order to minimize the risk of late entry into PMTCT (which increases the risk of transmission from mother to child).

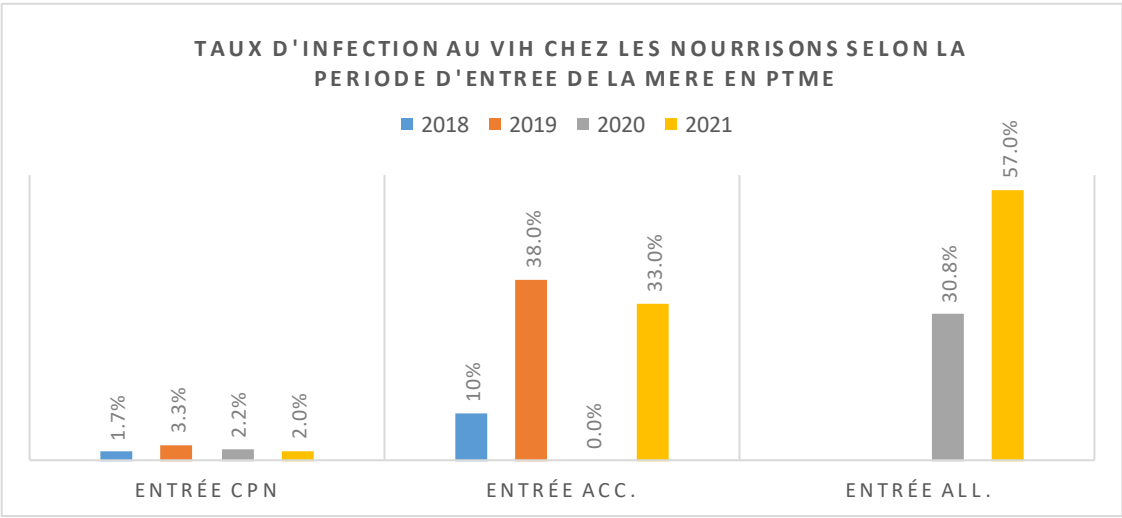


Figure 3. Hiv infection rates among infants according to time of entry into PMTCT of the mother (CPN = PNC, Entrée Acc = childbirth, Entrée All = breastfeeding) – structures supported by MSF

The graph shows that the infection rate is higher among children born to HIV-positive mothers who entered PMTCT during breastfeeding (30.8% in 2020 and 57% in 2021) or during childbirth (33% in 2021). The infection rate in children born to women who entered PMTCT during PNC remained low, between 1.7% and 2% over the period from 2018 to 2021. Nevertheless, no data provided details regarding which trimester of pregnancy women entered PMTCT via PNC. This data is important for the project to confirm the importance of achieving PNC early in pregnancy (in the first trimester of pregnancy) and could serve as an advocacy or awareness-raising tool on the value of an early first PNC

for PMTCT. Thus, the high rates of infected children among women who enter PMTCT late confirm the value of early HIV detection in all women of childbearing age (first pillar of PMTCT).

Exposed children are tested according to an MSF protocol established for PCR and rapid HIV testing. Follow-up is carried out for children up to 24 months of life. An important question arises here about the benefit of breastfeeding after 18 months in relation to the risk of HIV transmission through breastfeeding when a child follows a mixed diet (breastfeeding plus other foods). The period of the first 1000 days of a child's life known as the first window of opportunity in nutrition should be discussed in the specific case of PMTCT, with the initiation of nutritional support for mothers wishing to stop breastfeeding at 18 months after a negative screening test (18 months corresponding to the age at which the child's HIV antibodies are distinguished from those of the mother). The databases and the various reports produced by the project do not make it possible to know the number of children who would have been infected after 18 months of life due to the continuation of breastfeeding. This reflection should lead to the revision of PMTCT protocols in consultation with nutrition experts. Some countries stop PMTCT at 18 months to rule out the risk of HIV transmission through breast milk after that age. When alternative feeding is acceptable, feasible, affordable, sustainable and safe, it is recommended that HIV-positive mothers give up breastfeeding.³⁵

It remains important to support the revision of MSF protocols applied by recalling that the risk of transmission is 5 to 10% during pregnancy, 10 to 20% during childbirth, 5 to 10% during the first 6 months of breastfeeding and **10 to 15% when the breastfeeding period is extended to 24 months**³⁶. Although this risk decreases with the treatment of the mother, it remains a residual risk, especially considering the low retention rate of women observed in PMTCT. It is important to adopt strategies adapted to the context of the project and therefore to potentially review the content of the protocols developed by MSF. International guidelines and standard operating procedures are indeed generic tools for guiding interventions, but MSF develops more operational internal protocols that must be adapted and updated according to the context and changing needs.

There has been an update of the national protocols for PMTCT with the introduction of AZT+NVP-based prophylaxis validated in 2019, with a rather late implementation that started in 2021 in MSF's HIV project, according to interviews. Indeed, MSF recommends this combination for high-risk children (children of mothers who entered PMTCT late at the time of delivery or at the time of breastfeeding). Nevertheless, extractions from the Tier.net database show that, of all the children followed, 563 benefited from dual therapy, including 199 put on AZT and NVP between 2017 and 2020, before the validation of this approach. If these children were in the category of high-risk children, it means they benefited from an anticipation of the strategy in the project, but then the question arises of the follow-up of recommendations or protocols in some cases. It is also not possible, without analyzing the specific records of each child, to know if they have benefited from AZT and NVP at the same time or if molecules were received at different times, especially in the context of a change of drug because of side effect (such as anemia in the specific case of AZT) or contraindication (contraindicated

³⁵ <https://www.unhcr.org/fr/4b9f9f315.pdf>

³⁶ Soubeiga, S. T., Compaore, R., Djigma, F., Zagre, N., Assengone, E., Traore, L., ... & Simpore, J. (2015). Evaluation of treatment antiretroviral in HIV-1 positive pregnant women, on the transmission of HIV-1 infection Mother à the child: the case of the Centre Medical Saint Camille of Ouagadougou, Burkina Faso. *The Pan African Medical Journal*, 20.

combinations with other treatments). The conclusion of the evaluation on this subject is therefore to be taken with reservation but should allow the project management to initiate further reflections in the continuation of the project intervention, in particular with regards to the exploitation of data from PMTCT care.³⁷

The rate of prophylaxis in infants was at 80% for the year 2020 but the indicator was not followed for 2021. However, we should talk about the rate of initiation of prophylaxis because this data is nuanced by a very low retention rate in children from 0 to 4 years (38% in the first and second trimester of 2021 in Monitool). Initiation of prophylaxis and retention in care (especially for prophylaxis excluding retention for children confirmed positive for HIV) should be monitored and supported together as they are complementary for reducing the risk of MTCT.

The low retention rate, although not detailing retention in prophylaxis care for infants and children discharged on treatment (infected children), could explain the rate of MTCT remaining above the targets pursued by the project and the national plan for the elimination of MTCT in Guinea.

Positive points were noted regarding the organization of the initiation of prophylaxis in infants. It involves the initiation of a treatment regimen based on ABC+3TC+LPV/r immediately after confirmation of infection in children, and the supply of HIV+ mothers with NVP/AZT syrup for their future babies from the eighth month of pregnancy, in order to minimize the risk of late initiation of prophylaxis.

3.3.1.4. Inputs & medicines

The project has contributed to the supply of first- and second-line medicines since 2003. In 2016, a decision was taken to phase out the supply of front-line medicines over three years. Since 2019, MSF has withdrawn from the supply of front-line medicines, but due to national supply difficulties on the side of the Ministry of Health, MSF keeps a buffer stock that is loaned at times to supplement national stocks in case of stock-outs. Observation in the health facilities visited revealed the following positive points:

- Availability of HIV and Syphilis testing inputs;
- Availability of ARVs (Atripla, AZT Sp; AZT/3TC cp; NVP sp and ABC+3TC+LPV/r) and drugs for the treatment of opportunistic infections;³⁸
- Availability of inputs for family planning;
- Realization of a regular inventory of drugs and other inputs within the structures.

It should be noted, however, that the evaluators did not have access to MSF's supply chain report in order to assess the supply of ARVs for PMTCT and cross-reference them with data from observation and interviews with stakeholders encountered.

³⁷ <https://samumsf.org/sites/default/files/2021-05/PTME%202020%20%281%29.pdf>

³⁸ ABC: Abacavir; 3TC: Lamivudine; LPV: Lopinavir ; r: ritonavir

In the first quarter of 2022, the rate of testing women for HIV was 98%. Nevertheless, it should also be noted that there was a break in screening inputs and Cotrimoxazole syrup (essential in the prevention and treatment of many opportunistic infections) for three weeks in February 2022.

The quarterly indicator on the percentage of ARVs stock-outs at the time of monthly inventories carried out in health facilities shows break rates between 10% and 16% in the first and second quarters of 2021 for a target set at less than 5%. This shows a dysfunction of the supply chain and this could be further accentuated with MSF's disengagement from the supply of front-line ARVs and delay the achievement of the target of less than 5% TME. The Central Pharmacy of Guinea does not always manage to satisfy ARV orders from sites, and satisfaction rates remain low (55% in the first quarter of 2021 and 42% in the second quarter of the same year). This led to an increase of the project's forecast for orders by around 48% in the first quarter of 2021 and 29% in the second quarter of the same year, while the maximum threshold should not exceed 20% of the forecasts.

3.3.1.5. Laboratory

All the centres where the MSF-supported PMTCT sites are located have a laboratory and some tests such as the CD4 test, the pregnancy test, the TB lam, the CrAg test, and the urine strip test are carried out on site. Other examinations such as biochemistry, PCR test, and viral load are carried out at MSF's laboratory located at CMC Matam. To transport the samples to the MSF laboratory from the treatment sites, a sample transport circuit was set up using two motorcycles for the nearest sites and a vehicle for the most remote sites.

The performance of the operation of the production circuit was assessed by the fact that in the majority of cases the results of the various examinations are made available within 24 to 48 hours.

It should be noted that outside the sites supported by the MSF project, the performance of the viral load examination remains limited with little access to this examination for patients, because it is not yet decentralized throughout Guinea (concentrated in Conakry). The problem of stock-outs of viral load inputs in non-MSF laboratories as well as the difficulties of transporting samples to the national laboratory are other limiting factors (hence the establishment by MSF of its own sample transport circuit for patients followed in the structures it supports). This leads to the conclusion that MSF's disengagement would be premature and that efforts should focus on strengthening local capacities in stock management and supplies of inputs, and even medicines, for the next four years of the 2021-2025 roadmap of MSF's HIV project in Guinea. With regard to capacity-building, at the Guinean level, at least three laboratory technicians have been authorized to carry out the viral load examination as part of a project led by the NGO Solthis. The latter are then responsible for training other laboratory technicians to carry out the viral load.

3.3.1.6. Psychosocial support for HIV+ women in PMTCT and community participation

Psychosocial support activities that are integrated into patient care go through HIV speaking groups in the PNC waiting room for women and also address the value of testing and adherence to ARV treatment. Individual interviews are conducted as part of the pre- and post-screening test and the evaluation noted the availability of image box-type awareness materials.

It should be noted that the psychosocial support system and community participation are based on several other activities aimed at making patients actors in their care pathway. The evaluation noted the following activities:

- Initiation of associations of people living with HIV (training in association management, material and financial support, etc.);
- Initiation of therapeutic education groups;
- Installation of PODI (Community ARV Distribution Point – Important step in the decentralization of ARV processing);
- Initiation of R6M/R3M (Appointment spacing at 6 months or 3 months) as part of differentiated patient care (One of the target themes of the Global Fund currently);
- Set up expert patients with uncovered face testimonials.

Despite a strong involvement of psychosocial counsellors who are mostly also people living with HIV, the rate of long-term retention of children in care remains low, at 38% (last data of 2020). The question then arises of the follow-up of HIV-positive women in their living environment and support for their families (4th pillar of PMTCT). Given the importance of HIV-related stigma in Guinea and the frequent non-sharing of HIV status among spouses, the future of the follow-up of infected children released from PMTCT remains a concern. The project should be able to better prepare children for PMTCT discharge, link their follow-up with the one of the mother and, where possible, rely on psychosocial counsellors to relaunch home visits to encourage adherence and retention in care. The new components around testing partners, PrEP and Sexual and Reproductive Health.

3.3.1.7. Achievement of PMTCT indicators in logical framework

Several indicators have been defined for the HIV project, but few have been defined to measure PMTCT interventions. For Q1 and Q2 2021, the last data that the evaluators could have, only two indicators of the monitoring sheet were specific to PMTCT:

- Percentage of pregnant women presenting to PNC or childbirth know their status;
- Percentage of exposed children who tested positive for HIV.

This meant that the rates of testing women during breastfeeding, the incidence of opportunistic infections in women with PMTCT and their children, or the retention rate for women in PMTCT were not monitored. Nevertheless, a database with information on specific PMTCT indicators for the first quarter of 2022 is available but cannot be used for this evaluation as it does not allow this information to be tracked over time (in previous years).

The main objective of reducing the MTCT below 5% was not achieved with the transmission rate remaining at between 7 and 12% (Q1, Q2 2021, the latest figures available to evaluators). The intermediate indicator on the rate of pregnant women knowing their status was achieved at more than 99% for women seen in PNC or at the time of delivery, which means that women in contact with health facilities were the main beneficiaries of treatment.

No indicators in Monitool show the screening rate of women at the time of breastfeeding and the evaluators question the reason for the absence of this key moment of mother-to-child transmission of HIV in the definition of indicators. Several other PMTCT indicators that could facilitate the assessment of project performance on this component have not been established. These include women's retention rate or women's adherence to PMTCT. It should be noted, however, that the documentation made available to the evaluators was not representative of the data available and monitored by the project, and that the multiple monitoring tools make a coherent overall analysis difficult.

The indicator on psychosocial support mentions only the percentage of people who initiated treatment and had a psychosocial interview. It should be possible to note whether the person had continuous support and not only an interview at the initiation of treatment.

Support for access to family planning for HIV-positive women was only introduced in 2020 with low results (about 20 women), while the prevention of unwanted pregnancies among HIV-positive women is a pillar of PMTCT. The initiation of pre-exposure prophylaxis (PrEP) for sero-discordant couples does not yet appear to have been introduced as part of PMTCT.

The overall retention rate of people on ARVs in 2020, the last year for which the evaluators received information on the indicator, was less than 50% after subtracting deaths and transfers.

TB prevention data are not systematically reported for the PMTCT group although site visits have objectified the initiation of isoniazid preventive treatment in women who have tested negative for TB.

The data accuracy rate reported in the Monitool for the Tier.net base, in the second quarter of 2021 is 87% for a minimum threshold of 95%. With this threshold the acceptable margin of error is therefore 5%.

The indicators show inexplicable differences in the transmission rate from one year to the next, for example 2.5% transmission rate in 2015 compared to 12% in 2019 while with the improvement of PMTCT services and the extension of ARV coverage among women this rate would be expected to remain low. Given those discrepancies, it would be necessary to consider more in-depth analysis to understand these dynamics on the basis of epidemiological exploration or even socio-behavioral studies in women with PMTCT. The cross-referencing of these rates with those of women's retention in PMTCT or more specifically adherence to treatment could also serve to answer several hypotheses to try to explain these data.

The evaluation found several errors in the material provided from Tier.net database. The main errors found in the database are:

- a. Children discharged from PMTCT with unknown result from last screening test (16 in total)

Managerial response of the project team: The last two columns of the extraction of the Tier.net database are confusing because they only concern the results of the PCR test while the last test performed to confirm the HIV seronegativity of the child after stopping breastfeeding is the rapid test at 18 or 24 months. The Tier.Net PMTCT module does not allow the encoding of the results of the rapid tests but only of the PCR. The BDD has been cleaned up with the deletion of the last two columns.

It should also be noted that the Tier.net database extracts provided to the evaluators do not enable to check which type of test is used to confirm HIV status before exit of infants from PMTCT, as this data was not included.

- b. Follow-up marked as finished for some children without PCR results and discharged before 18 months

Managerial response of the project team: The change of version of Tier.net causes data loss. Indeed, after verification code by code, we find that there is a difference between the individual data and the exported data. We reported the problem to the UAS team and corrections were made to the database.

- c. Children without conclusions about outcome (follow-up result – HIV positive or negative)

Managerial response of the project team: The outcomes were not up to date. All children without 'outcome' are followed in the PMTCT program. (See updated database).

- d. HIV MTCT rate calculated by evaluators, different from that of the Monitool project

Managerial response of the project team: In the reports the calculation takes into account not only the children of mothers who have followed PMTCT (therefore encoded in Tier.net) but also children of mothers who have not followed PMTCT: breastfeeding (children are already born and infected so will not be encoded as exposed but rather as patient).

- e. Typing errors probably, especially on the age of children and women with sometimes 80-year-old women in PMTCT and children born before the start of PMTCT activities on the project

Managerial response of the project team: These are encoding errors because the PMTCT module of Tier.Net is very recent (encoding began in 2018) and we had encoded only active women.

- f. Errors on entering the age of pregnancy in some women with either months or weeks of amenorrhea

Managerial response of the project team: This is indeed a small encoding error where some record the age of pregnancy in weeks of amenorrhea and others in months.

The evaluation enabled the project team to make some corrections to the database but there is still work to be done on the configuration of the database to improve monitoring, in particular by integrating features in order to allow for additional data entries, according to the indicators that the project wishes to monitor.

Positive was the responsiveness of the project team to the evaluators' comments on data quality and their commitment to improve monitoring.

3.3.1.8. Use of the OCB PMTCT standard indicators in the project's logical framework and Monitool

None of the PMTCT indicators proposed in the standard OCB list of indicators (see Table 5 below) were monitored by the project. The monitoring indicators were also different from year to year as illustrated by extracts from monitoring tables presented below. Some indicators were suddenly changed between the years 2020 and 2021. Similarly, some results have changed so much during this period that the

validity of the data may be questioned. The evaluators did not receive any reports or tables of indicators for the period prior to 2015. In 2015, four PMTCT indicators were tracked. For the period 2016-2018, seven PMTCT indicators were monitored. For 2019, the evaluators did not receive any information. In 2020, there were ten PMTCT indicators. Finally for 2021, there are only three PMTCT indicators in the Monitool for Q1 and Q2. Q3 and Q4 2021 indicator data were not obtained by the evaluators who were hence not able to complete the analysis for the full year 2021. The best year in terms of monitoring PMTCT indicators was 2020, where monitool also tracks data on PrEP³⁹, family planning, and retention of children and women. The viral load achieved in women with PMTCT was unfortunately not included as an indicator for PMTCT.

The monitoring sheets (Monitools) presented here show the various changes that have taken place in the monitoring of project indicators over the years.

Table 3. PMTCT Indicators 2016 (Q3 & Q4)

No	PMTCT Indicators	T3	T4	Evaluation Team Comments
1	> 90% of pregnant women with PNC1 are tested for HIV	94%	95%	<i>Screened and know their status? See in 2020, the indicators are better defined (women who know their status and that's how the UNAIDS 3x90 are defined).</i>
2	> 50% of pregnant women presenting for childbirth are tested for HIV (median) ⁴⁰	27%	35%	
3	> 95% of women who test positive for PNC1 are initiated into ARVs	97%	91%	
4	> 95% of exposed children received NVP/AZT prophylaxis	96%	100%	
5	> 95% of exposed children did PCR between 6-10 weeks of life	90%	91%	<i>(vs 8 weeks in 2019-2020)</i>
6	> 90% of exposed children did a rapid test at 18-24 months	75%	86%	<i>(vs 24 months in 2019-2020)</i>
7	< 5% of exposed children born to mothers who have undergone PMTCT are infected with HIV	2,5%	3,9%	

Table 4. PMTCT Indicators 2017 and 2018

No	PMTCT Indicators	2017	2018	Evaluation Team Comments
1	> 90% of pregnant women with PNC1 are tested for HIV	98%	98%	
2	> 75% of pregnant women presenting for childbirth are tested for HIV (median)	89%	86%	
3	> 90% of women who test positive for PNC1 are initiated into ARVs within 7 days of screening	97%	97%	
4	> 95% of exposed children received NVP/AZT prophylaxis	100%	100%	

³⁹ Pre-exposure prophylaxis (prevention) of HIV transmission within a sero-discordant couple, through the use of treatment taken in preparation for a situation of exposure to the risk of contamination (unprotected sex with a known HIV-positive partner)

⁴⁰ screened and know their status? See in 2020, the indicators are better defined (women who know their status and that's how the UNAIDS 3x90 are defined).

No	PMTCT Indicators	2017	2018	Evaluation Team Comments
5	> 95% of exposed children did PCR between 6-10 weeks of life	91%	87%	(vs 8 weeks in 2019-2020)
6	> 90% of exposed children did a rapid test at 18-24 months	78%	70%	(vs 24 months in 2019-2020)
7	< 5% of exposed children followed are tested positive for HIV	12%	5,4%	

Table 5. PMTCT Indicators 2019 & 2020

No	PMTCT Indicators	2019	2020	Evaluation Team Comments
1	> 90% of pregnant women with PNC1 know their HIV status	No data	99,30 %	<i>indicators are better defined than in previous years (women who know their status) in line with the UNAIDS 3x90.</i>
2	> 95% of pregnant women presenting for childbirth know their HIV status	No data	99,34 %	
3	> 90% of pmTCT women in the cohort are in the active queue	No data	70,08%	
4	> 95% of exposed children received prophylaxis	No data	89,35%	
5	>95% of exposed children had a virological test at 8 weeks	No data	91,21%	<i>vs previous years 6 to 10 weeks. No progression to a PCR test at birth (conditional but not systematic).⁴¹</i>
6	> 90% of exposed children had a serological test at 24 months	No data	83,69%	<i>vs 18-24 months in 2017 and 2018. What may have prompted this change? Hence one of the recommendations of the evaluation to review this protocol and do the rapid test at 18 months⁴²</i>
7	< 5% of all exposed children followed are tested positive for HIV	No data	6,11%	
8	>5 partners per month did the oral self-test	No data	4,83	<i>Irrelevant indicator. If it is a positive partner the test cannot be offered. In addition, absolute value does not show the performance of the project on this self-test activity. It would be rather interesting to track "Percentage of partners who have performed an oral self-test within known sero-discordant couples"</i>

⁴¹ Systematic testing according to standard recommendations (6/8 weeks, 9 months) and conditional testing in special situations (at birth for children born to mothers screened in the delivery room / mother with high viral load at the time of delivery, baby of a mother who died of HIV to decide on the conduct, etc.).

⁴² S'it is negative confirmed by a PCR test and then propose weaning and get out of PMTCT. The risk of malnutrition in an 18-month-old child who eats is much lower and breast milk at this age does not represent the bulk of his diet. Facing the risk of contracting HIV by prolonging breastfeeding (even if under ARV).

No	PMTCT Indicators	2019	2020	Evaluation Team Comments
9	>10 HIV positive mothers per month accept family planning	No data	6	10 women? Or men too? (vasectomy is a contraception that would be effective in the context of PMTCT but what cultural acceptability in West Africa). It seems that the indicator lacks precision. Perhaps we should say "% of women WHO LIVEAs agree to be on contraception"
10	100% of victims of sexual violence receive medical and psychosocial care	No data	94,12	

Table 6. PMTCT Indicators 2021

No	PMTCT Indicators	T1	T2
1	>60% Retention rate in care among children aged 0-4 years	38%	38%
2	>95% Percentage of pregnant women presenting to NPC or childbirth know their status	96%	99%
3	<5% Percentage of exposed children who test positive for HIV	12%	7%

Table 7. OCB PMTCT standard indicators

Antenatal period
% of women whose HIV status is unknown at the first antenatal visit
% of women with unknown HIV status who were tested for HIV at the first PNC visit
% of HIV-positive women at the first antenatal visit
% of HIV-positive women screened for advanced HIV infection at the first antenatal visit.
% of HIV-positive women in PNC who were confirmed HIV-positive at an advanced stage at the first NPC
% of HIV-positive women on antiretroviral therapy at the 1st antenatal consultation
% of HIV-positive women screened for TB at first antenatal visit
% of HIV-positive women screened for tuberculosis at the first antenatal visit.
Period of childbirth / Maternity
% of women presenting for delivery with unknown HIV status
% of women with unknown HIV status who were tested for HIV at childbirth
% of births of HIV-positive women

% of HIV-positive women giving birth and on antiretroviral therapy during childbirth
Proportion of HIV-exposed babies (HIV-positive women) born alive
Proportion of HIV-positive babies starting ARV prophylaxis at the maternity ward
Post-natal period
% of HIV-exposed babies tested at 6 weeks
Proportion of HIV-exposed babies tested for HIV at 9 months (PCR or RDT, if PCR is not possible).
Proportion of HIV-exposed babies who test positive for HIV at 9 months (6 - 12 months)
Proportion of HIV-exposed babies who underwent a final confirmatory HIV test at 18 months.
Proportion of HIV-exposed babies confirmed positive for HIV at 18 months (15-21 months)

The evaluators therefore suggest tracking the 2020 indicators of the PMTCT project including active queue retention, partner screening and adding the following indicators/changes:

- Introduce the monitoring of the retention of the mother-child couple in care during the period of PMTCT;
- Consider replacing the virological test at 24 months with a test at 18 months after a negative rapid test;
- Introduce syphilis screening in pregnant women and define a specific indicator;
- Introduce an indicator on PrEP;
- Introducing the indicator on tuberculosis screening in pregnant women
- Review the wording of some indicators used in 2020 to better measure the changes generated by the project;
- Introduce the indicator on viral load achieved in the context of PMTCT as well as that of adherence in addition to retention.

The evaluators also find that some standard OCB indicators on PMTCT are not suitable to allow the project to track its activities on the PMTCT component and this could explain their low use on the project. For example, PMTCT indicators for the antenatal period and most indicators for the delivery period are more indicators of the epidemiological situation related to the risks of mother-to-child transmission of HIV, than indicators for monitoring PMTCT activities carried out by a project.

3.3.2. ANALYSIS AND CONCLUSION ON EFFECTIVENESS

The effectiveness of the project was difficult to assess on some aspects in an objective manner due to the relatively low quality of monitoring and reporting on project indicators and some errors in the database Tier.net. Triangulation of information was not always possible and monitoring of the performance of the PMTCT component between 2011 and 2021 was only done on the basis of interviews, observation, and available documents. Indeed, several reports were missing and over several years. The evaluators only received MSF data for 2015, 2016, 2018, 2020 and the first six

months of 2021. Thus, the periods 2011-2013, 2017, 2019, and Q3, Q4 2022 were not available to the evaluation team.

It should be noted that in terms of coverage, the project has taken care of a large proportion of women in PMTCT in Guinea and that it has set up several services related to the pillars of PMTCT. Nevertheless, the indicators developed by MSF have often not been achieved, most of them are marked as red in the monitoring tools. The specific main objective of PMTCT has not been achieved (target of increasing HIV MTCT to less than 5% not met at the time of the evaluation).

With the new 95-95-95 target of accelerating the response towards ending the AIDS epidemic by 2030 as proposed by UNAIDS, the definitive elimination of new HIV infections among children is one of the priorities set. Complementary actions to conventional PMTCT (syphilis screening, acceleration of the fight against HIV-related discrimination, breastfeeding counselling, strengthening PMTCT during breastfeeding, family planning, enhanced treatment of STIs.) are therefore recommended for a better contribution of the MSF project to the objectives of eliminating MTCT and the AIDS epidemic.⁴³

3.4. EFFICIENCY

At this level, it was a question of assessing whether resources had been used/allocated optimally.

The question asked was:

- ***EQ4: To what extent are resources (HR, financial, etc.) well used to implement the PMTCT component of the HIV project?***

3.4.1. SUMMARY OF KEY FINDINGS

3.4.1.1. Efficiency in relation to financial resources

It was not possible to assess the efficiency relative to the budget on the PMTCT component of the HIV project. Indeed, this is a major limitation, as the financial information requested by the appraisers has not been provided to them. Therefore, no conclusions can be made on financial efficiency.

3.4.1.2. Efficiency in relation to human resources

There are sufficient human resources for the management of the project but also for the care of women and their babies in the supported structures and this explains the capacity observed and the volume of the package of care deployed in PMTCT.

MSF rewards some of the health care providers on the sites according to performance but some replacements are not rewarded even though they assume the same responsibilities. This is a situation that has created a noticeable demotivation in some people met by the evaluation team.

The project ensures the continuous training of staff deployed in PMTCT care sites, thus contributing to the improvement of quality. Nevertheless, in view of some identified shortcomings, mentoring or

⁴³ https://www.unaids.org/sites/default/files/media_asset/201506_JC2743_Understanding_FastTrack_fr.pdf

training supervision on site should be strengthened in order to support staff in maintaining or adopting best practices. Quality improvement is part of a continuous process of improvement.

3.4.1.3. Efficiency in relation to the time resource

The HIV project has been implemented for about 20 years in Guinea and the PMTCT component for about 12 years. The evaluation finds that this period was sufficient to have a change but the problems of the care provision in Guinea are of a structural nature (insufficient human resources, unpaid HR in some structures, volunteer HR / replacement without civil servant status and without salary, low participation of the State in health financing, lack of skills in the management of HIV services, etc.).

Although it was not possible to assess the amount spent by MSF over the 12 years of implementation of PMTCT to crosscheck the results achieved against the time resource, it can be said that in view of the results obtained the project is not efficient on the time resource.

It would be necessary to innovate the processes (intervention strategy) with a focus on strengthening the capacities of the health system, in particular the PNLSH, and strengthening advocacy to bring the State to meet its commitments in terms of financing the fight against HIV. It would also be necessary to accelerate the decentralization of HIV services to other structures, and strengthen the partnership with other organizations active on PMTCT such as Jhpiego & Solthis, etc. for a better synergy of action.

3.4.2. ANALYSIS AND CONCLUSION ON EFFICIENCY

Efficiency is the criterion that obtains the lowest score of the assessment by the evaluation. Nevertheless, subject to a financial analysis that could have provided additional information, it must be said that effectiveness in the specific framework of PMTCT takes precedence over efficiency. The limitation is however that the evaluation cannot assess the cost of PMTCT as implemented by MSF in Guinea and therefore this cannot help other MSF projects in terms of "forecast based financing" approach, which would be very useful for planning the financial needs of the implementation of MSF's PMTCT approach in the rest of the countries of West and Central Africa. Data on expected pregnancies can be obtained but information on the HIV project's experience on PMTCT in terms of funding is not available.

3.5. IMPACT

The impact of the project on the PMTCT component was assessed in relation to the achievement of PMTCT objectives and the effects on patients and the health system. The aim was to answer the following evaluative question:

- ***QE5: What is the impact of the PMTCT component on stakeholders (patients, Ministry of Health midwives receiving peer support, community, etc.)?***

3.5.1. SUMMARY OF KEY FINDINGS

3.5.1.1. Achievement of the general and specific objectives of the PMTCT project

The project created a previously non-existent PMTCT care offer in Guinea with a quality improvement model that helped slow down the progression of HIV and especially prevent many infections of children

at risk of MTCT. The project has reduced the transmission rate to 7–12% of children at risk, while UNAIDS estimates vertical transmission of 16.5% for Guinea in 2020 in general. The project has achieved significant decentralization of services.

However, it should be noted that the objective of having a transmission rate <5% has not yet been achieved. Moreover, the early handover of purchasing responsibilities for front-line ARVs, as well as the transfer of PMTCT to another actor without putting in place stronger foundations in the 4 pillars would risk creating a rebound effect on the mother to child transmission in Guinea. The context would need to be more favourable, particularly with regard to the availability of treatments and inputs as well as funding, in order not to widen a gap after MSF's disengagement.

The project has improved the quality of services in the supported structures by providing them with protocols and technical capacities to meet the growing demand of HIV patients in general but especially of HIV-positive women.

3.5.1.2. Effects of the project perceived by beneficiaries and other actors

Impact of the project as perceived by the end users of the services, in this case HIV+ women, was assessed through a sample of patients. This highlighted a valorization of the HIV-positive woman who became an actor of their own care through the talking groups as well as expert patients or psychosocial counselors.

At the community level, a demystification of HIV through peers' education seems to have contributed to reduce the stigma, that is one of the major challenges for access to HIV health care in Guinea. There are also fewer and fewer opportunistic infections among patients followed by MSF-supported health facilities. The women we met testified that they had a better quality of life thanks to the quality of the follow-up and that free care came at the right time. Women also shared that they have regained hope that they can have uninfected children.

3.5.2. ANALYSIS AND CONCLUSION ON IMPACT

MSF's HIV project has been working in eight PMTCT sites in more than 500 sites across the country. Nevertheless, the eight sites are among the largest PMTCT sites in the country, including Matam, which is the first. In 2020 alone, more than 1,000 women benefited from PMTCT follow-up in these structures supported by MSF, out of 6,000 women followed in PMTCT throughout Guinea. While the impact of the project is negligible in terms of the number of sites supported, it is important in terms of the quality of services, including TB prevention, treatment of opportunistic infections and the proportion of patients with viral load examined, as well as support for supply chain organization.

Several children could avoid being infected with HIV, as shown by the PMTCT figures with a reduction in MTCT to around 12% in 2021. The project could have a greater impact and accelerate the achievement of its target of a TME < 5% by decentralizing care in health facilities in the interior of the country as well.

3.6. DURABILITY

The sustainability of the project's intervention on the PMTCT component was assessed through the following evaluation question, emanating from the evaluators' proposal. Indeed, sustainability analysis was not a priority of this evaluation.

- **QE 6: To what extent are the results achieved by the PMTCT project/can be sustained?**

Issues of decentralization, exit strategy, and economic and technical sustainability were analyzed.

3.6.1. DECENTRALIZATION OF ARV TREATMENT AND PMTCT SERVICES

Policymakers, health workers and communities recognize that health services in low- and middle-income countries need to improve people's access to HIV treatment and retention in treatment programmes. One strategy is to shift the supply of antiretrovirals from hospitals to more peripheral health facilities or even beyond health facilities. This could increase the number of people with access to care, improve health outcomes and increase retention in treatment programmes. On the other hand, the provision of care at less sophisticated levels of the health service or at the community level can diminish the quality of care and lead to a deterioration in health outcomes.⁴⁴

In the case of MSF's HIV project in Guinea and PMTCT in general, a decentralization of HIV care has been carried out with delegation of the management of simple cases to peripheral structures. A decentralization of the provision of ARVs has also been made at the community level with the creation of community distribution points. Structures still under the direct management of MSF such as the Donka centre currently focus on management of serious cases or unstable patients (patients not observing ARV treatment or keeping a viral load greater than 1000 copies/ml of blood despite well-conducted treatment). For MSF, this is a step in the process of exit and disengagement, especially on PMTCT in the perspective of a possible transfer of responsibility for managing PMTCT to another actor.

Differentiated models of ARV treatment delivery, including the decentralization of stable cases, should be based on patient choice in addition to objective criteria. Decentralization should not be imposed on patients, for example with the aim of reducing the workload of health care staff in concentrated or central structures. During interviews, some patients said they would feel more comfortable if they continued to be followed in Matam, for example, rather than in peripheral facilities close to their homes. Other patients are reported to have sought MSF's quality care in Conakry following MSF's disengagement from Guéckédou.

Decentralisation is a theme present in many MSF projects but it is essential to clarify definitions and strategies to reflect the fact that implementation goals and approaches may vary from one project to another and depending on the central themes of the projects or the contexts of implementation. Indeed, decentralization covers different realities, and different objectives, of disengagement, better care, or coverage.

⁴⁴ Kredo, T., Ford, N., Adeniyi, F. B., & Garner, P. (2013). Decentralising HIV treatment in lower-and middle-income countries. *Cochrane database of systematic reviews*, (6).

3.6.2. EXIT STRATEGY

MSF's exit strategy from PMTCT is not clearly specified in the 2021-2025 roadmap, but is mentioned as a potentiality. Indeed, MSF is hesitant to exit from four decentralized structures during 2022 and this hesitation could be explained by a lack of preparation in the long term. The disengagement from front-line ARV supply appears not to have been sufficiently prepared. The Central Pharmacy of Guinea is unable to fulfill the orders of the sites causing ruptures at times. Thus the transfer of responsibility for PMTCT to another structure seems premature; it is necessary to prepare with a plan for the transfer of skills and responsibility by specifying the reasons for the transfer, the services transferred, and to draw up a timetable for a gradual transfer (Specify when to activate the exit plan).

It should also be possible to assess the organizational maturity and absorptive capacity of the structure or institution/organization that would take over responsibility for PMTCT.

3.6.3. SUSTAINABILITY AFTER MSF'S DISENGAGEMENT FROM PMTCT

3.6.3.1. Technical sustainability and good PMTCT practices

For several years, the project has deployed international technical expertise to support HIV care since 2003 and the PMTCT component since 2011 within a health system that was struggling to cope with the HIV crisis. This expertise has covered key areas such as the ARV supply chain with quantification support provided to the National Programme for the fight against AIDS and Hepatitis (PNLSH), training of local staff, conducting molecular biology (viral load) examinations, etc.

Today, midwives in MSF-supported health facilities seem to have acquired sufficient skills to monitor women in PMTCT, but the high turnover of health staff in Guinea poses a risk to the sustainability of the institutional skills acquired by these structures. These competences have long been stabilized by the system of granting MSF performance bonuses, which may not be continued after MSF's disengagement, and would de facto lead to a decrease in the overall financial compensation of the staff concerned.

The lack of ownership by national partners (PLNSH) of the laboratory solution is also another issue that limits technical sustainability. The laboratory solution where MSF manages its own sample transport, supervises laboratory staff and purchases MSF laboratory inputs works, while the management of this component by national actors on open or closed multipurpose platforms seems to be unsatisfactory (stock-outs, difficulties in organizing the transport of samples, delay in the delivery of results, etc.). This would result in a lower use of viral load testing in the follow-up of women with PMTCT outside MSF-supported sites.⁴⁵

The public sector would need additional funding to manage the laboratory solution even though there is already a gap in state participation in HIV financing.

One of the solutions proposed by the evaluation team would be to build on the current approach in MSF, with the use of GeneXpert devices to conduct viral load testing. Indeed, these easy-to-use devices available throughout Guinea could be a solution, and their use could be optimized by including the diagnosis of tuberculosis or other diseases. Although these devices cannot process a large number of

⁴⁵ Viral load delivery platforms are devices designed to perform viral load tests. There are multipurpose platforms (possibility to do several other tests, including tuberculosis, hepatitis, etc.) open (accepting parts and reagents from several manufacturers). Closed platforms only accept parts and reagents from a specific manufacturer.

samples, as the viral load is not an emergency examination, good planning could make it possible to enable viral load examination for all women in PMTCT and more broadly for all persons living with HIV in Guinea.

3.6.3.2. Economic sustainability

Although the evaluators could not assess the cost of implementing the PMTCT project, it appears that reducing mother-to-child transmission of HIV to 7–12% did cost a lot of resources over the 10 years of implementation of PMTCT activities.

In the event of MSF's disengagement from PMTCT, knowing that MSF supports large PMTCT sites and absorbs a large volume of PMTCT activities in Conakry, there is the question of the possibility of financing these activities, in a sustainable way. With little involvement of local actors, especially the State, in the financing of health, the financing of PMTCT after handover of MSF to another actor should be planned.

The choice of the actor to whom to transfer the PMTCT component should also take into account its ability to mobilize funds for PMTCT in the future and its ability to act over time in Guinea. Indeed, an international actor could have the ease of mobilizing funds but there is no guarantee over the duration of its engagement in Guinea on the PMTCT thematic. A local actor of the civil society or state could allow a better local anchoring through the appropriation of good practices in PMTCT as driven by MSF, but it would have difficulty in mobilizing funds as this is currently the case. An international actor Jhpiego is already active on PMTCT in Guinea as a sub-recipient of Global Fund funding but it would struggle to meet all PMTCT needs if depending only on Global Fund funding. And there is no certainty that in the next 4 or 5 years Jhpiego will remain a sub-recipient of the Global Fund on PMTCT.

As part of institutional advocacy, MSF should support the Guinean State in advocating with donors and donors to increase the envelope for PMTCT.

3.6.4. ANALYSIS AND CONCLUSION ON DECENTRALISATION, EXIT STRATEGY AND SUSTAINABILITY

The decentralization of PMTCT by the MSF HIV project in Guinea has helped to relieve congestion at the Matam CMC, but the decentralization approach remains to be strengthened by including it as part of a broader MSF exit strategy.

The sustainability of MSF's actions on PMTCT does not seem to be possible if disengagement is carried out without preparation and a transition period allowing for structural and cyclical change at the local level in Guinea. Economic sustainability appears to be a worrying issue that should be discussed during the round tables organized by MSF for the future orientations of the project, with a view to adopting actions that could increase the chances of sustainability.

It appears that a transfer of responsibility for PMTCT would be premature, and that preparation is still needed before considering such a transfer. This responsibility should also be transferred only after exceeding the project target (<5%), corresponding to the targets of the national plan for the elimination of MTCT and providing initial support to the strategy 95-95-95.

3.7. ANALYSIS OF CROSS-CUTTING THEMES: GENDER & ENVIRONMENT

Most of the midwives in the sites are women and the project itself is a project contributing to the promotion of HIV+ women's rights to good reproductive health by limiting the risk of HIV transmission to their children.

It should be noted that currently the project management team in the field is made up only of men and this raises questions in general, but even more so given the theme of the project. Nevertheless, in previous years, especially over the last 6 years, the project has had 5 female project coordinators against 1 male coordinator. The primary health team is composed of 2 men and 5 women, one of whom oversees PMTCT. Gender mainstreaming in a specific way should be addressed in the setting up of projects with some specific gender indicators. Indeed, the mobilization of partners is essential to support their women in PMTCT. Screening partners during NPC 1, as already routinely conducted in several African countries, will help change the approach.

The project carries out a destruction of viral load waste by high temperature incineration with the indicator of 100% of waste destroyed by this method in the first and second quarter of 2021. This therefore contributes to the safety of care and protection against contamination of the environment by infectious waste.

The health structures supported all have the means to manage current waste from their activities (garbage cans, incinerators, etc.).

4. CONCLUSION

The MSF HIV project since 2003 with its PMTCT component since 2011 responded to the UNAIDS declaration of the HIV epidemic in Guinea in 2003. The relevance of this response was assessed in relation to the needs covered in terms of PMTCT coverage at national level. The project's intervention on the PMTCT component has remained and continues to be relevant as the target of raising the threshold of HIV transmission to less than 5% in the supported sites has not yet been met. In relation to the objectives of the PMTCT project, the intervention is considered consistent with Guinea's objectives on PMTCT, including those of reducing MTCT (to less than 7% in 2019) and eliminating (reducing MTCT to less than 5% in 2023) of the National Plan for the Elimination of Mother-to-Child Transmission of HIV. Nevertheless, some PMTCT protocols, particularly in connection with therapeutic combinations used in prophylaxis in infants exposed to HIV, were introduced late with babies who continued to receive only one molecule instead of dual therapy.

The effectiveness of the project was demonstrated by MSF's responsiveness to the crisis as soon as the HIV epidemic was declared in 2003, the number of women treated with PMTCT, the technical platform installed in particular to make available the viral load test, support for the supply of ARV drugs and for opportunistic infections, as well as the reduction of the rate of mother-to-child transmission of HIV to 7 – 12% in 2021 (Q1 2021 result 7%, Q2 2022 result 12%). However, there is still a step to be taken to achieve the goal of reducing the rate of HIV transmission to less than 5% by 2023. On the eve of this date, action should be taken to speed up the pursuit of this main objective. Difficulties in monitoring activities were noted, including reporting with several missing documents and a Tier.net database that did not allow the encoding of all data relevant to the monitoring of PMTCT activities. The accuracy rate of the data in this database also remained below the 95% target set by the project, showing that data management useful for project management remains an area for improvement.

It was not possible to assess efficiency in all these dimensions, particularly on the financial side because the financial information was not received by the evaluators. Nevertheless, based on the available information, the evaluation finds that the time resource was not used efficiently because after more than 10 interventions on PMTCT, the rate of MTCT could not fall below the 5% mark. However, the factors of non-achievement of the project's results are internal but also external with an intervention context particularly marked by a weakness of the local health system to coordinate the entire response against HIV with aspects of quality of services remaining insufficient and a financing system for the fight against HIV dependent in part on funding from the Global Fund, and with commitments on government side not always fulfilled.

The impact of the project is perceptible in terms of coverage in relation to the number of women who have benefited from PMTCT monitoring in MSF-supported sites compared to all PMTCT sites in the country and in terms of the feelings of beneficiaries. Indeed, the project has enabled HIV positive women, beyond obtaining PMTCT care, to improve their sense of value and social inclusion in a country marked by high HIV-related stigma. The impact on the health system, although appreciated, in particular on the training of health personnel who have generated skills, remains to be improved to

allow a sustainable transformation of the capacities to manage in an autonomous manner the response to HIV on the PMTCT, especially on the laboratory component.

The technical and economic sustainability of the project seems unlikely if appropriate measures including an elaborate exit and transfer of responsibility plan are not taken. The premature withdrawal of MSF funding through disengagement from PMTCT would risk putting a step back on the efforts and the progress made on PMTCT in Guinea. The consequences of MSF's withdrawal from the purchase of front-line ARVs is already being felt with orders sometimes not fulfilled by the Central Pharmacy of Guinea and by stock-outs of certain medicines at the level of health facilities.

5. RECOMMENDATIONS

Recommendation 1: Improve the management of project data and information through better reporting and archiving. Specifically:

- Create a system for archiving project reports by outcome within the SharePoint platform that is already used by MSF and synchronize these files on the computers of the Project Coordinator, the Medical Coordinator, the Medical Referent of the project, and the Technical Referents of the Headquarters;
- Review the configuration of the Tier.net database to include the possibilities of entering all the data useful for monitoring the project and especially the PMTCT ones;
- Provide ongoing refresher training for database users Tier.net to minimize encoding errors that were identified during the evaluation.

Recommendation 2: Update the 2021-2025 project roadmap by clearly highlighting PMTCT activities. Specifically:

- Define the PMTCT strategy over the period 2021 – 2025 including the exit strategy/ process of a possible transfer of responsibility regarding PMTCT to another actor;
- Present the capitalization aspects of Guinea's different experiences on PMTCT as one of the priorities for the period 2021 – 2025;
- Insert an exit strategy over 2 to 3 years in the roadmap by specifying the ideal profile of the actor who could take over all PMTCT activities from MSF's disengagement (It should ideally be a local actor to strengthen in terms of capacity over time and make the disengagement process gradual by delegating activities one after the other – it does not seem appropriate to transfer the liability on PMTCT to an international actor whose PMTCT funding cannot be guaranteed thereafter over time).

Recommendation 3: Accelerate the decentralization of PMTCT to other structures prior to MSF's disengagement from PMTCT in Guinea. Specifically:

- Keep the monitoring of PMTCT under the responsibility of MSF over the period 2021 – 2025 while preparing its disengagement and transfer to another partner;
- Increase actions that allow the sustainability of PMTCT activities in decentralized structures, in particular by advocating for greater state involvement in PMTCT funding and the participation of other funding institutions other than the Global Fund;
- Decentralize PMTCT in structures outside Conakry over the period 2021 – 2025 to increase equity in access to health care.

Recommendations 1-3 (of 6)

Recommendation 4: Strengthen PMTCT action across all four pillars over the transition period, before the transfer of responsibility to another actor. Indeed, it would be wiser to transfer responsibility to a complete package. Specifically:

- Increase HIV testing among women of childbearing potential by exploring the appropriateness of introducing community-based testing;
- Strengthen family planning activities with the prevention of unwanted pregnancies among HIV-positive women;
- To the extent possible, involve family members of HIV-positive women (if they agree to share status and this does not result in exclusion), in supporting them in their living environment, to increase the retention of women in care, and that of their children if they are infected.

Recommendation 5: Initiate reflections on updating MSF protocols and the application of the new recommendations in relation to the period of discharge of children from PMTCT and the prophylaxis scheme to be established. Specifically:

- Ensure that all babies receive PCR at 6 weeks and 9 months and initiate a reflection on how to ensure that PCR is extended outside of MSF programs (or even on optimizing the use of GeneXpert);
- Develop specific strategies to improve access to HIV testing and PMTCT care for women who do not have access to antenatal care;
- Strengthen HIV self-testing programs among partners of women with PMTCT (polygamy being prevalent, this could reduce the risk of transmission among co-wives of women in PMTCT);
- Perform viral load testing for all women on ARVs in the 3rd trimester of pregnancy;
- Integrate pre-exposure prophylaxis (PrEP) into the PMTCT (primary HIV prevention) strategy, particularly among groups of women at high risk of HIV infection (Sero-different couples, sex workers, etc.);
- Accelerate the integration of family planning (contraception / prevention of unwanted pregnancies) among HIV-positive women;
- Review, in conjunction with nutrition experts, the possibility of taking children out at the age of 18 months after a negative rapid test and a negative PCR and consider weaning from breast milk if the woman has the opportunity to feed the child without the risk of incurring malnutrition during this crucial period for the growth of the child (Several children remained in PMTCT with breastfeeding which puts them at risk of transmission from mother to child, yet preventable by getting these children out);
- Accelerate the implementation of protocols for initiating AZT+NVP prophylaxis in all exposed children (not just high-risk children), whether their mothers have entered PMTCT via prenatal consultation or later in the 3rd trimester of pregnancy or delivery.

Recommendations 4-5 (of 6)

- Adopt a prophylaxis combining AZT/3TC/NVP for children seen too late, after delivery or at the time of breastfeeding, since these children are then considered at very high risk;
- Introduce emergency PCR as soon as possible for adequate decision-making on the conduct of care in special situations, including the children of women who test positive for HIV during breastfeeding;
- For newborns and infants with presumptive clinical signs of HIV infection, promptly initiate triple antiretroviral therapy including Dolutegravir (DTG), this initiation can be done from the 4th week of life.

Recommendation 6: Conduct a review of the standard OCB indicators on PMTCT as most appear to be indicators to measure the risks of mother-to-child transmission of HIV but less so the performance or changes generated by PMTCT projects. Specifically:

- Revise some indicators to make them more operational, some being adapted to inform the development of PMTCT strategies but less to monitor the PMTCT activities of an HIV project;
- Refer to the 4 pillars of PMTCT to define the specific activities of PMTCT and thus the indicators to be monitored on the project;
- Adapt the PMTCT indicators of each MSF project according to the package of activities deployed, involving the expansion of the standard OCB list of indicators but also the removal of less relevant indicators, such as children born alive from HIV-positive mothers⁴⁶.

Recommendations 5-6 (of 6)

46. PMTCT is not aimed at the prevention of mortality in utero or during childbirth but at the prevention of mother-to-child transmission of HIV. This indicator is likely to be tracked on projects when it will not be used to inform the project's PMTCT performance. This is an example here of an indicator to be removed, according to the evaluation team.

ANNEXES

ANNEX 1. EVALUATION MATRIX

<u>Evaluation Criteria and Question</u>	<u>Sub-questions</u>	<u>Indicators</u>	<u>Data sources</u>
Relevance QE 1: Is the PMTCT component of the HIV project aligned with the priorities and needs of stakeholders?	1.1 Who are the stakeholders (e.g. communities, patients, local authorities, etc.) 1.2 What are the priorities and needs of the stakeholders identified? Have they been independently evaluated? 1.3 How did the project take into account the needs expressed by HIV patients and their families? 1.4 Have the project objectives and corresponding activities met the identified PMTCT needs? 1.5 Was the intervention on PMTCT relevant to MSF's priorities? 1.6 Have the activities of the PMTCT component of the project been able to adapt in a relevant and timely manner to the changing needs of the health system and beneficiaries? 1.7 How could the PMTCT component be more relevant given the identified priorities and needs of stakeholders?	A. Documentation of the formal needs assessment that takes into account the needs of patients and the community (HIV patient associations) including MSF's strategy. B. Stakeholder perceptions of the connection between PMTCT project objectives/activities and identified needs. C. Stakeholder perceptions of project adaptations or modifications in response to changing PMTCT needs. D. Documentation of the adaptation or modifications made to the project in response to changing needs. E. Stakeholder views on increasing the relevance of the project on the PMTCT component.	<ul style="list-style-type: none"> Literature review Key Informant Interviews (CITS)
Coherence EQ 2: Is the PMTCT component well designed to meet the priorities and needs of stakeholders?	2.1 How are PMTCT activities tailored to the priorities and needs of stakeholders? 2.2 Has the PMTCT intervention been adequately designed given the context? 2.3 Has the intervention been able to adapt over time to changes in context? 2.4 How did the project take other actors into account in its PMTCT strategy? 2.5 How could the design of the PMTCT component be improved?	F. Stakeholder views on the link between pmTCT strategy/intervention design and the local context, and its ability to adapt to contextual change. G. Documentation of project changes in response to contextual change H. Stakeholder perception of the inclusion of other PMTCT actors I. Stakeholder views on increasing project coherence on the PMTCT component.	<ul style="list-style-type: none"> Literature review Key Informant Interviews (CITS)
Efficiency EQ 3: Does the PMTCT component achieve the predefined objectives and expected results?	3.1 What are the predefined objectives and expected results of the PMTCT component? 3.2 To what extent has the project achieved its general and specific objectives?	J. Documentation of PMTCT project results and comparison with expected outcomes in the logical framework (PMTCT specific indicators). K. Stakeholder reports on the reasons for insufficient results (if any).	<ul style="list-style-type: none"> Literature review EIIC Field visits Medical data

Evaluation Criteria and Question	Sub-questions	Indicators	Data sources
	<p>3.3 What were/are the main opportunities and constraints that led/lead to the achievement or non-achievement of results?</p> <p>3.4 What changes could be made to the PMTCT component to improve the achievement of objectives and expected results more effectively?</p> <p>3.5 What are the results already obtained (outputs)?</p> <p>3.6 To what extent are these results in line with quality standards and expected results?</p> <p>3.7 What were the reasons for whether the expected results were achieved or not?</p> <p>3.8 What could have made the project's PMTCT strategy more effective in terms of results?</p>	<p>L. Stakeholder views on how to make the PMTCT strategy/intervention more effective.</p>	
<p>Efficiency EQ 4: To what extent are resources (HR, financial, etc.) well used to implement the PMTCT component of the HIV project?</p>	<p>4.1 What resources (human, logistical, financial, advocacy, etc.) have been allocated to achieve the above results?</p> <p>4.2 How has MSF coordinated and collaborated with other actors in Guinea, including to strengthen existing capacities on PMTCT and the HIV response in general?</p> <p>4.3 Could resources have been used more efficiently?</p> <p>4.4 In what ways is the PMTCT component of the project efficient in achieving objectives?</p> <p>4.5 How could efficiency be improved in the implementation of the PMTCT component of the project?</p>	<p>M. Document review to assess resources (human, logistical, financial, advocacy, etc.) allocated and trends over time.</p> <p>N. Documentation of collaboration with other actors (MoU).</p> <p>O. Stakeholder perceptions of collaboration with other actors.</p> <p>P. Stakeholder views on the efficient use of PMTCT resources over the life of the project.</p>	<ul style="list-style-type: none"> ● Literature review ● EIIC ● Field visits
<p>Impact EQ 5: What is the impact of the PMTCT component on stakeholders (patients, Ministry of Health midwives receiving peer support, community, etc.)?</p>	<p>5.1 Who are the different stakeholder groups impacted or affected by the intervention?</p> <p>5.2 What are the effects of the project on PMTCT as perceived by beneficiaries and other counterparts?</p> <p>5.3 What are the different impacts or effects of activities, positive or negative, intended or not, on these stakeholders?</p> <p>5.4 How can we increase the positive impact and reduce</p>	<p>Q. Review of project indicators from project reports.</p> <p>R. Stakeholder perceptions of the impact of the project and any unintended consequences (positive/negative).</p>	<ul style="list-style-type: none"> ● Literature review ● EIIC

Evaluation Criteria and Question	Sub-questions	Indicators	Data sources
	<p>the negative impact of the PMTCT component on stakeholders?</p> <p>5.5 On its PMTCT component, did the project have any unintended consequences? If so, which ones?</p>		
<p>Sustainability and transfer of responsibility: To what extent are the results achieved by the project on the PMTCT component sustainable/ can be sustained?</p>	<p>6.1 Has the project developed a strategy for exiting and transferring PMTCT management to another partner?</p> <p>6.2 Was the exit strategy coherent and planned for the transfer of skills to the partner who will take over the PMTCT component of the project?</p> <p>6.3 Did the exit strategy take into account the potential challenges, and how were they addressed?</p> <p>6.4 What local capacities and resources have been identified? How did the project link with them to ensure the sustainability of the results after MSF's withdrawal?</p> <p>6.5 Has the project identified the partner to transfer the project to in 2-4 years? If so, what elements guided the choice and what transfer plan was established?</p> <p>6.6 Are there any facilitating/considerate factors specifically related to the Guinean context?</p> <p>6.7 What general elements could be reproduced in other contexts on PMTCT, particularly in the West and Central African region?</p>	<p>S. Document review to map the exit/transfer strategy of PMTCT management, its implementation and potential challenges.</p> <p>T. Stakeholders' perception of the exit strategy and transferability to another part, including implementation, modification/adaptation, communication and problem solving.</p> <p>U. Documentation of the link/capacity utilization/local partners for the exit strategy.</p> <p>V. Stakeholder perception of the link/use of local capacities/partners, including barriers and facilitators.</p> <p>W. Stakeholder views on lessons learned and elements that can be replicated in other contexts.</p>	<ul style="list-style-type: none"> ● Literature review ● EIC ● Field visits

ANNEX 2. INTERVIEW GUIDE

REMARK:

- We provide an overview of the interview script that addresses the main themes of the evaluation. This script will be tailored to specific types of respondents, and appropriate questions will be asked (or modified/added, if necessary; for example, beneficiaries will not be asked about the history/context of the project, etc.)
- In addition, surveys will be used to obtain more in-depth information as needed.

Submission and request for consent

Hello, my name is [YOUR NAME] and I am part of a team that is conducting an evaluation of the PMTCT component of the HIV project of the NGO MSF in Guinea. I would like to ask you a few questions that will help MSF learn from the project and its implementation, which will help MSF improve its future projects and interventions, especially on PMTCT [READ PMTCT IN FULL: Prevention of Mother-to-Child Transmission of HIV].

The interview will last approximately 40 minutes and all your answers will remain completely confidential and will only be transmitted to MSF in aggregate form without the possibility of linking your answers to your person. I will not record the interview and will not take any images, but I will take detailed notes.

Your participation is voluntary and you can stop and withdraw from the interview at any time. If you have any questions or concerns, please feel free to contact me [GIVE YOUR CONTACT INFORMATION].

Are there any questions I can answer for you now?

If you are feeling comfortable, do I have your permission to start the interview?

Date of interview:	Interviewer: Théophile / Oumou / Amardeep / Lenka
Role of the interviewee in the project:	Dates (From/to):

PROJECT HISTORY/CONTEXT

- When and how were the needs assessments carried out and what were the main findings and conclusions?
- Can you describe how the project started? How has it evolved?
- How many people have worked on the project in total (nationals and expatriates) since its launch?
- What have been the main changes you have noticed on the project in its logic / intervention strategy since 2003 and since the integration of the PMTCT component in 2011?
- On which pillars of PMTCT is the project's work focused?
- What are the strengths and weaknesses of the PMTCT project?
- Who are the stakeholders of the PMTCT project?

- How could the PMTCT component be more relevant given the identified priorities and needs of stakeholders?

RELEVANCE AND RELEVANCE

- Who was involved in the needs assessment and planning phase of the PMTCT project?
- Did the PMTCT needs assessment take into account the needs and perspectives of different stakeholders (patients, community, Ministry of Health structures)?
- How can you assess the congruence between the objectives/activities of the PMTCT intervention and the identified needs?
- What is your assessment of adaptations or modifications to the project in response to changing PMTCT needs?
- Are there other needs that have emerged since 2011 and how do you think the project has adapted? How should he have adapted if you think things should have been different?
- How do you think the project should increase its relevance to the community's PMTCT needs?
- Can you tell me from your point of view, if the project has met important needs of the population since 2011? In addition, afterwards, do you think it remained responsive to changing needs and how?
- Do you think the project was implemented according to national PMTCT priorities or the way you were used to? Whether or not, can you explain how?
- Which civil society organisations does MSF work with and how? Has it strengthened them in any way?
- What does pmTCT coordination (financial and programmatic/activities) look like between MSF and other parties on HIV in Guinea (state institutional partners, patient associations, other national and international organizations)? Where are the synergies? Where are the gaps?
- How has coordination among partners changed in recent years on PMTCT activities?
- Is MSF taking a leadership role on certain aspects of PMTCT or the HIV response in Guinea? If so, on which and how?
- In your opinion, did the project meet the needs of PMTCT as you expected?
- How do you think the project should better meet your expectations in terms of meeting your PMTCT needs?
- How does MSF work in national HIV technical groups? Is he a member of a technical group on PMTCT? What is its place?
- How could the design of the PMTCT component be improved?

EFFICIENCY

- What is the country's status in terms of PMTCT in achieving PMTCT objectives? What has improved since 2011? What was MSF's contribution to these results?
- What are the predefined objectives and expected results of the PMTCT component?
- How can you assess the effectiveness of the project on the PMTCT component in achieving its objectives in terms of expected effects/outcomes?
- What were/are the main opportunities and constraints that led/lead to the achievement or non-achievement of results?
- What is the difference in achieving results between MSF-supported health facilities and other public health facilities?
- Is there an alternative to coaching and MSF's other programmatic principles that could be more effective? Are there big differences between rural areas and Conakry - in terms of

numbers, stigma, loss of sight, adherence, quality of the health structure? Where would you place the structures with which MSF works in terms of comparison?

- What proportion do women treated for PMTCT in MSF-supported sites compared to all women admitted to PMTCT over the period from 2011 to 2021 (estimate)?
- How is privacy respected? Does each person receive a unique identifier that allows them to move freely between institutions?
- What are the strong and weak links in the continuum of care provided in MSF-supported PMTCT sites? Please explain screening, prophylactic treatment, adherence and retention in care, viral load testing, screening and prophylaxis chex newborns and infants.
- Efficiency of the laboratory chain: How is the laboratory organized? Enough laboratory technicians/today and in the future? How is the transport of samples organized? How is the processing of laboratory samples carried out in a timely and complete manner? What is the price paid, is it adequate? Where are the problems of the laboratory, such as the lack of equipment, the lack of adequate maintenance, the lack of test reagents, the too long turnaround times, the problems to find breastfeeding women? Laboratory statistics? Is it within MSF's competence to improve the components of the laboratory chain?
- How is family planning included in PMTCT on MSF's HIV project?
- What changes could be made to the PMTCT component to improve the achievement of objectives and expected results more effectively?

EFFICIENCY

- How is the PMTCT component efficient in achieving objectives and outcomes?
- In relation to the needs, how can you assess the resources allocated to the project? Human resources according to specific expertise needs and workload, logistical, financial and advocacy resources? Do you think they were well aligned to allow even more of the expected results?
- How was the collaboration with the other partners during the project life cycle? Do you think this collaboration has played a role in the level of results achieved on the PMTCT component?
- Do you think that the results obtained on PMTCT were proportional to the resources used?
- Is the project structure and hierarchy flexible to internalize changes in workflows, protocols, and policies?
- What are MSF's competitive advantages in terms of efficiency?
- HR effectiveness - is MSF's HR stable and how many people have been there since 2011? What is their workload and how has it evolved? How has HR efficiency in healthcare facilities improved and what impact has this had (quality and quantity of services - nursing, laboratory, procurement)?
- How is the supply chain organized? What is the ARV supply chain and its availability? What is the supply chain for other medicines and reagents? Are there specific constraints or facilities for women in PMTCT in health facilities supported by MSF?
- Efficiency of the use of financial resources: What are the components of the budget? How many funds are used per patient or per planned goal? How much is used per institution or compared to the other components of the HIV project? What is the overall budget for the PMTCT component? What is the distribution of the budget over the different pillars of PMTCT? How much money has been spent since 2011 on the PMTCT component? For how many women who benefited from PMTCT between 2011 and 2021?
- How (if applicable) can the efficiency of pmTCT implementation and monitoring be improved?

IMPACT

- Who are the different stakeholder groups impacted or affected by the intervention?
- What have been the immediate and long-term effects of pmTCT intervention on individuals, the community, the quality of health services and the health system?
- What are the different impacts or effects of activities, positive or negative, intended or unintentional, on these stakeholders?
- What has been the contribution and impact (on you or your loved ones) of the health care received by you, your neighbour, a family member, etc. from MSF in terms of PMTCT? Can you tell me about this impact in terms of quality of life, prevention of HIV-related complications, savings (reduced spending), etc.
- What difference has been made between 2011 and now in the health zones/structures supported by MSF?
- And in the general objectives of the national HIV plan, such as transmission and adherence, etc.
- What changes are observed on factors favorable to the performance of PMTCT such as capacity building of nurses, destigmatization of HIV infection, etc.
- How can the project increase the positive impact and reduce the negative impact of the PMTCT component on stakeholders?

SUSTAINABILITY AND TRANSFERABILITY OF PMTCT MANAGEMENT TO ANOTHER PARTNER

- Can you tell me about the lessons learned from the implementation of MSF's PMTCT project and what MSF could replicate in other contexts?
- What are the chances of sustainability? What would happen if all MSF activities on PMTCT stopped now? What would be left and how long would it persist (in health facilities, among HIV women, in the community in general)?
- What is the weakest link in the sustainability chain?
- What stands in the way of sustainability? What are the limiting factors? Could MSF do more to improve sustainability?
- Could MSF increase or limit its activities on PMTCT or transfer activities to someone else to increase the chances of sustainability?
- To what type of partner should MSF transfer the activities of the PMTCT (Patient Association? Ministry of Health? International partner? Other local partner?) ? Why does the choice of this partner seem the most appropriate to you?
- If MSF wants to capitalize and resume PMTCT activities in other contexts or countries, what are the positive aspects and strengths of the HIV project in Guinea that MSF can build on and what would be the things to avoid to maximize the chances of success of a PMTCT project /PMTCT activities?

ANNEX 3. EVALUATION TERMS OF REFERENCE

Médecins Sans Frontières/Doctors without Borders (MSF) is an international humanitarian medical organization committed to providing quality medical care to people in crisis around the world, when and where they need it, regardless of religion, ethnicity or political opinion. Our core principles are neutrality, impartiality, independence, medical ethics, testimony and accountability. The Stockholm Evaluation Unit (SEU), based in Sweden, is one of three MSF units responsible for managing and guiding evaluations of MSF's operational projects. For more information, see: www.evaluation.msf.org

Evaluation Name:	Prevention of mother-to-child transmission (PMTCT) in the Conakry HIV project, Guinea
Start Date:	From 6 December 2021 (the date is negotiable)
Duration:	The final report must be submitted by March 31, 2022.
Requirements:	Interested candidates must submit: (1) a proposal describing how this evaluation will be carried out (including the budget in a separate file), 2) a CV, and 3) a written sample of previous work
Deadline for applications:	23:59 CET of 23 November 2021
Send your application to:	evaluations@stockholm.msf.org

CONTEXT

According to the Human Development Index (HDI, 2020), Guinea-Conakry is one of the least developed countries in the world. With a comparatively high level of poverty, weak infrastructure and an unstable political regime, the country has for decades faced complex public health challenges, such as the Ebola and HIV epidemics, which have compounded pre-existing difficulties in providing quality basic care to patients in need of medical treatment and assistance.

In 2003, the World Health Organization (WHO) declared a "widespread epidemic" of HIV in Guinea, where the WHO estimated that HIV prevalence rates were between 1.2% and 8% of the national population. Lack of access to antiretroviral (ARV) treatment was a major concern at the time, with coverage rates estimating that only 20% of the population living with HIV was receiving ARV treatment. Médecins Sans Frontières - Centre opérationnelle de Bruxelles (MSF-OCB) took the decision to launch an HIV project in the country from the beginning of the epidemic in 2003, in Matam and Guéckedou, focusing on the prevention and treatment of HIV and co-infection (HIV/TB). In the years that followed, this HIV project increased its reach in the country, establishing a presence in Wanindara, Gbessia, Flamboyants, etc. In 2011, prevention of mother-to-child transmission (PMTCT) activities were added to the HIV project's portfolio of activities in Gbessia and Flamboyants and remain a key component of MSF's HIV project in the country, a project that aims to contribute to the reduction and control of the spread of HIV in Guinea.

[MSF-OCB's HIV project in Guinea-Conakry](#)

Since 2003, MSF-OCB has been on the ground in Guinea-Conakry to implement and support the Ministry of Health (MDS) in setting up HIV-related health services in different project sites. The overall objective of the HIV project has been from the beginning and continues to be to reduce HIV-related morbidity and mortality rates in Guinea-Conakry. The HIV project consists of four thematic areas: Advanced HIV, Paediatrics, Tuberculosis and Sexual and Reproductive Health (SRH).

The specific objectives of the HIV project are:

- Ensure that quality free services for target populations living with HIV (and co-infected with TB/HIV) are provided by service providers supported by MSF-OCB,
- Ensure access to quality psychosocial support and care in the services supported by MSF-OCB,
- Strengthen civil society and procurement for the benefit of the target population.

The PMTCT component in the HIV project

Since 2011, the HIV project has integrated a PMTCT component, which falls under the SRH thematic area. The main objective of the PMTCT component is to provide PMTCT support to Ministry of Health maternity wards that are supported by MSF-OCB. This is achieved through two main activities: a midwife supervisor from MSF-OCB and two midwives from MSF-OCB provide weekly peer-to-peer mentoring to 42 midwives employed by the Ministry of Health in Conakry and the surrounding area, supporting the provision of services in eight of the Ministry's health centres. MSF-OCB provides medicines, tests and material support to MSF-supported Ministry of Health health centres. Peer-to-peer mentoring includes formative supervision, training, follow-up and coaching support, etc.

The PMTCT component encompasses the services that are carried out and supported by MSF-OCB in health centres, namely:

- HIV testing for pregnant and lactating mothers,
- The provision of ARV treatment for HIV-positive mothers,
- Monitoring and providing prophylactic treatment (if necessary) to newborns of HIV-positive mothers,
- HIV testing in babies (virological, 6 weeks and 4 months) and infants (serological, 24 months).

While the Guinea HIV project has historically had good results, as demonstrated by an external evaluation of HIV/TB in Guinea that was conducted in 2016, some challenges and bottlenecks have been identified in the PMTCT component of the project. These challenges and bottlenecks include:

- Long waiting times for test results from external laboratories, which has an impact on the treatment offered to people waiting for their results;
- Problems with the retention rate of patients (mothers and children) whose HIV test is HIV-positive.

GENERAL PURPOSE/OBJECTIVE AND INTENDED USE

GENERAL GOAL/OBJECTIVE

MSF-OCB has been managing a PMTCT component as part of the HIV project in Guinea and other settings in West and Central Africa for more than two decades. It is expected that the PMTCT component of the HIV project in Guinea will be transferred to a partner organization in the near future (within 2-4 years). There is therefore a strong interest on the part of colleagues in the national HIV project to evaluate the PMTCT component and other related activities that are not directly related to PMTCT in order to identify good practices and gaps in programming.

There is also an organizational interest on the part of MSF-OCB to capitalize on the experience of the PMTCT component in Guinea-Conakry, in order to generate learning of good practices that could be relevant for PMTCT programming in the Central and West Africa region, both for MSF-OCB, other MSF sections such as OCBA, as well as for the international community as a whole.

INTENDED USE

The intended use of this evaluation is as follows: by identifying what works for whom, where, under what circumstances and why, the evaluation should address two different but complementary uses:

- a. Contribute to MSF-OCB's internal discussions that will lead to the improvement of the PMTCT component of the HIV project in Guinea,
- b. Contribute to internal and external discussions on programmatic approaches to PMTCT in the context of West and Central Africa (but not only).

EVALUATION CRITERIA AND QUESTIONS

The following questions and sub-questions have been developed based on the DAC criteria, but we encourage qualified evaluators and evaluation teams to submit proposals that formulate the questions differently and/or use other criteria that could add greater value within the defined framework of the evaluation.

E1. Is the PMTCT component of the HIV project aligned with the priorities and needs of stakeholders?

- a. Who are the stakeholders (e.g. communities, potential and actual patients, local authorities, etc.
- b. What are the priorities and needs of the stakeholders identified?
- c. How could the PMTCT component be more relevant given the identified priorities and needs of stakeholders?

E2. Is the PMTCT component well designed to meet the priorities and needs of stakeholders?

- a. How are PMTCT activities tailored to the priorities and needs of stakeholders?
- b. How could the design of the PMTCT component be improved?

E3. Is the PMTCT component achieving the predefined objectives and expected results?

- a. What are the predefined objectives and expected results of the PMTCT component?

- b. What were/are the main opportunities and constraints that led/lead to the achievement or non-achievement of results?
- c. What changes could be made to the PMTCT component to improve the achievement of objectives and expected results more effectively?

E4. To what extent are resources (HR, financial, etc.) well used to implement the PMTCT component of the HIV project?

- a. How is the PMTCT component effective in achieving objectives and outcomes?
- b. How (if so) can the effectiveness of the implementation and monitoring of the PMTCT component be improved?

E5. What is the impact of the PMTCT component on stakeholders (patients, Ministry of Health midwives receiving peer support, community, etc.)

- a. Who are the different stakeholder groups impacted or affected by the intervention?
- b. What are the different impacts or effects of activities, positive or negative, intended or not, on these stakeholders?
- c. How can we increase the positive impact and reduce the negative impact of the PMTCT component on stakeholders?

EXPECTED DELIVERABLES

1. Initial report

In accordance with SIU standards, after conducting an initial document review and preliminary interviews. It will include a detailed evaluation proposal, including methodology.

2. Preliminary Assessment Report

In accordance with SIU standards. It will answer the evaluation questions and include conclusions, lessons learned and recommendations.

3. Working session

With the participation of the Commissioners and members of the consultation group. As part of the report writing process, the evaluator will present the results, gather feedback from participants, and facilitate discussion of lessons learned.

4. Final Evaluation Report

After taking into account the comments received during the working session and written contributions.

5. Other dissemination deliverables to be defined in a separate dissemination plan.

PROPOSED TOOLS AND METHODOLOGY

In addition to the initial evaluation proposal submitted as part of the application (see the chapter on requirements), a detailed evaluation protocol must be prepared by the evaluators during the start-up phase. It will include a detailed explanation of the proposed methods and their justification on the basis of validated theories/systems. It will be reviewed and validated as part of the initial phase in coordination with the SIU.

RECOMMENDED DOCUMENTATION

- Project documents (project proposals, logistics frameworks, situational reports, annual reports, field visit reports),
- Documentation of ongoing operational research initiatives under the project,
- National and regional documentation,
- External literature and documentation on similar experiences.

PRACTICAL IMPLEMENTATION OF EVALUATION

Number of evaluators	Open
Evaluation Timeline	Estimated between December 2021 and March 2022

PROFILE/REQUIREMENTS FOR EVALUATOR(S)

Requirements:

- Proven skills in conducting evaluations in development and/or humanitarian aid,
- Experience in medical programming or evaluation of medical programming in low-resource settings,
- Fluency in English.

Assets:

- Experience in evaluating PMTCT activities, projects, programs or policies,
- Experience working in medical programming in PMTCT,
- Experience and/or understanding of MSF,
- Fluency in French highly desirable.

APPLICATION PROCESS

The application must include a technical proposal, a budget proposal, a CV and a sample of previous work. The proposal should include a reflection on how adherence to ethical standards for evaluations will be taken into account throughout the evaluation. In addition, the evaluator(s) must take into

account the sensitivity of the subject matter in the methodology and be reflected in the composition of the team.

Offers must include a separate quote for all services, expressed in euros (EUR). The budget must present the consultancy fees according to the number of days of work planned over the entire period, both in their entirety and in the form of a daily fee. Travel expenses, if any, should not be included as the SIU will arrange and cover them. Please note that MSF does not pay a daily allowance.

Applications will be evaluated on the basis of the submitted proposal's understanding of the key deliverables in accordance with these RDTs, the relevant methodology for achieving the expected results, and the overall ability of the evaluator(s) to perform the work (i.e. inclusion of the CVs of the proposed evaluators, reference to previous work, certification, etc).

Interested teams or individuals must send their application to evaluations@stockholm.msf.org mentioning HIVGU no later than 23 November 2021 at 23:59 CET. We would appreciate it if the necessary documents were submitted as separate attachments (proposal, budget, CV, work sample, etc.). Please include your contact information in your CV.

Stockholm Evaluation Unit
<http://evaluation.msf.org/>
Médecins Sans Frontières

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