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EVALUATION OF

THE DECENTRALIZATION COMPONENT OF MSF'S AIDS PROJECT IN DRC

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ACRONYMS

ARV	Antiretroviral / antiretroviral
AIDS	Acquired Immunodeficiency Syndrome
CAD	Development Assistance Committee
CMC	Communal Medical Center
CNLS	National Committee for the Fight against AIDS
CS	Health Center (*Centre de Santé*)
GC	Evaluation Consultation Group
HIV	Human immunodeficiency virus
MSF	Médecins Sans Frontières
OCB	Brussels Operational Centre
OECD	Organization for Economic Co-operation and Development
PCR	Polymerase Chain Reaction
PEC	Case Management (*prise en charge*)
PLVIH	Person Living with HIV (*PVVIH* in French)
PNLS	National AIDS Control Program
PODIUM	Community ARV Distribution Point
PTME	Prevention of Mother-to-Child Transmission of HIV
SEU	Stockholm Evaluation Unit
TB	Tuberculosis
TME	Mother-to-child transmission of HIV (*Transmission Mère-Enfant*)
UNAIDS	Joint United Nations Program on HIV/AIDS
WHO	World Health Organization

EXECUTIVE SUMMARY

CONTEXT

The Democratic Republic of Congo (DRC) is a highly decentralized unitary state. The DRC's national health policy, adopted in 2001, focuses on primary health care (PHC). The operational unit for the implementation of the national health policy is the Health Zone, which organizes the structures responsible for providing comprehensive, continuous and integrated healthcare. The Ministry of Public Health, the main provider of health services, is structured in 3 levels, namely: the central level, the provincial level and the peripheral or operational level. The main health problems in the DRC are related to reproductive health, maternal health, malnutrition, malaria, road traffic injuries, tuberculosis and HIV/AIDS. HIV/AIDS is still a widespread epidemic, the DRC has an average adult HIV prevalence of 1.2%, with an HIV prevalence of 1.6% in Kinshasa.

MSF works to care for people living with HIV, with activities in Kinshasa since 1993. Since 2002, to address the problem of access to HIV services, MSF launched a HIV project at Kabinda Hospital, a referral hospital southwest of Kinshasa (AIDS project) in collaboration with the Ministry of Health. The centralization of care led to overcrowding, and long wait times became common while access was difficult for some patients (travel time). To overcome this problem, the project began in 2005 to support the decentralization of services to other health facilities. The AIDS project therefore includes two major operational components: the Kabinda Hospital Center (CHK) and support for decentralization.

THIS EVALUATION

An evaluation of the decentralization component was already carried out in 2019 and finalized in 2020 and focused on the evolution of the decentralization strategy from 2005 to 2017, as well as the results achieved. In 2022, MSF commissioned a group of independent evaluators to carry out a second evaluation of the decentralization component of the project, covering the period 2017 to 2022. The scope of the evaluation focused on (1) the relevance and coherence of decentralization objectives; (2) coherence between the objective of decentralization, the strategy deployed and the implementation on the ground; and (3) identification of lessons learned in relation to decentralization in general and the types of organization of the decentralization intervention in the city of Kinshasa (integrated and non-integrated). A sample of health facilities in both approaches was visited during field data collection (a total of 11 facilities were visited during the evaluation process). In addition, the evaluators conducted a systematic review of MSF documents and external literature to describe the decentralization component of the AIDS project and explain the results achieved. Qualitative primary data collection was carried out through interviews and focus group discussions with selected stakeholders through functional sampling. A total of 58 people were interviewed as part of the assessment, representing stakeholders from MSF, the Ministry of Health, patients and other stakeholders. In addition, primary clinical data routinely collected by project team members in health facilities were cross-referenced with data from other sources (monitoring sheets, project reports, etc.) in order to reach conclusions.

RESULTS

RELEVANCE

The results of the evaluation indicate that MSF's support for the decentralization of HIV services (extension of the quality and free care) of Kabinda to other structures, particularly at the primary level (health center & hospital center), or even at the community level (PODI), was relevant in view of the difficulties of access to treatment for HIV patients in Kinshasa and the low quality of care (high rate of loss of follow-up). The objective of decentralizing stable patients from the CHK was also relevant to allow the Kabinda Hospital Center to focus on cases of unstable patients (severe cases) and also to be able to maintain the same level of quality of care. However, the project did not intervene by extending care services to other health facilities between the period 2017 to 2022, despite national reports mentioning significant challenges in terms of access to testing, prevention of mother-to-child transmission (PMTCT) and pediatric HIV care. These themes seem to have been dealt with less specifically in the context of support for decentralization. The theme of inclusion and consideration of vulnerable groups such as pregnant women and key populations in support of decentralization also does not seem to have been defined in the decentralization strategy, and the various reports produced on the project do not highlight how these vulnerable groups have been particularly targeted and impacted.

Support for the decentralization of the AIDS project had two objectives: (1) to increase access to HIV services, and (2) to improve the quality of HIV care in Kinshasa. Support for the decentralization of HIV care services by the AIDS project in Kinshasa (support in terms of strengthening pre-existing services in peripheral structures) was initially initiated to relieve congestion at the Kabinda Hospital Center, which could almost no longer contain the number of patients to be cared for with more than 6,500 as a cohort reached before the start of decentralization. The results of the evaluation indicate that the problem of vision loss was a major problem in 2017, justifying an effort on the quality of care. Despite an improvement over the period, lost follow-up remains a major problem and the AIDS project remains relevant in its efforts to decentralize the quality of services to the peripheral level. In addition, the AIDS project worked on strengthening the quality of services in decentralized structures, particularly through clinical mentoring and the allocation of certain equipment. Given the needs, it is clear that MSF's support for decentralization consists of supporting structures already operational in the city of Kinshasa, aimed at improving quality but not expanding HIV services.

COHERENCE

MSF's approach to supporting decentralization through the process of continuous improvement of the quality of HIV care services at the peripheral level is consistent with the context of peripheral structures, which were characterized by poor quality of care (many lost to follow-up and low retention in care). Support for decentralization as developed by the AIDS project over the period evaluated has evolved towards a zonal approach that has developed two modes of intervention, non-integrated and then integrated within the same health zone, in coherence with the organization of care that provides for the continuum of care within the same health zone. The decentralization of HIV services in Kinshasa takes place in a multi-actor environment with intervention approaches

specific to each, and the project was able to set up collaboration with these actors, particularly for care in structures such as the King Baudoin Hospital and the PODI. The support for decentralization deployed by the AIDS project is consistent with the orientations of the National AIDS Control Program (PNLS), the country's normative body for HIV care, with the decentralized package that is the one retained and recommended by the program. MSF has transferred skills to peripheral structures to improve the quality of care and access to HIV testing and treatment services. However, the very high level of quality of the decentralized services created by the AIDS project does not allow the structures to maintain the same level and the other partners to continue the activity after the withdrawal of MSF.

In its strategy to support the decentralization of HIV care, MSF's AIDS project intervened more in areas supported by the Global Fund and less in areas supported by PEPFAR. Indeed, the areas supported by the Global Fund would have more difficulties in terms of performance and the needs would be greater than in the PEPFAR areas within the city of Kinshasa according to the interviews carried out. The approach deployed by MSF calls on the workforce of health structures (doctors, nurses, hygienists, etc.), which strengthens local roots and offers the possibility of perpetuating the skills acquired at the local level.

As part of the decentralization of the AIDS project, the zonal approach deployed by MSF has evolved with the implementation of an *integrated* zonal approach where the entire chain of HIV care is organized within a single health zone. This evolution seems consistent with the organization of the health system (referral of patients) from the health center (lowest level of care provision) to the general hospital (the highest level of care offer at the level of a health zone) via the hospital center. The evolution of the decentralization approach towards an integrated zonal approach (intervention at different levels within the same health zone) therefore seems consistent for alignment with the functioning of health services and the integration of HIV services at the primary and secondary levels of the health system.

There is synergy with other partners who provide ARVs, TB drugs and HIV diagnostic tests. These include the Global Fund and PEPFAR. The main collaborator of the MSF project at the level of the Ministry of Health is the PNLS with its national coordination and coordination at the level of the city-province of Kinshasa.

EFFECTIVENESS

The evaluation found that the AIDS decentralization initiative was effective primarily in reducing the number of people lost to follow-up over the period evaluated, maintaining an overall high retention rate in care across all health care facilities, and dramatically increasing access to viral load testing. However, there are still gaps in indicators relating to the initiation of routine prophylactic treatment among people living with HIV (PLHIV) who test negative for tuberculosis, and the availability of ARVs in decentralized facilities. Nevertheless, the quality of data and the monitoring of indicators to better assess effectiveness remain a point of attention, both in terms of the completeness and

compatibility of databases, and the choice and longitudinal monitoring of indicators. The contribution of the South African Medical Unit of MSF to support decentralization was assessed in terms of organization and activities carried out, but it was not possible to assess the improvement in the skills of supervised staff due to lack of data.

While decentralization seems to have had positive effects on the extension of care and the quality of HIV care at the level of decentralized health facilities, it appears that the available data, the indicators monitored and the duration of support are not sufficient to assess all these effects on health structures and beneficiaries of HIV services. On the other hand, the objective of decongesting the CHK has been achieved. In 2022, there are less than 2000 patients followed at the CHK level, mainly cases of unstable patients. Decentralization has made it possible to increase the rate of ARV screening and treatment in general and especially at the level of decentralized structures. The analysis of the contribution of support to decentralization by the AIDS project in improving access to HIV care services analyzed the indicators of the logical framework related to HIV services, these include the number of tests, the percentage of patients who benefited from viral load, the retention rate at 12 months, etc. For example, decentralized facilities had high rates of loss of follow-up before MSF support, between 50% and 77% of newly enrolled patients on antiretroviral therapy (ART). With the integration of MSF's approach to improving the quality of care, the rate of vision loss has been divided by 3 and would have remained below 10% for three health facilities in 2022 with the exception of the Mokali Hospital Center (CH) and the Tshimungu Health Center (CH) which have maintained dropout rates of 77% and 67% respectively, showing a low effectiveness of the project's intervention in these structures while we are on the eve of MSF's disengagement. The number of deaths to follow-up remains high in the two health facilities and could also be explained by the fact that the support of the project is relatively recent and that it takes time to install good practices in the area of quality of care. On the other hand, retention in care within decentralized structures has not improved significantly with the support of the AIDS project. Structures that had good retention before the start of support kept relatively the same retention rate, some even had retention rates slightly lower than the retention rates before MSF support.

EFFICIENCY

To assess the success of project management, it is necessary to define the relative effectiveness of project management. For this evaluation, the evaluation team could not identify MSF's internal standards (and/or external references) that could be used for this purpose. Despite this shortcoming, the results of the evaluation sub-criteria indicate that the resources invested in the HIV project (human resources, thematic capacity-building interventions) are sufficient to achieve the originally planned outcomes. The recording of project expenditure did not make it possible to highlight the costs incurred by supporting decentralized structures with a breakdown by health structure in order to estimate the cost-benefit of the investment made in supporting decentralization. The use of local human resources of the supported structures was appreciated, but incentives in the form of performance bonuses could have a perverse effect by discouraging providers from providing free care to PLHIV after MSF's withdrawal. Finally, the time MSF remains in a health facility seems insufficient to bring about lasting changes, and the reduced chances of sustainability could be considered as a factor in the low effectiveness of the intervention on decentralization.

Given the nature of the project, the evaluators recognized that the level of criticality of the project's success is directly related to the specific requirements and priorities of the different project stakeholders (mainly the Ministry of Health). The interviews confirmed that all stakeholders have favorable views on the effectiveness of implementation. On the other hand, this lack of financial visibility is likely to affect the chances of a successful transition for the transfer of responsibility for the project to another partner, whether national or international. Indeed, the resumption of an activity requires sufficient information on its assembly, its operation at the technical level, and its cost of realization. The absence of this type of information could be a source of reluctance on the part of a potential buyer.

IMPACT

The impact of the decentralization of quality of care and free access to peripheral structures has been primarily on improving the quality of life of PLHIV who are satisfied that they no longer have to travel long distances or spend a lot of money to seek quality care at CHK. The CHK has also benefited from the extension of the quality of care to decentralized structures because it has made it possible to relieve it. The fact that MSF remains in a structure for a relatively short period of time would not allow to consolidate the gains and when MSF leaves, there would be a feeling of being neglected at the level of providers and patients. MSF's intervention on decentralization has had an impact on improving the quality of care and especially on reducing the number of people lost to follow-up, which is one of the major problems of HIV care in the DRC and specifically in Kinshasa. Feedback from caregivers who have benefited from clinical mentoring services says that MSF's intervention at the level of decentralized structures has allowed them to increase their skills and self-confidence in managing HIV infection. PHAs have seen their quality of life improved by proximity to services, including ARV supply by avoiding long queues if they all have to go to CHK and for patients living far from CHK, money is saved. Nevertheless, PLHIV deplore the deterioration in the quality of the caregiver-patient relationship following the return to coverage of certain costs after MSF's withdrawal from certain structures.

SUSTAINABILITY

The technical skills acquired can continue to be used even after MSF's withdrawal from decentralized health facilities, as well as some equipment. Nevertheless, good practices and the level of quality of services do not seem to have much chance of being sustainable after release. The duration of MSF's two-year support within a health facility also seems insufficient, as some indicators of the success of decentralization, such as retention in care, can only be calculated when MSF is preparing to or has already left. It should therefore be concluded that sustainability seems unlikely today with the adjustment of MSF's commitment and disengagement in favor of decentralized structures. It should be noted that the resumption of payment for care by the patient after MSF's withdrawal from the health structures supported remains difficult, questioning the relevance of free care as it is organized today in a context of the DRC where essential care services are paid for with a low contribution from the State. The situation of the health system with poorly paid or sometimes unpaid human resources means that MSF's intervention remains relevant until a reform of the health system allows

autonomy in the management of HIV services. Currently, the National AIDS Control Program (PNLS) does not have sufficient resources to cover the deficit after MSF's disengagement. No standard sustainability strategy has been defined clearly explaining how MSF will leave and transfer responsibility (to which actor and under what conditions).

KEY FINDINGS

MSF's support for decentralization as part of the AIDS project in Kinshasa aimed to relieve congestion in the central structure of the CHK by extending free access to HIV care services and quality of care to decentralized structures.

The intervention at the different levels of the pyramid of care within a health zone with evolution from the non-integrated approach to the integrated approach, the multi-stakeholder dynamic initiated with the collaboration of the PNLS at the national and provincial level, other actors also confirm the coherence of MSF's intervention logic with the configuration of the health system in the DRC and also with the organization of the HIV response in the Congolese context.

The effectiveness of support for decentralization was assessed by the high overall performance rates of decentralized structures, the decrease in the rate of loss of follow-up, and the high retention rates in care, confirming the effectiveness of MSF's support to decentralization, although the sustainability of the effects remains a major challenge. However, decentralization has focused efforts on supporting the clinical component (clinical mentoring) and less on aspects of care relationships, which are an important determinant of adherence to care and therefore retention in care.

It was difficult to assess the financial effectiveness of the project due to expenditure recording procedures that did not correspond to the analyses required by the evaluation and it did not allow for the identification of details in relation to the use of budgets allocated to decentralization.

The impact of decentralization has been much greater on the decongestion of CHK (ultimately focusing only on cases of unstable patients), and allowing an increase in the quality of care and quality of life of PLHIV as a whole, thanks to the extension of quality care in decentralized structures. The impact of decentralization was therefore perceived differently by beneficiaries depending on whether MSF was still present or had already withdrawn.

Technical sustainability, especially with regard to the skills acquired by care providers, is possible because they can continue to use these skills even after MSF's disengagement, but economic sustainability does not seem possible in the absence of cost-recovery mechanisms. The early disengagement after two years of support also does not seem to offer the chances of appropriating good practices within the decentralized structures supported.

KEY RECOMMENDATIONS

Recommendation 1:
Extend support for decentralization to other health facilities in non-integrated areas.

Recommendation 2:
Strengthen support for health structures through long-term technical support.

Recommendation 3:
Improve the management of project data and information.

Recommendation 4:
Improve the preparation of MSF's disengagement to increase the chances of sustainability of the results obtained by supporting quality improvement in decentralized structures.

Recommendation 5:
Advocate for the inclusion of quality improvement aspects in the decentralization process of HIV care in the DRC.

INTRODUCTION

GENERAL AND HEALTH CONTEXT OF THE DRC

PRESENTATION OF THE DRC[1]

The Democratic Republic of Congo (DRC) with its area of 2,345,410 km^2, is the second largest country on the African continent after Algeria. It is located in Central Africa, straddling the equator. Under the 2006 Constitution, the DRC is a highly decentralized unitary state. It has been subdivided into 26 provinces since 2015, including the city of Kinshasa. The latter has a large degree of autonomy in certain matters defined by the Constitution. Provinces are subdivided into cities and territories, cities into urban communes, territories into rural communes, sectors and chiefdoms. Urban or rural communes are divided into districts. The Sectors and Chiefdoms are subdivided into groups and the groupings into villages. The last general census of population and housing organized in the DRC dates back to July 1984. Recent projections by the National Institute of Statistics (INS) place the Congolese population for the year 2018 at more than 85 million inhabitants with a density of 36 inhabitants per km². The population is concentrated on plateaus, in savannahs, near rivers and lakes. With an estimated fertility of 6.6 children per woman (DHS 2014), and an annual population growth rate of 2.9% (INS 2015), the DRC expects its population to double every 25 years. This corresponds to an annual increase of more than 2 million people. If appropriate measures to control fertility are not taken, this population could reach more than 120 million inhabitants in 2030; and will be composed of more than 45% of young people under 15 years of age and only 3% of people aged 65 and over. This demographic situation contributes to keeping the country in poverty, especially since the proportion of the non-active population exceeds that of the active population.

The City of Kinshasa, capital of the Democratic Republic of Congo, is located on the left bank of the Congo River opposite the City of Brazzaville, capital of the Republic of Congo. It has the administrative status of a Province. The area is 99 965 km² of which 2 500 km² constitute the agglomeration and its population is estimated at 12 million inhabitants with a density of more than 1000 inhabitants/km².

HEALTH SITUATION IN THE DRC[2]

1. Health policy

The mission of the Ministry of Health is to contribute to the improvement of the health status of the entire Congolese population by organizing quality and equitable health services for the restoration

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[1] Statistical Yearbook 2020 – National Institute of Statistics (Democratic Republic of Congo) https://ins.cd/wp-content/uploads/2022/03/UNDP-CD-ANNUAIRE-STAT.-2020-.pdf

[2] Reframed National Health Development Plan for the period 2019-2022 (Democratic Republic of Congo): Towards universal health coverage - https://www.globalfinancingfacility.org/sites/gff_new/files/documents/DRC_Investment_Case_FR.pdf

of people's health and the promotion of the best possible health status in all communities (Ordinance No. 014/078 of 7 December 2014). More concretely, it involves:

- Ensure legislation, regulation, standardization and development of health policies and strategies;
- Ensure the production and mobilization of internal and external resources necessary for the implementation of the Government's health policies and strategies;
- Provide quality health care services that are preventive, curative, promotional and rehabilitative to the entire population living in the national territory;

The National Health Policy, adopted in 2001, focuses on primary health care (PHC). The operational unit for the implementation of the national health policy is the Health Zone, which organizes the structures responsible for providing comprehensive, continuous and integrated health care.

2. Organization of the health system

The Ministry of Public Health is structured in 3 levels, namely: the central level, the provincial level and the peripheral or operational level.

- Central level

This level is in the midst of administrative reform. Thus, the new organizational framework plans to move from 13 to 9 Directorates. The current reform also provides for the consolidation of some specialized programs and the transformation of others into specialized services. The provincial level is composed of the Provincial Minister in charge of Health, a Provincial Health Division, a Provincial Health Inspectorate, the provincial hospital and other provincial health structures. Decentralization gives the provinces exclusive responsibility for the organization and management of primary health care. Provincial Health Divisions (DPS) are decentralized structures under the supervision of Provincial Ministers responsible for health. They provide technical supervision, monitoring and translation of directives, strategies, policies in the form of instructions to facilitate the implementation of actions at the level of Health Zones.

- Operational level

This level includes 516 Health Zones with 393 General Reference Hospitals, and 8 504 planned Health Areas (HAs) of which 8 266 have a Health Centre. The mission of this level is the implementation of the primary health care strategy.

3. Organization of the provision of care

The organization of the provision of care is ensured by public and private structures. The public sector is organized around health centers (HCs), hospitals, general referral hospitals (HGRs), provincial hospitals, armed forces hospitals, police and other departments organizing care for their workers. The private sector is divided into two categories, private for-profit and non-profit (health services of non-governmental organizations and faith-based organizations) and traditional medicine. The private confessional and associative sector represents about 40% of the care offer. The main actors are the Catholic churches (Diocesan Offices of Medical Works), Protestant, Kimbanguist and Salvationist which manage health facilities (hospitals and health centers).

4. Key population health issues and HIV status

The main health problems in DRC are related to reproductive health, maternal health, malnutrition, malaria, road injuries, HIV/AIDS, and tuberculosis.

With regard to HIV/AIDS, still a generalized epidemic, the DRC has an average adult HIV prevalence of 1.2% and this is unevenly distributed by both province and age group. The capital of the Democratic Republic of Congo (DRC), Kinshasa, is a densely populated mega city where HIV prevalence is 1.6%. There is also a disparity between women (1.6%) and men (0.6%). There are 516 617 people living with HIV in the country, and at the end of 2017 it was estimated that 46 % of people living with HIV know their HIV status and less than 25% of people living with HIV (PLHIV) are on ARV treatment. HIV still remains highly stigmatized in the DRC.

DESCRIPTION OF MSF'S AIDS PROJECT IN DRC

BACKGROUND AND PRESENTATION OF THE PROJECT

The roll-up of antiretroviral therapy (ART) has increased the number of HIV-infected patients on treatment to 15 million in 2015, 11 million of whom live in sub-Saharan Africa. The number of clinically stable patients accessing health services for ART without the need for regular medical care has increased accordingly. This exacerbates existing problems in low-resource settings, such as overburdened health services, and diversion of scarce human resources from caring for unstable HIV-positive patients[3].

MSF had already intervened in the field of care for people living with HIV with activities in Kinshasa as early as 1993. Since 2002, to address the issue of access to HIV services, MSF has launched a HIV project at Kabinda Hospital, a referral hospital in south-west Kinshasa (AIDS project), in collaboration with the Ministry of Health, and by 2010, more than 6 500 patients were receiving antiretroviral treatment in this facility. Centralization of care has led to overcrowding and long hours of waiting have become common, with patients having to drive up to three hours to reach Kabinda Hospital due to traffic jams and poor public transport in the city center. Therefore, even a simple collection of ARVs could easily cost a patient an entire day[4]. To overcome this problem, the project began in 2005, the decentralization of project services to other structures. The project supported several health structures through the decentralization component and disengaged from some of them, passing the baton to other actors. The decentralization strategy has also evolved over the years.

[3] Vogt, F., Kalenga, L., Lukela, J., Salumu, F., Diallo, I., Nico, E., ... & Van Griensven, J. (2017). Brief report: decentralizing ART supply for stable HIV patients to community-based distribution centers: program outcomes from an urban context in Kinshasa, DRC. Journal of acquired immune deficiency syndromes (1999), 74(3), 326.

[4] Vogt, F., Kalenga, L., Lukela, J., Salumu, F., Diallo, I., Nico, E., ... & Van Griensven, J. (2017). Brief report: decentralizing ART supply for stable HIV patients to community-based distribution centers: program outcomes from an urban context in Kinshasa, DRC. Journal of acquired immune deficiency syndromes (1999), 74(3), 326.

Table 1: Key moments of the project and the decentralization of HIV care from 2017 to 2022

YEAR	BACKGROUND AND CONTEXTUAL ELEMENTS
2017	▪ Completion of the second round table that set the strategic objectives for 2017 – 2022
2019-2020	▪ Mid-term round table that led to the adjustment of the project's intervention strategy, particularly on its decentralization component: introduction of the integrated zonal approach, support to community actors, health centers, health zone offices, and general reference hospitals ▪ Interim evaluation of decentralization: evolution of the decentralization strategy
2022	▪ Second evaluation of decentralization: performance of decentralization & appreciation of integrated and non-integrated approaches

Table 2: Summary of the AIDS project fact sheet. Source: Excerpted and adapted from AIDS 2020 project document

PROJECT	HIV/AIDS PROJECT
Project duration	20 years (from 2003 – 2022) – unspecified closure period
Project objectives (as presented in the log frame)	▪ General objective: Mortality and morbidity of PHAs in the city-province of Kinshasa are reduced. ▪ Specific objective: PLHIV have access to free and comprehensive HIV services.
Project decentralization objectives (as presented in the log frame)	▪ Increase access to HIV services; ▪ Improving the quality of HIV care in Kinshasa.
Geographic focus of the project	City of Kinshasa
Beneficiaries	▪ People living with HIV (access to care) ▪ Caregivers (training and mentoring)
Key players	▪ Government: PNLS National, PNLS Provincial, PNMLS, PNLT, PNLTS, MCZ and BCZ, DPS; ▪ International agencies: WHO, UNAIDS, UNICEF; ▪ Two major HIV donors in the DRC: Global Fund (GM) and PEPFAR; ▪ PEPFAR implementing partners and FM recipients: USAID, CDC, ICAP, EGPAF, IHAP/CORDAID, ADS, BDOM; ▪ Other INGOs: CHAI, DREAM, MDM; ▪ PLHIV/civil society associations : RNOAC, Jeunesse Espoir, UCOP+, Femmes +, RACOJ.
Activities and areas of intervention	CHK (hospital MSF): ▪ Management (ECT) of advanced HIV on an outpatient and inpatient basis – complete package;

	▪ Viral load (CV) offer for MSF cohorts and cohorts of other partners; ▪ Training hospital for MSF and partners to strengthen skills transfer; ▪ Reference and Operations Research Centre to improve the PEC. Support to 2 partner hospitals: ▪ Multiplication of hospital CEP sites; ▪ Mentoring to improve the quality of the JEP for 4-5 years (reduced to 3 years after the mid-term roundtable). Support to 5 partner health centers: ▪ Implementation of PEC models (screening, initiation, referral to PODI/Rapid Circuit); ▪ Mentoring to improve the quality of the CEP for 2 to 3 years (reduced to 2 years after the mid-term roundtable). Support to health zones: ▪ Support for the ZS framework team (participation in the supervision of health structures) and other non-supported CS (staff training and support for access to viral load testing). Support for the multiplication of Membership Clubs for Youth: ▪ Management of 5 clubs; Support training and knowledge transfer to partners. Advocacy with key partners to improve access to care and CEP. Operations research **Three areas of intervention:** (1) Diagnostic (screening tests), (2) access to care (pediatric JEP, advanced HIV JEP, implementation of psychosocial support), (3) availability of inputs (work on stock-outs).

The following Figure 1 shows the area of intervention of the AIDS project in the city of Kinshasa between 2017 and 2022.

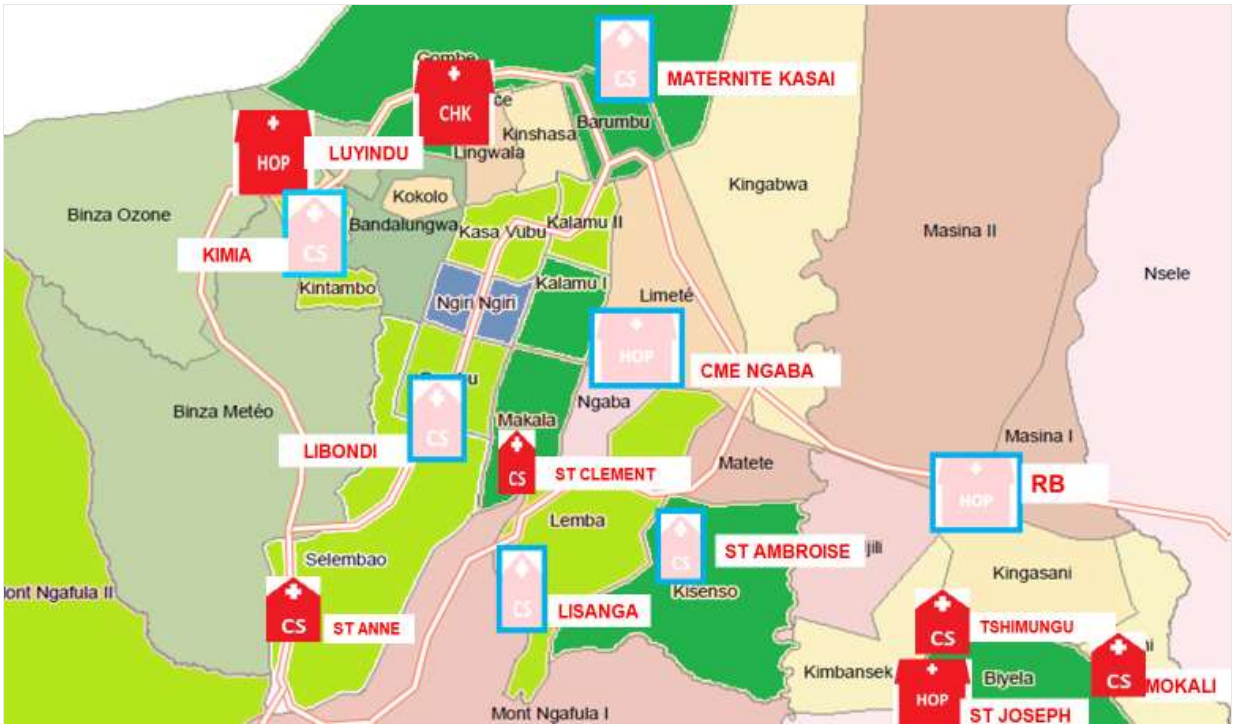


Figure 1. Map of the HIVKII project intervention area

The AIDS project consists of two main operational components; Kabinda Hospital (CHK) and decentralization. The CHK is a referral and training hospital center (for MSF and its partners). It is a totally MSF structure that takes care of people with AIDS. This structure consists of an inpatient part with 41 beds and an outpatient part where a cohort of about 1 900 patients is followed by (CHK cohort: 980; cohort patients referred to CHK by CS: 904). The decentralization component provides support at the primary (health centers), secondary (general hospitals) and community levels (support in increasing the number of ARV distribution points: PODI and youth observance clubs). The AIDS project aims to ensure access to care (screening, pediatric and adult treatment, psychosocial support), quality of care (monitoring, pharmacy and laboratory management, and data management), innovation and patient advocacy as a "catalyst for change" project in the sense that it aims to influence national policy.

The activities on decentralization, carried out by MSF through the AIDS project, also included support for the creation and operation of community distribution points (PODIs), which were subsequently transferred to other actors such as Cordaid. IDPs were included in the Ministry of Health (MOH) Strategic Plan for 2011-2015 as an approach to reduce workload in facilities with high numbers of ART patients, and increase retention in care and adherence by providing care closer to home in a stigma-free environment.[5]

[5] Moudachirou, R., Van Cutsem, G., Chuy, R. I., Tweya, H., Senkoro, M., Mabhala, M., & Zolfo, M. (2020). Retention and sustained viral suppression in HIV patients transferred to community refill centres in Kinshasa, DRC. *Public Health Action*, *10*(1), 33-37.

DESCRIPTION OF THE DECENTRALIZATION COMPONENT OF THE AIDS PROJECT

GENERAL DEFINITION OF DECENTRALIZATION

Decentralization is a difficult concept to define. Different specialists consider it through a variety of diverse, often incoherent, sometimes openly contradictory analytical lenses. This divergence is compounded by differences between those who write about decentralization as it applies in the field of public administration in general, as opposed to those who seek to apply decentralization specifically to the health sector. A series of additional questions arise when seeking to assess the real results of decentralization on pressing policy issues within health systems - its impact on the ability of health systems to meet the needs of patients and families - its impact on the ability to provide long-term care, for example, or to build integrated care networks.

When it comes to health, there is little evidence that countries with more decentralized health systems have better health outcomes. So far, only a limited number of studies have attempted to measure the extent of the effect of public sector decentralization on health indicators. Overall, these studies find a beneficial effect of decentralization on health outcome indicators.[6]

DEFINITION AND CONCEPT OF DECENTRALIZATION IN THE FRAMEWORK OF THE AIDS PROJECT

In the context of the AIDS project, the definition of decentralization refers to the decentralization of MSF's activities to health structures at the peripheral level in the organization of the health system, structures already carrying out HIV care activities; it can therefore more accurately be considered as support **for the decentralization** of HIV care services, carried out by the Ministry of Health. The objective of MSF's support for decentralization is to **improve access and quality of care** within health facilities in the city of Kinshasa (other than the Kabinda Hospital Center in order to relieve congestion) for testing, treatment and follow-up, to better detect the signs of advanced HIV and respond as quickly as possible to treatment failures and adherence issues, to prevent people living with HIV (PHAs) from falling out of the cascade of care. The "good governance/management" of health facilities (FOSA) is a major selection criterion for health facilities established by MSF to determine where support for decentralization is implemented. An evaluation tool has been set up to make this selection as objective as possible. The duration of MSF's support to decentralized structures is 2 years for health centers and hospitals and 3 years for general referral hospitals.

Care through outpatient therapeutic centers was initially deployed, but this vertical, specialized, and cost-effective approach had proved difficult to export to integration with primary health care. It had to be adapted and manageable at the primary health care level by versatile, nurse-level staff with

[6] Jimenez, D., & Smith, P. C. (2005). *Decentralisation of Health Care and Its Impact on Health Outcome* (Vol. 10). Department of Economics and Related Studies, University of York.

simple but effective guidelines. [7] Psychosocial counsellors, sometimes from the population of people living with HIV, have also been used to make care horizontal (peer support).

MSF's current decentralization strategy is based on a Health Zone **(Zone de Santé, ZdS) or zonal approach** that strengthens collaboration between MSF and the ZdS management team and took shape in 2019. In each of these ZdS, MSF provides technical and financial support (coaching, performance bonus, etc.) to the ZdS management team for the supervision of HIV/TB activities in the mother CS and in the satellite CS. The other activities developed in these intervention areas are more focused on health structures with support for increasing/improving the care of PLHIV (technical training, working group on viral load, and supply of inputs, etc.), as well as the integration of HIV/TB services (*One Stop Shop*) and monitoring & evaluation of the actions carried out.

The zonal approach deployed by MSF in the context of the decentralization of HIV care activities is based on three types of decentralization organization:

1. The non-integrated zonal approach: decentralized health structures where MSF operates within the same health zone can either be at the health center level, at the hospital level (first reference level after the health center), or at the level of the general referral hospital (second reference level after the health center). MSF does not intervene at all these different levels within the same health zone;
2. The integrated zonal approach: In this approach, MSF intervenes simultaneously at several levels of care (of the referral chain) within the same health zone with at least 1 CS / hospital center and 1 general referral hospital. ;
3. In 2010, a model of decentralization of ARV supply for stable patients to community resupply centers ("community distribution station" (PODI) was initiated in collaboration with the national organization "National Network of Community Assembly Organizations". The main objective was to provide rapid and de-medicalized access to ARV treatment by separating medical care from drug supply. In one year, three PODI were opened across Kinshasa. PODI are small entities and are staffed by lay community workers, most of whom are themselves HIV-positive. Appointments are scheduled every three months, plus an annual check-up, at Kabinda Hospital. The entire process of recording, assessing adherence and distributing ART usually takes less than 15 minutes. No medical care is offered, but referral to Kabinda Hospital is arranged if necessary. Failing patients are found by community volunteers. [8]All services are free of charge. MSF supported this strategy of decentralizing HIV care (ARV refueling) to the level of the PODI until its disengagement with the transfer of this activity to Cordaid. MSF provided medicines, financial and technical support, and organized training for PODI staff.

Particular emphasis is now given to the network system between the different health facilities (FoSa): PODI - CS satellite - CS mother - General Referral Hospital - CHK as part of the integrated

[7] MSF (December 2007). Decentralization of HIV/AIDS testing and care to health centres: capitalization report 2004-2007.
[8] Antiretroviral therapy

zonal approach. One of the proposals of the 2020 Round Table was to develop a system adapted to patient mobility (health passport, opening for patients returning to the PEC, etc.).

ROLE OF MENTORING IN THE CENTRALIZATION INITIATIVE: THE IMPORTANCE OF TRAINING

To support decentralization, there is clinical mentoring, a strategy to extend learning from the classroom to the workplace. In a structured program, the most experienced clinicians are paired with less experienced clinicians, so that practical support is provided in the actual workplace.

Mentoring is particularly appropriate in highly changing situations that require creativity, advanced problem-solving skills and the ability to make good decisions.[9]

On the AIDS project implemented in Kinshasa, the mentoring program worked as follows to support decentralization:[10]

General organization

- Deployment of 3 clinical mentors / 6 primary care sites (1 mentor covers 2 clinics);
- 2-3 visits per week (one day for teaching and another day for field support);
- The same principles are applied in IPD mentoring;
- Parallel mentoring with PSE, and light support provided to the laboratory and pharmacy department, as well as data management and reporting.

Organization of teaching

- Is done in the afternoon;
- Average duration of a course - 1h to 2h;
- Average attendance of 20 people (clinicians from different departments participate);
- Based on the principles of adult learning;
- Different pedagogical methods implemented;
- Use of an observation grid;
- Certification for the completion of the mentoring program (based on 90% attendance, 90% summative evaluation, 90% formative evaluation).

[9] https://mentoring-coaching.msf.org/fr/le-mentorat-a-msf/

[10] Field visit report of the mentoring and learning advisor of the SAMU in Kinshasa DRC - AIDS Project, from October 11 to November 06, 2021.

EVALUATION BACKGROUND, OBJECTIVES, AND SCOPE

BACKGROUND TO THE EVALUATION

An evaluation of the decentralization component was already conducted and finalized in 2020 and focused on the evolution of the decentralization strategy from 2005 to 2017, as well as the results achieved. This evaluation noted a good performance of decentralized structures overall, but patient retention rates at 12 months varied between 77.8 and 88.9%. The evaluation also found that the standards set by MSF in terms of laboratory equipment, training and patient service are not sustainable once MSF withdraws.[11]

From 2017, MSF introduced a zonal approach to decentralization with two types of intervention organization: non-integrated zonal approach from 2017, coupled with an integrated zonal approach from 2021. To assess support for decentralization since 2017, MSF commissioned an external evaluation in 2022, the results of which are presented in this report.

OBJECTIVE OF THE EVALUATION

The objective of this new 2022 evaluation was to assess the decentralization component of the project from 2017 to 2022 by exploring the following:

1. Relevance and coherence of decentralization objectives;
2. Concordance between the objective of decentralization, the strategy deployed, and the implementation on the ground;
3. Identify lessons learned in relation to decentralization in general and types of organization of the decentralization intervention in the city of Kinshasa (integrated and non-integrated).

The purpose of this evaluation was to answer the following evaluation questions :

- EQ 1: Were the objectives relevant given MSF's observed and expressed needs, context and priorities ?
- EQ 2: Was the strategy, design and implementation coherent given the context and existing resources? How could the approach have been more consistent?
- EQ 3: To what extent have past experiences (including the previous evaluation) been taken into account in the definition and implementation of the 2017-2022 decentralization strategy?
- EQ 4: Have the different actors and counterparties been sufficiently taken into account?
- EQ 5: Has the decentralization component achieved its expected outcomes (effectiveness)?
- EQ 6: What resources were needed, were they available, could they have been mobilized more effectively or sustainably?
- EQ 7: What is the impact of the decentralization component?

[11] Doctors Without Borders. Decentralization of HIV Treatment: Evaluation of the HIV Treatment Decentralization Initiative, Kinshasa, DRC - https://evaluation.msf.org/sites/default/files/attachments/evl_2020june18_kinde_fre_decentralisationvih_rdc_seu.pdf

- EQ 8: Are the benefits or changes brought about by the decentralization of HIV care by the AIDS project sustainable?
- EQ 9: What capabilities has the project created that can help ensure sustainability?

SCOPE OF THE EVALUATION

The evaluation process documented lessons learned and reflected on how they are integrated into the implementation of decentralization.

The evaluation covered the entire decentralization process and the two subtypes of the current approach to decentralization: integrated zonal approach and non-integrated zonal approach. Thus, a sample of health facilities in both approaches was visited during data collection in the field. IDOs that had already been transferred to another partner at the beginning of the evaluation period were not included in the evaluation. On the timeline, the evaluation essentially covered the period from 2017 to 2022.

The indicators of decentralization defined on the project, as well as the standard OCB indicators for the monitoring of HIV medical projects/activities, were analyzed to assess the extent to which these indicators make it possible to monitor the changes, and impacts generated by the support of the AIDS project to the decentralization of HIV care services at the level water from health centers, hospitals, and general referral hospitals.

EVALUATION CONCEPTUAL MODEL

The focus of the evaluation has been placed on the decentralization component of the project and not on the entire project; it is important to keep this in mind to avoid any source of confusion in the evaluation results.

The conceptual framework presented below helped guide the evaluation process by highlighting the areas analyzed but also the link between the 2020 evaluation and this new evaluation.

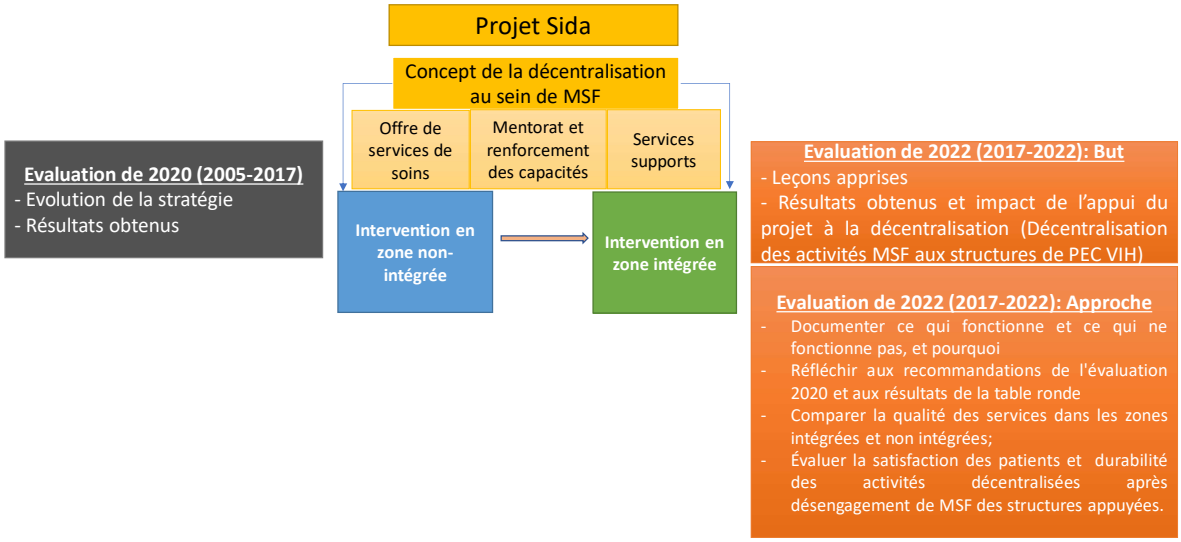


Figure 2. Conceptual framework for the evaluation of the decentralization component of the HIVKII project

EVALUATION METHODOLOGY

METHODOLOGICAL APPROACH

A **mixed** *quantitative and qualitative* methodology was used for this evaluation. The evaluation process followed the project throughout the results chain, from inputs to outcomes (i.e. logical framework), linked to support to HIV services in decentralized structures.

DATA COLLECTION

DATA SOURCES

1. Literature Review

The evaluators conducted a systematic review of MSF documents and external literature to describe the decentralization component of the AIDS project and explain the results obtained. The team gathered a set of resources available at MSF level in general, at project level, and at UAS level. The evaluation team mainly used program monitoring data for further analysis. Other documents from scientific publications or reports prepared by other organizations, such as the ONUSIDA, were also used.

2. Key informant interviews and focus group discussions

Qualitative primary data collection was done through interviews and group discussions with stakeholders selected by functional sampling. Guided by the key themes already identified during the literature review, the interviews and FGDs provided a platform to collect more qualitative evidence, develop conclusions and perform the necessary validations of the evaluation results.

In order to have several points of view and to arrive as much as possible at information reflecting the opinions and perceptions of the key actors in decentralization and the HIV response in the DRC, stakeholders such as MSF representatives (DRC Mission, OCB headquarters, and SAMU), representatives of the Ministry of Health (PNLS, PNMLS, etc.), health structures supported in decentralization, representatives of beneficiaries (patients and associative actors partners of the project), etc.

Table 3: Presentation of respondents and number of interviews conducted

TYPE OF STRUCTURE	*TYPE OF INFORMANTS*	*INDIVIDUAL INTERESTS*	*FOCUS GROUPS*
Médecins Sans Frontières	AIDS Project Team, DRC Mission SAMU, RST (Regional Support Team)	12	0

TYPE OF STRUCTURE	*TYPE OF INFORMANTS*	*INDIVIDUAL INTERESTS*	*FOCUS GROUPS*
Ministry of Health (PNLS, Health Zones)	Coordination PNLS & Medical Officers Heads of Health Zone	5	0
Patient association	Coordination & PLHIV members RENOAC and UCOP+	3	0
	Patients	13	2
HIV CEP structures	Staff of health structures (managers, caregivers, other providers)	23	3
Partners	BDOM (Medical Directorate)	2	0
TOTAL		58	5

3. Field observation

Field visits to the MSF Mission in Kinshasa (AIDS Project and country coordination team) as well as to the health structures / organizations supported by the project, were carried out to see the achievements of the project on decentralization and conduct interviews. The observation concerned the infrastructure, equipment, and practices of the service providers trained by the project in the supported structures.

4. Secondary data

The data encoded in the Tier.net database – from the primary data collected in a routine manner by the members of the project team in the health structures were cross-referenced with the data from other sources (monitoring sheets, project reports, etc.) to draw substantial conclusions, particularly with regard to the quality of the data and their use in the management of the project or the intervention on decentralization. The indicators used in the monitoring of project activities were appreciated and the use of standard CBO indicators for monitoring HIV activities was analyzed to assess their use and adequacy in monitoring activities under the decentralization support component.

DATA ANALYSIS

THEMATIC CODING

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

- Project management data, strategy, and response mechanism;

- Data on medical activities in health facilities supported in Kinshasa.

TRIANGULATION & COMPARATIVE ANALYSIS

Analysis of qualitative data was performed by **triangulation and comparison**. To ensure internal validity, triangulation and comparison was made between methodologies (qualitative and quantitative), data collection tools (document review, key informant interviews, data from care providers, and field observations) and stakeholder groups/types (project coordination, implementing partners, beneficiaries, other HIV stakeholders in the intervention area, etc.).

The statistical analyses of the raw data contained in the databases provided by the project were descriptive in order to highlight the frequencies (number / percentages) allowing the measurement of the achievement of the different indicators. The analysis did not include statistical tests to measure the association between the different variables. The analysis was therefore limited to simple statistics (frequency calculation) carried out on the MS Excel software.

EVALUATION CRITERIA

The evaluation criteria drawn from the traditional evaluation criteria of the Development Assistance Committee of the Organization for Economic Cooperation and Development (OECD-DAC), made it possible to assess and conclude on the functionality of the decentralization process as well as the zonal approach and the integrated and non-integrated models deployed. The table below provides a clear definition of the evaluation criteria used and the corresponding questions.

Table 4: Presentation of evaluation criteria and related questions

EVALUATION CRITERIA	CORRESPONDING EVALUATION QUESTION	DEFINITION OF THE EVALUATION CRITERION[12]
Relevance	EQ 1: Were the objectives relevant, given MSF's observed and expressed needs in context and priorities?	Extent to which intervention objectives and design align with the needs, policies and priorities of beneficiaries, the country, the international community and partners/institutions and remain relevant even as the context changes. ***Note:*** The term "correspond to" means that the objectives and design of the intervention take into

[12] https://www.oecd.org/fr/cad/evaluation/criteres-adaptees-evaluation-dec-2019.pdf ; https://www.oecd.org/fr/cad/evaluation/criteres-cad-evaluation.htm

EVALUATION CRITERIA	CORRESPONDING EVALUATION QUESTION	DEFINITION OF THE EVALUATION CRITERION[12]
		account the conditions – economic, environmental, equity, social, political economy and capacity – in which the intervention is conducted. The term "partners/institutions" includes administrations (national, regional, local), civil society organizations, private entities and international agencies involved in funding, implementing and/or supervising the response. Relevance assessment involves examining differences and trade-offs between different priorities or needs. It also requires an analysis of any changes in the context in order to determine the extent to which the intervention can be (or has been) adapted in order to remain relevant.
Coherence	EQ 2: Was the strategy, design and implementation coherent, given the context and existing resources? How could the approach have been more coherent? EQ 3: To what extent have past experiences (including the previous evaluation) been taken into account in the definition and implementation of the 2017-2022 decentralization strategy? QE 4: Have the different actors and counterparties been sufficiently taken into consideration?	Extent to which the intervention is consistent with other interventions within a country, sector or institution. ***Note:*** The criterion seeks to examine how other interventions (particularly policies) support or weaken the intervention being evaluated, and vice versa. It encompasses complementarity, harmonization and coordination with other actors, and verifies that the intervention brings added value while avoiding duplication of activities. In particular, it verifies evidence of active, free and meaningful participation of the various stakeholders, equity and non-discrimination in the process and outcomes. The criterion covers both internal and external coherence:

EVALUATION CRITERIA	CORRESPONDING EVALUATION QUESTION	DEFINITION OF THE EVALUATION CRITERION[12]
		▪ Internal coherence refers to synergies and inter-dependencies between interventions carried out by the same institution/administration, as well as coherence between the intervention and the relevant international standards and criteria to which the institution/administration adheres. ▪ External coherence concerns the coherence between the intervention under consideration and those carried out by other actors in the same context.
Effectiveness	EQ 5: Has the decentralization component achieved its expected results?	▪ Extent to which the objectives and outcomes of the intervention have been or are being achieved, including population-specific outcomes. ▪ Note: Effectiveness analysis involves considering the relative importance of objectives or outcomes.
Efficiency	EQ 6: What resources were needed, were they available, could they have been mobilized more effectively or sustainably?	Extent to which the intervention is producing, or is likely to produce, results economically and in a timely manner. ***Note:*** The term "economic" refers to the conversion of inputs (funds, expertise, natural resources, time, etc.) into outputs, outputs and impacts in the most cost-effective manner that is most cost-effective relative to options available in the context. The term "on time" refers to meeting established deadlines or deadlines that are reasonably

EVALUATION CRITERIA	CORRESPONDING EVALUATION QUESTION	DEFINITION OF THE EVALUATION CRITERION[12]
		adapted to the requirements of the changing context. This may include assessing operational efficiency (the extent to which the intervention was well managed).
Impact	QE 7: What is the impact of the decentralization component?	Extent to which the intervention has produced, or is expected to produce, significant and far-reaching effects, positive or negative, intended or unintentional. ***Note:*** The impact criterion focuses on the ultimate importance and potentially transformative effects of the intervention. It aims to determine its social, environmental and economic effects in the longer term or on a larger scale than those already assessed under the effectiveness criterion. Beyond the immediate outcomes, the impact criterion aims to assess the indirect, secondary and potential consequences of the intervention, through the examination of global and sustainable changes in systems or standards, as well as potential effects on people's well-being, human rights, gender equality and the environment.
Sustainability	EQ 8: Are the benefits or changes brought about by the decentralization of HIV care by the AIDS project sustainable? EQ 9: What capabilities has the project created that can help ensure sustainability?	Extent to which the net benefits of the intervention/project will continue or are likely to continue. ***Note:*** This includes consideration of the financial, economic, social, environmental and institutional capacities of the systems necessary to sustain net benefits over time. This includes analyses of resilience, risks and potential trade-offs between priorities. Depending on when the valuation is made, this process would allow for an analysis of the actual net

EVALUATION CRITERIA	CORRESPONDING EVALUATION QUESTION	DEFINITION OF THE EVALUATION CRITERION[12]
		benefit stream or an estimate of the likelihood that net benefits will persist in the medium to long term.

ETHICAL CONSIDERATIONS

Reviewers have responsibilities to society at large, their clients, partners and collaborators; to the institutions that employ them; to their colleagues and the research and evaluation community; to the individuals who participate in their evaluations; and to their safety and well-being. Thus, to exercise these responsibilities during this evaluation, ethical standards were set during the start-up phase of the evaluation by mutual agreement with the evaluation manager at the level of the Stockholm Evaluation Unit and the Evaluation Advisory Group. The evaluators committed to observing honest behaviors throughout the evaluation process with this commitment materializing through the signing of the SEU guidelines in this area (Ethical Guidelines).

CLEAR CONSENT AND PREVENTION OF DAMAGES

- Detailed and comprehensive information was provided verbally to targeted individuals to be interviewed or observed during data collection in order to obtain their informed consent for any use of their information. This consent was obtained verbally.
- Some people have a reduced capacity to give consent and are therefore less able to protect themselves from possible harm and require special attention. These include persons under the age of 18. They were not included as respondents during this evaluation.
- The evaluators complied with the legal requirements relating to data protection. Steps have been taken to preserve the integrity and security of evaluation or research data , but also to avoid intentional or unintentional disclosure of the personal data of people met or interviewed.
- The evaluators refrained from any politically or culturally sensitive or inappropriate content in the context of the DRC, marked in particular by high HIV-related stigma and low prioritization of HIV in care services.

EQUITABLE REPRESENTATION AND RESPECT FOR DIGNITY AND DIVERSITY

To ensure broad inclusion of diverse groups, the evaluators reached out to different stakeholder groups and sought to interview different MSF staff (by profile, experience, location) and representatives (both at the operational level and at the coordination/managerial level) of partners, from the Ministry of Health, and health structures supported by the AIDS project on the decentralization component. A random group of patients were interviewed to take into account their views on decentralization. Nevertheless, within this sample of patients, attention was paid to

gender representativeness, in order to inquire about possible differences in their perception of the intervention of the AIDS project at the level of decentralized HIV care structures.

TRANSPARENCY

All evaluation findings are supported by credible evidence and the evaluation team conducted a mutual review of its peer-to-peer work to guard against unintentional personal bias. Regular exchange sessions between the evaluation team and the members of the advisory group and the project management increased transparency by making the evaluation process very participatory.

CONFIDENTIALITY

The names of the patients are not mentioned in the evaluation documents and the sources of information have remained anonymous, including data from the database Tier.net shared with the reviewers. 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 findings of the interviews are presented in this report, only in aggregate form without the possibility of linking to the person responsible for the narrative.

DIFFICULTIES AND LIMITATIONS OF THE EVALUATION

In general, there were no major difficulties in conducting the evaluation, with the exception of obtaining some key information from the project on the financial side, as well as cross-checking of data. It should also be stressed that the fact that the integrated zonal approach was new in itself, it did not allow for a definitive conclusion to be drawn on its effectiveness compared to the non-integrated model.

The limitations of the evaluation are as follows:

1. **Recall bias –** Interviews with informants are sensitive to the degree of memory retention. Some interviewees may recall specific events in more detail than others. This may lead to knowledge gaps, but this has been mitigated by triangulation with other data sources (other respondents, published documents, cross-referencing information with project management to clarify, etc.).
2. **Data quality and/or insufficiency –** Quantitative data (Base Tier.net and Monitoring sheets) depend on the quality of primary data since production, correct capture, and proper processing. Indeed, for data recording, it was found that two different versions of the Tier.net database were used, one for non-integrated areas (version 10 with fewer input options) and the other for integrated areas (version 14 more developed and offering more possibility of data entry, especially those of PMTCT). It should be noted, for example, that some detailed information on the operational costs of decentralization remains difficult to identify or retrieve because no encoding distinction allows decentralization expenditure to be distinguished from other project expenditures.

3. **Opportunities to generalize evaluation results:** The results of this evaluation, in terms of database configuration, can be generalized to the entire HIV project in DRC and to other MSF projects in other countries using the same Tier.net database. For example, some data, such as PMTCT, cannot be encoded in the earlier version of the database, and conversely the current configuration of the database prevents some previous data from being included.
4. There was a certain desire on the part of the project to make a **comparison between MSF's intervention in integrated and non-integrated areas,** but we did not do so given the very recent nature of the integrated zonal approach that did not allow sufficient hindsight.
5. It should be noted that the **archiving of documents and information on the project** remains to be improved. Indeed, it turned out that although most information about the project exists, some data was not found, or with difficulty, due to the non-centralized archiving system and a potential challenge of coordination between the different departments.

RESULTS OF THE EVALUATION

ASSESSMENT OF THE PERFORMANCE OF DECENTRALIZATION BY EVALUATION CRITERION

1. RELEVANCE

1.1 Definition of the criterion

Extent to which intervention objectives and design align with the needs, policies and priorities of beneficiaries, the country, the international community and partners/institutions and still remain relevant even as the context changes.

1.2 Evaluation Question(s)

The analysis of relevance involves answering the following evaluative question :

EQ 1: Were the objectives relevant given MSF's observed and expressed needs, context and priorities?

1.3 Responding to HIV needs, policies and priorities

Policymakers, health workers and communities recognize that health services in low- and middle-income countries need to improve people's access to and retention in HIV treatment. 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 accessing care, improve health outcomes and increase retention in treatment programs.[13]

The decentralization of the AIDS project had two objectives:

1) Increasing access to HIV services

In Kinshasa, HIV prevalence is 1.6%. Screening and treatment coverage has long remained low in the DRC. An estimated 64% of PLHIV were diagnosed and 62% of PLHIV have access to ARV treatment between 2006 and 2017, although DRC has expanded access to HIV care since 2004.[14]

Nearly half a million people are living with HIV in the Democratic Republic of the Congo (DRC) and thousands are dying needlessly. Effective tests and treatments have existed for years, but many Congolese still do not have access to them, or start treatment too late. This results in a significant need for medical care that the local health system cannot adequately handle. HIV prevention and access to care remain huge challenges in the DRC. Access to voluntary testing is nearly impossible,

[13] 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).

[14] Ngongo, N. M., Darcis, G., Nanituna, H. S., Mambimbi, M. M., Maes, N., Mashi, M. L., & Lepira Bompeka, F. (2021). Longitudinal analysis of sociodemographic, clinical and therapeutic factors of HIV-infected individuals in Kinshasa at antiretroviral therapy initiation during 2006-2017. *PloS one*, *16*(11), e0259073.

and many health facilities do not offer free testing to people with symptoms. This situation is further compounded by the level of fear and stigma surrounding the virus. The impact is clear: according to UN estimates, nearly a quarter of people living with HIV in the DRC simply do not know they have the virus. It is in response to this situation that MSF is stepping up HIV care in Kinshasa.[15]

Support for the decentralization of HIV care services by the AIDS project in Kinshasa (support in terms of strengthening pre-existing services in peripheral structures) was initiated initially to relieve congestion at the Kabinda Hospital Center, which was almost unable to contain the number of patients to be cared for. The beginning of decentralization was also a question of allowing new inclusions of patients. In view of the needs and challenges of care in Kinshasa, support and access to free care services (capacity building for screening, access to treatment, etc.) was therefore relevant, justifying MSF's approach to support for decentralization. It is therefore an intervention aimed at increasing the capacity of services, access, and the use of services to support peripheral structures.

2) Improving the quality of HIV care in Kinshasa

The health structures supported by MSF as part of the decentralization of care services already had several care activities with relatively good retention rates but contrasting with the large number of people lost to follow-up.

The percentage of people lost to follow-up was defined as the percentage of patients who initiated ART who were lost to follow-up 3 months after starting ARV treatment. Thus, for the calculation of this indicator, we refer to a) Numerator, the total number of patients reported PDV, 3 months after initiation of ARVs and b) Denominator, the total number of patients newly enrolled in ARVs for the period.

[15] Doctors Without Borderseras (2021). DRC: People are still dying unnecessarily from HIV - https://www.msf.org/people-are-still-dying-unnecessarily-hiv-drc.

Table 5: Percentage of PLHIV lost to follow-up in MSF-supported health facilities between 2017 and 2022.

HEALTH STRUCTURES	PERCENTAGE OF LOST TO FOLLOW-UP OVER THE PERIOD COVERING THE EVALUATION					
	2017	2018	2019	2020	2021	2022
CS ST Clement	58,3%	65,7%	40,9%	45,7%	20%*	2%
St. Joseph's Hospital	30,7%	52,6%	41,3%	18%*	10,8%	Data not available in databases or documentation reviewed by reviewers.
CH Mokali	61,1%	66,6%	73,3%	73,6%	12,5%*	Data not available in databases or documentation reviewed by reviewers.
CS Tchimungu**	93,7%	50%	58,8%	76,4%	43,7%	3,5%*
CS St Anne	66,6%	60,8	54,5%	16,6%	9%	No data

* Start of support by MSF: remarkable drop in the rate of loss of SUVs at 3 months after initiation of ARV treatment in these facilities (<20%).

** Problem of attendance at this structure (fewer screenings, fewer patients).

It appears from the analysis of the data of the cohort of patients of these structures presented in the table above, that the problem of lost to follow-up was a significant problem in 2017, justifying an effort in terms of the quality of care. Despite an improvement over the period, the loss of sight remains a major problem and the AIDS project remains relevant in its efforts to ***decentralize the quality of services*** to the peripheral level.

MSF's support for decentralization is relevant for having affected the integration or improvement of the quality of services and not the extension of services as in traditional decentralization. This therefore confirms the importance of accompanying decentralization in the sense of extending

services to the peripheral level by decentralizing quality (increasing the technical platform and skills of health structures).

1.4 Adapting the decentralization approach to changing context and needs

The performance of the fight against HIV in the DRC recorded over the last 5 years shows a gradual improvement in programmatic indicators and the latest figures note from 2020. Indeed compared to the first 95, the country has achieved 75%. Compared to the second 95 the DRC reached 74%, and 22% for viral load suppression (3rd 95). Several problems are currently identified in the field of the fight against HIV in the DRC in specifically vulnerable groups[16]:

- Elimination of mother-to-child transmission (eMTCT):

The results show that MTCT elimination services have stagnated slightly below 40% with an annual rate of change over the past four years in spite of upward coverage of PNC (antenatal consultation) and reaching 85% in 2020 compared to 39% of pregnant women living with HIV receiving ARVs for MTCT elimination. There is a large gap of 46% between the two interventions, reflecting a very low integration of HIV into Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH). The two major bottlenecks are: (i) the low supply of services due to the selective national implementation strategy in a limited number of health zones and health facilities and (ii) the high rate of loss to follow-up due to the weak monitoring system for HIV-positive women and those on ARV treatment.

- HIV management in adults:

The coverage of care for adults living with HIV aged 15 years ≥with ARV treatment has more than doubled in five years to reach 82% in 2020 with an annual rate of change that remained consistently ≥15% during this period. Data show that all adults living with HIV aged ≥15 years who are tested and know their HIV status (82%) are put on ART (82%). The three major barriers are: (i) the low access to viral load measurement observed in only 19% of adults living with HIV on ART who have evidence of viral suppression mainly due to the low availability of viral load tests, (ii) the significant disparities with more men living with HIV on ART (>98%) than women living with HIV (74%) and (iii) access to non-HIV testing, still universal to recover the rest of adults living with HIV who are not yet on ART.

- HIV management in children aged 0-14 years:

The management of children living with HIV aged 0-14 years with ART showed lower coverage: 31% versus 82% among adults living with HIV, a gap of 51%. The annual rate of change has also evolved in a rollercoaster ride, as has the elimination of MTCT of HIV, alternating between one year of progression and one year of regression. The problem of access to ART for children living with HIV

[16] Analytical barometer of the fight against HIV/AIDS in the Democratic Republic of the Congo Progress towards the objectives 95-95-95 - https://www.unaids.org/sites/default/files/2021_RDC_barometre_fr.pdf.

combines the first barrier to *eliminating MTCT*, particularly the low level of testing, and the first barrier to care for adults living with *HIV which is low access to* viral load measurement (only 11% of children living with HIV on ART have evidence of viral load suppression) the low availability of tests and the weak monitoring system for HIV-positive children.

In light of these results, reported in the analytical barometer of the fight against HIV in the DRC, priorities have been set by the Ministry of Health in the DRC to accelerate progress towards the achievement of the UNAIDS 3x90 targets:

- The universalization of screening with a networking system, especially for pregnant women;
- The institutionalization of active and individualized follow-up of HIV-positive pregnant women;
- The reduction of inequalities between men and women in care and in all services;
- Improving data quality through the appropriate use of DHIS2;
- Focus on pediatric HIV management;
- Access to viral load on which viral load suppression depends.

The AIDS project worked on decentralization by strengthening the quality of services at the peripheral level, including clinical mentoring and the provision of certain equipment. In view of the needs, it is clear that MSF's support for decentralization consists of supporting structures already operational within the city of Kinshasa, aimed at improving quality but not expanding HIV services. Indeed, support for the decentralization of services as conceived by the AIDS project was not in extension of geographical coverage but rather in catalyst mode of change for capacity building of pre-existing services and their optimal use. PMTCT and pediatric care needs have been less specifically affected by decentralization, while they are now the main bottlenecks in the fight against HIV in the DRC.

1.5 Conclusion on relevance

MSF's support for the decentralization of HIV services (access to care and quality improvement) from Kabinda to other structures, especially at the primary level (health center & hospital center), or even at the community level (PODI) was relevant in view of the difficulties of access to treatment for HIV patients in Kinshasa and the low quality of care (high rate of loss of follow-up). The objective of decentralizing stable patients from the CHK was also relevant to allow the Kabinda Hospital Center to focus on cases of unstable patients (severe cases) and also to be able to maintain the same level of quality of care. However, the project did not intervene over the period 2017 to 2022 to extend care services to other health facilities, despite national reports mentioning significant challenges in accessing testing, PMTCT and pediatric HIV services. These themes seem to have been dealt with less specifically in the context of the contribution to decentralization. The theme of inclusion and consideration of vulnerable groups such as pregnant women and key populations in support of decentralization, also does not seem to have been defined in the decentralization strategy and the various reports produced on the project do not highlight how these vulnerable groups have been particularly targeted and impacted.

1.6 Suggestions for improving the relevance of support for the decentralization of the AIDS project

- Strengthen activities on increasing HIV diagnosis/testing capacities for decentralized structures (donation of tests, mentoring, etc.);
- Make PMTCT a specific theme in decentralization with its integration into decentralization;
- Improve the work on the organization of access to viral load for patients followed in decentralized structures (organization of collection, transport of samples, link with laboratories, delivery of results to prescribers, and support for prescribers in the use of viral load results: integrate these aspects specifically into the clinical mentoring).

2. COHERENCE

2.1 Definition of the criterion

Extent to which the intervention is compatible with other interventions within a country, sector or institution. The aim is to clarify the degree to which design and implementation have achieved internal and external coherence.

2.2 Evaluative Question(s)

The analysis of coherence involves answering the following evaluative questions:

EQ 2: Was the strategy, design and implementation consistent given the context and existing resources? How could the approach have been more coherent?

EQ 3: To what extent have past experiences (including the previous evaluation) been taken into account in the definition and implementation of the 2017-2022 decentralization strategy?

QE 4: Have the different actors and counterparties been sufficiently taken into consideration?

2.3 Feedback on the implementation of the 2020 evaluation recommendations

In 2020, an evaluation of the evolution of the decentralization strategy was carried out and developed recommendations which are summarized in the table below, with an assessment of their implementation status, based on the data available to the evaluators and the interviews conducted. It should nevertheless be noted that the year 2020 and part of 2021 were marked by strong disruptions at all levels of the administration and the health system due to the Covid-19 crisis, leading to a need to contextualize the conclusions on the implementation of the recommendations of this evaluation.

Table 6: Status of implementation of the recommendations of the 2020 evaluation

No.	RECOMMENDATION	STATE/LEVEL OF IMPLEMENTATION	COMMENT
1	Simplify, strengthen and intensify the training of	Partially completed	Implementation with the support of

No.	RECOMMENDATION	STATE/LEVEL OF IMPLEMENTATION	COMMENT
	mentors for the development of mentoring activities.		SAMU, in particular by relying on local MSF experts during the travel restrictions caused by the Covid-19 crisis between 2020 and 2021.
2	In order to access tracking and treatment services, develop a "light decentralization" model according to these principles: shorter duration training and longer-term mentoring (with the possibility of working with senior health center officials to supervise new arrivals); one-off assistance and minimum package of services; and simplified withdrawal process for MSF's departure.	Partially realized	Over the period from 2020 to 2022, staff training for care in decentralized structures has been organized, but long-term mentoring as recommended cannot be provided if MSF withdraws from support to health facilities after 2 years.
3	Discuss the formalization of PODIs, perceived in very different ways (by Cordaid, PEPFAR, RNOAC) and with various practices.	Not done	No evidence of this discussion for the formalization of PODI. The PODI were already formalized by the Ministry of Health in its 2011-2015 strategic plan.
4	In order to monitor the quality of care and the stability of patients, conduct a study over the next three years on a small number of patients enrolled in a health facility recently transferred by MSF to a partner institution, to	Not done	This evaluation proposes to renew this recommendation.

No.	RECOMMENDATION	STATE/LEVEL OF IMPLEMENTATION	COMMENT
	assess the quality of care and stability. patient access to services and satisfaction levels, and to understand the reasons for their departure.		
5	Evaluate the accessibility and quality of services for key populations, in order to measure the need for a specific service provided through the IDPs. MSF teams are currently considering a PODI for certain key populations.	Not done	If this study is to be carried out, it should be combined with the study on quality and retention in care at the level of health facilities, in order to draw conclusions on the groups of patients with more difficulties in accessing health care (pregnant women and children aged 0 to 14 years, key population). Nevertheless, for the opening of a PODI dedicated to key populations, MSF should advocate but not be the creator of this PODI because it has already transferred responsibility for the management of PODI to the Ministry of Health and other partners.
6	Develop a thorough withdrawal strategy for the transfer of health facilities to partners according to the following	Partially completed	This strategy has not been developed and as for MSF's disengagement,

No.	RECOMMENDATION	STATE/LEVEL OF IMPLEMENTATION	COMMENT
	principles: minimum quality standards of care (with preparation for a transition from MSF's strict standards to those guaranteed by partners), strategy Effective communication EIG, and awareness of health center staff and patients.		several situations are observed ranging from dysfunctions in organizational terms, to the departure of patients including a decrease in the quality of services. Nevertheless, MSF has decided to adapt laboratory equipment to what can be more affordable for the Ministry of Health, especially POCs versus heavy and budget-hungry machines in terms of reagents. This evaluation suggests further implementation of this recommendation on the project in the further implementation of decentralization.
7	Assist and strengthen the PNLS through regular information meetings and regular supervision with the MSF project coordinator, and strengthen MSF's presence within the CCM.	Completed	MSF participates in meetings organized with the PNLS and in the various technical/thematic groups.

2.4 Quality of design/logic of decentralization

Support for decentralization by the AIDS project is consistent with the guidelines of the PNLS, the country's standard-setting body for HIV care, with the decentralized package which is the one

agreed and advocated by the program. MSF has transferred skills to peripheral structures to improve the quality of care and access to HIV testing and treatment services. Nevertheless, the very high level of quality of decentralized services created by the AIDS project does not allow the structures to maintain the same level and the other partners to continue the activity after MSF's disengagement.

In its strategy to support the decentralization of HIV care, MSF's AIDS project intervened much more in areas supported by the Global Fund and less in areas supported by PEPFAR. Indeed, the areas supported by the Global Fund would have more difficulties in terms of performance and the needs would be greater than in the PEPFAR areas within the city of Kinshasa according to the interviews conducted. The approach deployed by MSF uses the workforce of health structures (doctors, nurses, hygienists, etc.) This strengthens local anchoring and offers the chances of sustainability of skills acquired at local level. The recommendations of the previous evaluation on decentralization have been partially implemented, raising the question of monitoring and the use of recommendations for evaluations carried out on projects. It should be noted, however, that some recommendations could not be achievable, including the recommendation to hold discussions on the formalization of the PODI because this training was already included in the strategic plan of the Ministry of Health and the creation of a PODI specific to key populations because responsibility for the PODI had already been transferred by MSF to the other partners.

2.5 Adapting MSF's decentralization approach to the organization of the health system

As part of the decentralization to the AIDS project, the zonal approach deployed by MSF has undergone a development with the implementation of an integrated zonal approach where the entire chain of the HIV continuum of care is organized within the same health zone. This evolution seems consistent with the organization of the health system (referral of patients) from the health center (lowest level of care provision) to the general hospital (the highest level of care provision at the level of a health zone) via the hospital center. It should be noted that until 2020 the zonal approach deployed was not integrated (intervention at certain levels of the reference chain within health zones, mainly at the level of health centers).

Moving the decentralization approach towards an integrated zonal approach (intervention at different levels within the same health zone) therefore seems consistent for alignment with the functioning of health services and the integration of HIV services at the primary and secondary levels of the health system.

2.6 Stakeholder Participation and Engagement

There is synergy with other partners who provide ARVs, anti-TB drugs and HIV diagnostic tests. These include the Global Fund and PEPFAR. The main collaborator of the MSF project at the level of the Ministry of Health is the PNLS with its national coordination and coordination at the level of the city province of Kinshasa.

Health zones are particularly involved in the implementation of decentralization through the deployment of decentralization monitoring activities (joint evaluations of the performance of health structures, supervision, etc.), and direct participation in certain costs related to decentralization. The example of the cost-sharing between MSF and the health zone in the installation of the radiology machine in Luyindu supports the affirmation of this good multi-stakeholder participatory approach. Nevertheless, some health zone officials seem to be unaware or not very interested in the AIDS project and even less in decentralization activities (according to interviews). Also, psychosocial assistants are not supported by other funding and if MSF disengaged this activity would hardly continue. These psychosocial assistants are awarded by MSF and no action seems to have been taken to integrate them into the staff of health facilities, as staff recruited with a clear status of function, or to allow the payment of their premium by a possible other partner or by the Ministry of Health.

When MSF withdrew from support for the PODIs, these IDPs were taken over by other partners such as Cordaid, which now collaborates with civil society organizations (RNOAC, UCOP+) for the management of the PODIs.

As part of the preparation of the disengagement of the project from the supported structures, it was planned that before starting in parallel a collaboration in a new Health Zone, an analysis of the socio-economic and medical context should be carried out, but this was not the case during the engagement with the Luwindu Hospital. Indeed, according to the AIDS project, it was necessary to identify beforehand a potential buyer and in the absence of a possible buyer at this stage for Luyindu, the partners being few. Indeed, the PEPFAR, which had been favorable to this recovery before, no longer pronounced itself from 2018. The project was nevertheless able to interest and associate ICAP (PEPFAR's implementation partner) for the takeover of the King Baudouin Hospital. It should be noted that on the eve of the disengagement of the other structures at the end of 2022, still no discussions have been initiated with other actors such as the Global Fund to prepare the resumption and sustainability of the activities / achievements created by MSF (Interviews with the MSF team).

The involvement of the various partners is essential to ensure the quality and sustainability of activities. An in-depth and ongoing study of the community context has made it possible to define civil society organizations, implementing partners, vulnerable populations (girls, orphans, etc.), key populations (PS, MSM, etc.) and adapted sites (churches, schools, etc.). By collaborating with civil society organizations (technical and financial support), an action plan was developed in relation to HIV awareness (+ fight against stigma), testing, identification of advanced HIV, improvement of retention (club in CS or churches), especially for vulnerable populations.[17]

[17] AIDS project document: collaboration with civil society.

The project carried out an analysis of partnership dynamics appreciated by the evaluation as a positive point or even to be replicated to better align interventions in a complex and multi-stakeholder intervention context to identify complementarities and avoid duplication of interventions. It should also be noted that although the interviews reported a relatively better involvement and commitment of those responsible for the integrated zone than those in the non-integrated areas, no specific explanation can confirm that this is due to the setting up of the intervention in integrated versus non-integrated areas.

Table 7: Analysis of stakeholders in the HIV response by MSF's AIDS project in Kinshasa, project document.

STAKEHOLDER	ABSTRACT / PRESENTATION	INTEREST IN THE PROJECT	LEVEL OF INFLUENCE
PNLS-national	▪ National AIDS Program; ▪ Development of standards and guidelines; ▪ Coordination of the fight at the country level; ▪ National training and supervision.	▪ Viral load; Data; ▪ CHK as a center of excellence: advanced HIV, 3rd line, operational research, new approaches (self-test, ...) ▪ A community approach (development of differentiated models to be tested or even implemented elsewhere).	High
PNLS-provincial	▪ Coordination of the struggle at the level of the city of Kinshasa; ▪ Provincial training and supervision.	▪ Gap-filling ruptures ARV, Screening test , CTX ; ▪ Data; ▪ Formations of MDs and nurses of FOSA and BCZ.	Low
PNLT – national	▪ National Tuberculosis Control Program Development of standards and guidelines; ▪ Coordination of the fight at the country level; ▪ National training and supervision.	▪ Gap-filling treatments TB, cartouches GeneXpert ; ▪ CHK = Centre de référence co-infection VIH/TB, MDRTB.	Medium
Cordaid	▪ Caritas Hollande ; ▪ FM Principal Recipient (PR) for HIV.	▪ Visibility on ruptures; A community approach; ▪ Operational models.	High

STAKEHOLDER	ABSTRACT / PRESENTATION	INTEREST IN THE PROJECT	LEVEL OF INFLUENCE
Salvation Army	▪ International Protestant Organization; Under Cordaid Reef(SR); ▪ Multiple activities, HIV = very small component.	▪ Support to CS PODI.	High
BDOM	▪ Diocesan Bureau of Medical Works (Catholic, Kinshasa); ▪ Sub-Recipient (SR) of Cordaid; ▪ Multiple activities, HIV = very small component.	▪ Appui to the CS; ▪ PODI.	High
PEPFAR	▪ US President's Emergency Plan for AIDS Relief ▪ Direct operational activities on the ground via agencies and IP's	▪ MSF data (cascade, 3rd line, etc.) ▪ collaboration for appro gap-filling (screening tests, ARVs, CV inputs, etc.) ▪ Support for COP and business continuity DRC (budget, etc.)	High
USAID	US Agency for International Development	▪ Supply chain ▪ self-testing	Medium
CDC	US Centers for Disease Control and Prevention	▪ viral load strategies (scaling, CEP, etc.) ▪ MSF lab use for a maximum of ICAP/Egpaf CVs	High
ICAP	▪ Global Health Action Columbia Univerisity ▪ ONG, Implementing Partner de PEPFAR, sous le CDC	▪ CS support recovery ▪ Hospital takeover ▪ PODI – new approaches	High
EGPAF	▪ Elizabeth Glaser Pediatric AIDS Foundation * ONG, Implementing partner de PEPFAR, sous CDC ▪ IHAP has been integrated into EGPAF	▪ PODIUM ▪ CS support recovery ▪ Lingwala Health Zone ▪ Pediatric CEP	Medium

STAKEHOLDER	ABSTRACT / PRESENTATION	INTEREST IN THE PROJECT	LEVEL OF INFLUENCE
WHO	▪ Multilateral Health Organization ▪ Government Health Adviser	▪ CHK as center of excellence Clinical PEC, advanced HIV, 3rd line, operational research, new approaches (self-test, etc.) ▪ Field information, Community approaches	High
UNAIDS	United Nations Program on HIV/AIDS	▪ Community approach (PODI, Observatory) ▪ Field information ▪ PEC Children and Minors Law	Medium

2.7 Conclusion on consistency

MSF's approach to support decentralization through the continuous improvement of the quality of HIV services at peripheral level is consistent with the context of peripheral structures, which were characterized by low quality of care (many lost follow-ups and low retention in care). The conceptual model of decentralization as developed by the AIDS project over the period evaluated, has evolved towards a zonal approach that has developed two specific models tested: the non-integrated model and then the integrated model within the same health zone, which is consistent with the organization of care that plans to have the continuum of care available within the same health zone.

The decentralization of HIV services in Kinshasa is carried out in a multi-stakeholder environment with intervention approaches specific to each, and the project was able to set up collaboration with these actors, particularly for the resumption of structures such as the King Baudoin Hospital and the PODI.

2.8 Suggestions for improving the coherence

- Move from non-integrated areas to integrated areas to harmonize interventions and remain consistent with the organization of care in the Congolese health system;
- Document and communicate clearly on the MSF approach in order to increase internal coherence (understanding within MSF) and external coherence (dialogue with other actors), and thus avoid possible confusion related to terminology, potentially understood differently and covering different realities depending on the counterparties (see section 1 on definitions).
- Increase the duration of support to decentralized structures in order to be able to measure the changes or effects of MSF support (some indicators can only be assessed over the long term, such as detention at 12, 24, 36, 48, 60 months). The quality improvement cycle in a context of weak health systems cannot take place over two years and proceed with disengagement (risk of gradual decline in quality after disengagement).

3. EFFECTIVENESS

3.1 Definition of the criterion

Extent to which the objectives and outcomes of the intervention have been or are being achieved, including population-specific outcomes.

3.2 Evaluation Question(s)

The analysis of effectiveness involves answering the following evaluative question:

EQ 5: Has the decentralization component achieved its expected results?

Specifically, the following sub-questions are answered:

- To what extent has the decentralization component achieved its general and specific objectives?
- To what extent are the outputs in line with quality standards and expected results?
- What are the reasons (enabling or unfavorable factors, expected or unexpected challenges) that explain the achievement – or not – of the expected results?
- How could decentralization have been more effective?

3.3 Analysis of the achievement of the goal of improving access to HIV services

- *Dual objective of decongestion of CHK and bringing PHA care closer together*

The objective of relieving congestion at the CHK has been achieved. Initially, more than 6 000 patients flowed into this structure in search of quality care, MSF as a result initiated the decentralization of this quality to operational structures in Kinshasa. In 2022, there are less than 2000 patients followed at the CHK level, mainly cases of patients not stable or under treatment with molecules not available at the decentralized structures. Decentralization has made it possible to

increase the rate of screening and placing on ARVs in general, and especially at the level of decentralized structures.

- *Support in decentralized structures*

The analysis of the contribution of support to decentralization by the AIDS project in improving access to HIV care services analyzed, the indicators of the logical framework related to HIV services; these include the number of screenings, the percentage of patients who received viral load, retention rate at 12 months, etc.

The 2018 monitoring sheet shows that out of 10 indicators that were monitored, 5 were achieved at the end of the year while 5 others were not achieved, i.e. a 50% indicator achievement rate. The availability of inputs is an important factor in the achievement of the other indicators and this indicator was not reached in 2018, all structures having experienced breakdowns either in screening tests, ARVs, or Cotrimoxazole.

Table 8 presents the evolution of the indicators related to support services at the decentralized level (CS) during 2018, and the assessment of these indicators at the end of the year in the monitoring sheet.

Table 8: Monitoring of HIV services indicators in decentralized structures in 2018

Pays	RDC
Projet	Projet SIDA
Année	2018
Statut du document	Final

Indicateurs Objectivement Vérifiables	**Cible révisée**	**janvier-mars**		**avril-juin**		**juillet-septembre**		**octobre-décembre**		**Résultat annuel**	***Réalisé : oui, non, en partie***
		Résultat	***Réalisé : oui, non, en partie***	**Résultat**	***Réalisé : oui, non, en partie***	**Résultat**	***Réalisé : oui, non, en partie***	**Résultat**	***Réalisé : oui, non, en partie***		
Résultat Attendu 4	**Des soins de PEC de qualité du VIH sont disponibles au niveau des 4 CdS mères et 1 OPD**										
10.000 patients dépistés (DCIP,CDV, index testing)	2500/Trim	2430	*oui*	2578	*oui*	2004	*non*	1718	*non*	**8738**	***non***
90% des patients dépistés positifs sans IO majeures sont mis sous ARV dans les délais		ND		ND		ND					
90% des patients attendus ont une CV de routine		68%	*non*	70%	*en partie*	85%	*en partie*	90%	*oui*	**90%**	***oui***
90% des patients ont une CV de routine <40 copies/ml		77%	*non*	70%	*non*	74%	*non*	75%	*non*	**75%**	***non***
Retention à M12 >= 85%		75%	*non*	71%	*non*	88%	*oui*	77%	*non*	**78%**	***non***
90% des premiers EID réalisés parmi les bébés exposés 0 - 12 mois		94%	*oui*	97%	*oui*	100%	*oui*	93%	*oui*	**96%**	***oui***
90% des bébés exposés de 18 mois ont fait leur TDR de confirmation		71%	*non*	100%	*oui*	100%	*oui*	83%	*en partie*	**89%**	***oui***
30% de la cohorte sous ARVs utilisent les PODIs		41%	*oui*	41%	*oui*	48%	*oui*	66%	*oui*	**66%**	***oui***
60-70% des adolescents (10-17) ont eu une annonce totale		31%	*non*	33%	*non*	64%	*oui*	64%	*oui*	**60%**	***oui***
80% des PDV sont recherchés (appels téléphoniques et VAD)		76%	*en partie*	62%	*non*	44%	*non*	86%	*oui*	**70%**	***non***
100% des structures appyées par MSF ne connaissent pas de ruptures ARV, tests, CTX		33%	*non*	0%	*non*	0%	*non*	0%	*non*	**0%**	***non***

In 2019, the monitoring of indicators of care services in decentralized structures was carried out for in 3 CS with 10 indicators of which only 4 were achieved at the end of the year with targets achieved. Five indicators were partially achieved while one indicator had not been achieved. It should be noted that this unrealized, new indicator (not monitored in 2018) did not have a reference level or a target

defined / specified in the monitoring sheets. An important indicator on stock-outs, on which many other indicators depend, was removed from the monitoring of the indicators in 2019 and some targets were revised, including the one related to the number of screenings to be carried out.

Table 9: Monitoring of HIV services indicators in decentralized structures in 2019

Pays	RDC
Projet	Projet VIH/Sida
Année	2019
Statut du document	Draft

Indicateurs Objectivement Vérifiables		Niveau de référence	Cible révisée	Janvier-Mars		Avril-Juin		Juillet-Septembre		Octobre-Décembre		Résultat annuel	Réalisé : oui, non, en partie
				Résultat	Réalisé : oui, non, en partie	Résultat	Réalisé : oui, non, en partie	Résultat	Réalisé : oui, non, en partie	Résultat	Réalisé : oui, non, en partie		
Résultat Attendu 4		Des soins de pec de qualité du VIH sont disponibles au niveau de 3 CdS mères											
8.000 patients dépistés (DCIP,CDV, index testing)	2000/Trim	1718		1922	en partie	1971	en partie	1364	en partie	2132	en partie	7389	en partie
90% des patients dépistés positifs, Satde 1 et 2 sont mis sous ARV dans le ≤14 jours		NEW		57.9%	non	73.0%	non	83.3%	en partie	90.9%	oui	73.4%	non
90% des patients attendus ont une CV de routine		90%		76.9%	en partie	90.0%	en partie	76.0%	en partie	49.0%	non	76.2%	en partie
90% des patients ont une CV de routine <1000 copies/ml		75%		88.0%	oui	80.2%	en partie	83.3%	en partie	60.1%	non	83.3%	en partie
Retention à M12 >= 85%		77%		64.0%	en partie	66.0%	en partie	55.6%	en partie	67.9%	en partie	67.9%	en partie
90% des premiers EID réalisés parmi les bébés exposés 0 - 12 mois		93%		92.3%	oui	89.0%	oui	76.5%	en partie	94.1%	oui	88.0%	oui
90% des bébés exposés de 18 mois ont fait leur TDR		83%		90.0%	oui	83.3%	oui	25.0%	non	100.0%	oui	81.3%	oui
30% de la cohorte sous ARVs utilisent les PODIs		66%		49.0%	oui	49.0%	oui	52.7%	oui	51.0%	oui	51.0%	oui
60-70% des adolescents (10-17) ont eu une annonce totale		64%		82.0%	oui	50.0%	en partie	47.0%	en partie	84.2%	oui	84.2%	oui
80% des PDV sont recherchés (appels télephoniques et VAD)		86%		87.0%	oui	78.0%	en partie	42.2%	non	71.6%	en partie	69.0%	en partie

From 2020, with the zonal approach in decentralization, new indicators have been introduced in the monitoring of the activities of the decentralized structures supported, including indicators related to the collaboration and participation of health zones in the monitoring of structures, as well as indicators on the screening of pregnant women seen in prenatal consultations (CPN).

This change in indicators from year to year complicates the analysis of the evolution of the results of decentralization support from year to year. *It should be noted that targets not met in previous years were subsequently revised downwards, with some being achieved in 2020 and 2021*. The achievement of the lowered targets does not lead to the conclusion that the performance of the decentralization project has improved during this period.

Indicators related to viral load and retention in care have always remained with unmet targets. The indicator on the availability of inputs (tests, ARVs, and Cotrimoxazole) was no longer followed in the monitoring sheets of 2019, 2020 and 2021, questioning the overall performance achieved on the other indicators dependent on the indicator on stock-outs.

The Table 10 presents the monitoring of the various indicators related to care services in decentralized structures supported by the AIDS project between 2020 and 2021.

Table 10: Monitoring of indicators of HIV services within decentralized structures in 2020 & 2021

Pays	**RDC - Kinshasa**
Projet	**Projet VIH/SIDA**
Année	**2021**
Statut du document	**Final (révisé 11/01/2022)**

Indicateurs Objectivement Vérifiables	Cible révisée	Année 2020		Année 2021	
		Résultat	Réalisé	Résultat	Réalisé
Résultat Attendu 3 Appui ZdS					
Les ZS participent à 100 % des évaluations de performance de 2021 dans les structures où le mentoring a lieu	100%	**100%**	**oui**	**100%**	**oui**
100% des structures ayant reçu la formation mentoring sont supervisées trimestriellement par leur ZS en 2021	100%	**N/E**		**100%**	**oui**
Les ZS appuyées participent à 100% des réunions trimestrielles organisées par MSF en 2021	100%	**N/E**		**100%**	**oui**
Résultat Attendu 4 Appui Centres de santé					
≥ 7500 patients sont dépistés (DCIP, CDV, index testing, PTME) en 2021 (1875/trimestre)	1,875	**7,650**	**oui**	**14,801**	**oui**
90% des patients dépistés positifs en stade 1 ou 2 en 2021 et éligibles sont mis sous ARV dans ≤14 jours	90%	**98%**	**oui**	**99%**	**oui**
90% des patients attendus réalisent leur CV de routine en 2021	90%	**60%**	**non**	**65%**	**non**
90% des charges virales de routine sont < 1000 copies/ml en 2021	90%	**85%**	**en partie**	**91%**	**oui**
La rétention à M12 sous ARV es ≥ 85% pour les cohortes de décentralisation en 2021	85%	**57%**	**non**	**58%**	**non**
90% des EID réalisés parmi les bébés exposés en 2021 ont lieu entre 4 et 6 semaines	90%	**83%**	**en partie**	**100%**	**oui**
90% des bébés exposés de 18 mois font leur TDR de confirmation en 2021	90%	**100%**	**oui**	**100%**	**oui**
60% de la cohorte décentralisation sous ARV utilisent des modèles de soins différenciés	60%	**46%**	**en partie**	**57%**	**en partie**
90% des adolescents (12-17) ont une annonce totale	90%	**58%**	**en partie**	**77%**	**en partie**
90% des PPDV recherchés (appels téléphoniques et VAD) en 2021 reviennent dans le système de prise en charge	90%	**63%**	**non**	**54%**	**non**
90% des patients TB sont dépistés pour VIH		**N/A**		**100%**	**oui**
95% des femmes enceintes en consultation (CPN) ont reçues la proposition de dépistage VIH		**N/A**		**100%**	**oui**
95% des femmes enceintes en consultation (CPN) sont dépistées		**N/A**		**94%**	**en partie**

The interviews and the document review report overall a good availability of drugs, mentioning some breaks, but also an improvement in medication management through monitoring and supervision. Support for quantification would have enabled health structures to anticipate orders for medicines and screening inputs. Nevertheless, the structures from which MSF has withdrawn are experiencing supply problems. It should nevertheless be noted that in 2018 stock-outs were reported in all the decentralized structures supported; this indicator was removed from monitoring sheets from 2019, without specific explanation. This could call into question the reliability of certain reported data or indicators and the conclusions in this regard.

3.4 Analysis of the achievement of the goal of improving the quality of HIV care

To assess the effectiveness of decentralization in improving the quality of HIV care, the evaluation used the analysis of the following indicators:

- Rate of loss of follow-up in supported structures (evolution over the period from 2017 to 2022);
- Retention rate in supported structures (evolution over the period from 2017 to 2022);
- Viral load access for patient monitoring in decentralized structures;
- Mortality rate in decentralized structures;
- Access to second-line treatments in decentralized structures;
- Rate of initiation of preventive treatment against tuberculosis;

- Performance scores calculated by the AIDS project during quality assessments.

It should be noted

- That some of the indicators analyzed below are difficult to use. For example, the mortality rate for CS is not monitored in the logical framework as an indicator of the quality of care through support for decentralization, but it is nevertheless monitored by the AIDS project as a whole. The indicator of retention in care does not allow firm conclusions to be drawn. See below.
- That the disaggregation of data by age and gender could not be obtained by the evaluation team and that it is to be recommended for optimal analysis, should it not be implemented in the database.

The extracts from the project's databases linked to the performance indicators (Annex 3) detail the different indicators studied on quality at the level of the decentralized structures supported by MSF as part of the decentralization initiative of the AIDS project.

- *Rate of loss of follow-up in supported structures*

Prior to MSF's support, decentralized structures experienced high rates of loss of follow-up, ranging from 50% to 77% of patients newly enrolled in ART. With the integration of MSF's approach to improving the quality of care, the rate of loss of follow-up has been divided by 3 and would have remained below 10% for three health facilities in 2022 except for CH Mokali and CS Tshimungu, which have kept loss of follow-up rates of 77% and 67% respectively while we are on the eve of MSF's disengagement. The number of remaining high follow-ups in both health facilities could also be explained by the fact that support from the project is relatively new and that it takes sufficient time to install good practices in quality of care. The decision to disengage should therefore not only be based on the time spent in a health structure (2 years), but also on the significant changes made particularly in terms of improving the quality and estimating the chances of sustainability of these changes.

Table 11: Percentage of lost PLHIV in health facilities between 2017 and 2022, source project document

The CS Tsimungu would also experience problems with having a small cohort of PHAs so, any variation within the cohort can lead to AIS in the interpretation and conclusions drawn from the analysis of its data.

	2017			2018			2019			2020			2021			2022		
	Cohorte	# PDV	% PDV	Cohorte	# PDV	% PDV	Cohorte	# PDV	% PDV	Cohorte	# PDV	% PDV	Cohorte	# PDV	% PDV	Cohorte	# PDV	% PDV
OPD HGR RB	546	92	***17%***	489	65	***13%***												
KIMIA	651	100	***15%***	652	213	***33%***	654	99	***15%***									
LISANGA	331	155	***47%***	403	85	***21%***	437	100	***23%***	453	8	***2%***						
LIBONDI				361	137	***38%***	416	159	***38%***	463	85	***18%***						
KASAI							33	9	***27%***	98	15	***15%***	173	20	***12%***			
ST AMBROISE										70	12	***17%***	93	31	***33%***	100	5	***5%***
OPD ST JOSEPH										192	75	***39%***	236	31	***13%***	258	11	***4%***
ST CLEMENT													117	59	***50%***	143	15	***10%***
CH MOKALI													106	64	***60%***	81	59	***73%***
CS TSHIMUNGU													54			55	37	***67%***
CS STE ANNE																135	3	***2%***

The major challenge for the future is to maintain the quality of care after MSF's withdrawal. An important point of attention is that none of the structures from which MSF disengaged between 2018 and 2021 managed to reduce the rate of loss of follow-up to less than 10%, which could lead to questions on the time spent in a health structure before disengagement (possible premature disengagement; two years may not be enough to bring about some important changes in decentralized structures). Under the sustainability criterion, what remains of the quality of care after MSF disengagement (6 months later) is analyzed. Specific comments are elaborated under this criterion in the remainder of this evaluation report.

- *Retention in care*

Definition: Percentage of people starting ARV treatment who are still on treatment at 6 months, 12 months, 24 months, 36 months later, etc.

Retention in care within decentralized structures has not improved significantly with the support of the AIDS project. Structures with good retention before the start of support kept relatively the same retention rate, some even had retention rates slightly lower than retention rates before MSF support. For example, for the Saint Joseph Health Center, retention at 6 months, which was 75.4% in 2019, increased to 76.2% in 2021 and retention at 12 months, which was at 52.4% in 2019, increased to 66.7% in 2021 (start of MSF support in 2020). In some decentralized health facilities, retention rates have even dropped during the period of support by MSF; this is particularly the case of CH Mokali which has maintained retention rates at 6 months above 75% during the 5 years preceding the support by the project but in 2021 this rate was 65%. However, the retention rate at 12 months improved from 76.5% to 100% between 2020 and 2021 (start of MSF support in 2021).

It is important to note that there was no difference in performance in relation to retention in care between integrated and non-integrated areas. However, MSF's recent and relatively short support does not make it possible to assess with certainty the possible effect of this support on the retention of patients in care, and therefore on its effectiveness in terms of contributing to improving the quality of care. Longer-term support for health structures is needed so that the analysis of this indicator can allow a comparison between MSF's pre-support, the support period, and the post-disengagement period.

- *Access to viral load for patient monitoring in decentralized structures*

Access to viral load and viral load suppression rate are indicators of quality of care and adherence to antiretroviral therapy. The evaluation therefore observed the viral load achievement rate in decentralized health facilities supported by MSF's AIDS project in Kinshasa between 2017 and 2022.

It shows that the AIDS project's support for decentralization in the city-province of Kinshasa has significantly contributed to improving demand for and access to viral load testing. It should be noted that before the support by the project, for patients newly initiated to treatment, the rate of

achievement of the first viral load at 6 months and that of the viral load at 12 months increased to more than 80% except, for Saint Anne and Tshimungu who experience very low rates of viral load achievement (1st and 2nd viral load). This difference could be explained by the fact that support for the latter two structures is recent and activities are still in their infancy at the time of the evaluation. It should also be noted that viral load suppression has not yet reached 95% (3rd UNAIDS target), but that the figures of more than 75% in 2022 in all decentralized health facilities are higher than the national average in the DRC (19% of adults living with HIV on ART have evidence of viral suppression in the DRC).[18]

- *Mortality rate in decentralized structures*

Mortality at 3 months, 6 months, and 12 months after initiation of treatment in MSF-supported decentralized facilities remained low; it even decreased between the period before MSF's intervention and during MSF support. Nevertheless, this indicator does not allow us to conclude on the effectiveness of the AIDS project's intervention on decentralization for two reasons:

- Cases of unstable patients or patients with serious health problems, are not monitored in decentralized structures at the primary level and therefore mortality in this group at high risk of death can only be calculated for hospitals (CHK and decentralized hospitals) – the indicator is therefore not appropriate to assess the effectiveness of decentralization in CS in particular;
- Mortality in the first 3 months can be attributed to delayed entry into care (patients screened in advanced disease/AIDS);
- Mortality after 24 months of follow-up cannot be used as an indicator of the quality of care provided by the decentralization component of the AIDS project (mortality at 36 months, 48 months, 60 months is calculated for the period including MSF's post-disengagement and can therefore be influenced by many other factors not controlled by the project).

Indeed, the objective of ARV treatment is long-term survival for people living with HIV, and in the case of MSF's disengagement after 2 years from decentralized structures, it is difficult to conclude on effectiveness using the mortality indicator although monitored by the AIDS project.

- *Access to second-line treatment in decentralized structures*

Access to second-line ARV treatment in decentralized facilities remains a challenge for patients with only two patients having been put on second-line treatment in decentralized facilities (1 at CS Saint Clément and 1 at CS Saint Joseph) during the period covered by the evaluation (2017 – 2021). It should be noted, however, that the viral load suppression rate was not 100% in decentralized structures, which therefore presages a possible shift to the second line for patients who have failed first-line treatment. The low number of patients on second line treatment in decentralized structures can be explained by the fact that non-stable patients (the absence of viral load suppression is in the

[18] Analytical barometer of the fight against HIV/AIDS in the Democratic Republic of the Congo Progress towards the objectives 95-95-95 - https://www.unaids.org/sites/default/files/2021_RDC_barometre_fr.pdf.

definition), are followed at the Kabinda Hospital Center (CHK) and therefore the decentralization approach of the AIDS project has not emphasized the availability of second-line treatment at the decentralized structures.

- *Preventive treatment of tuberculosis in decentralized structures*

With the exception of CS Saint Clément, which put 19.5% of new inclusions on isoniazid-based preventive treatment against tuberculosis (2021), none of the other structures supported by MSF as part of the AIDS project at the decentralized level initiated this treatment during the period from 2017 to 2022. It should also be noted that the results of CS Saint Clément cannot be attributed to MSF's support as this center already had higher figures on this indicator before the start of MSF support in February 2021. It should be noted, however, that in all the facilities supported by MSF, 1/3 to 2/3 of the newly enrolled patients received a chest X-ray without indicating whether it was an X-ray taken as part of the TB screening or not (which is normally done on the basis of the elements of the interrogation and clinical data). No information on the conduct of clinical screening for tuberculosis could be found to conclude on the effectiveness of preparation for the initiation of preventive treatment against tuberculosis. As TB-related mortality is known to be high among PHAs in general, the lack of routine initiation of TB preventive treatment for newly enrolled PHAs indicates a gap in the quality of care.

- *Overall performance of supported structures*

The overall performance of the decentralized structures supported by MSF was assessed at the project level through care indicators, including psychosocial care, as well as laboratory and pharmacy monitoring.

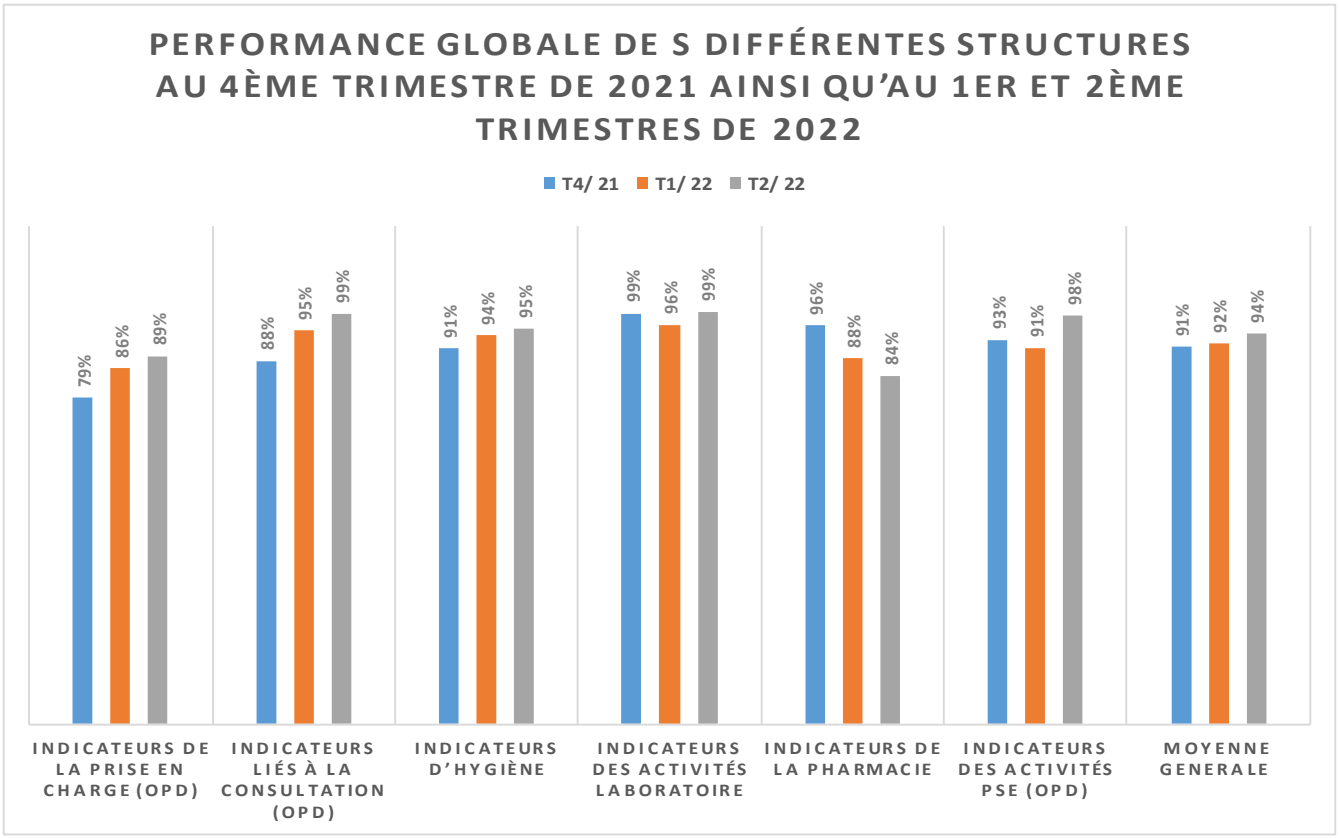
The data was obtained to analyze six sets of performance indicators that include:

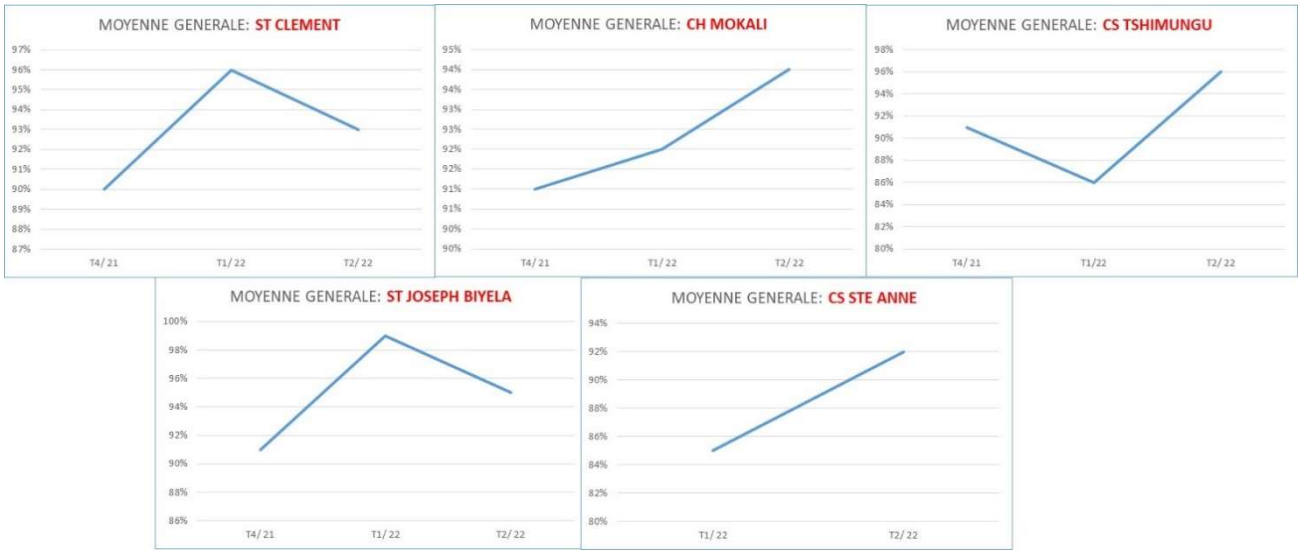
- Support Services Indicators (OPD);
- Consultation related indicators (OPD);
- Hygiene indicators;
- Laboratory activity indicators;
- Pharmacy indicators;
- PES Activity Indicators (SPOs).

The graphs below reflect the overall performance of the different health facilities in Q4 2021 and Q1 and Q2 2022 (see Annex 4 for the method of calculating the indicators).

The general trend observed in the five supported structures is a better performance when comparing the 4th quarter of 2021 and the 2nd quarter of 2022, except for pharmacy indicators. Of the five institutions, only two institutions (CH Mokali and CS STE Anne) experienced an improvement in the performance of the overall indicators over the entire period.

Table 1212





- *Role of clinical mentoring in the decentralization initiative*

One of the main messages of the Teaching and Learning Unit of MSF's South African Medical Unit (SAMU) in recent years has been that, if teaching activities are to truly transform performance in the workplace, they must have much more in the workplace after classroom training than during classroom activities themselves. However, it is difficult to demonstrate that the implementation of a clinical mentoring program

in primary health care settings and, more recently, in the CHK and general referral hospitals has contributed to improved practices and quality of care. In the first quarter of 2017, two people from the SAMU visited the project to deliver mentoring training and launch a clinical mentoring program in primary health care settings. The various interviewees all seem to agree that the clinical mentoring programs have worked well. These programs were evaluated in 2021 to adapt them and additional training was carried out to adapt the level of knowledge to needs. Clinical mentoring targeted key competencies for diagnosis, treatment management, identification of complications, and referral organization.

- *Role of CHK in teaching and learning activities*

A concept note was drafted for the formalization of many teaching and learning activities at CHK towards the development of a teaching and learning hub for clinical education in HIV and TB, with a central message to make CHK a practical clinical training site for the management of patients with HIV and tuberculosis (TB/HIV co-infection). Although not specifically and solely focused on supporting decentralization, the CHK served the intentions of the decentralization initiative in several ways by providing:

- A space for classroom clinical training for doctors and nurses, as well as bedside teaching rooms, an essential practical element of the training;
- A space for train-the-trainer courses on generic teaching principles and clinical mentoring;
- Mentoring in the workplace in services for the development of clinicians in decentralized structures;
- The provision of well-trained CHK doctors who can be seconded to decentralized sites to pass on their clinical and pedagogical expertise.

Following the successful launch in late 2021 of a new IPD mentoring initiative to equip 15 Ministry of Health doctors working in the Quaternary Reference Hospital in Beira, Mozambique, the same teaching and learning principles were introduced into the Kinshasa project in the second quarter of 2022. Thus, in addition to separate classroom training for doctors and nurses, a short train-the-trainer was provided to a selected group of doctors and nurses to equip them to deploy the additional elements of this new mentoring plan. However, it is difficult to assess the extent to which these initiatives actually contribute to improving the quality of care in decentralized structures, given the lack of specific data.

- *Availability and quality of data management*

Overall, data on project activities and decentralization are available, including the various performance evaluation reports of decentralized structures. Databases make it possible to analyze the data and track the different indicators over time. It was also possible to have data on care activities in the structures before MSF support, thus making it possible to make comparisons to a certain extent and to identify the added value of MSF's support to decentralized structures. However, there are some limitations in the monitoring of indicators and the availability of certain data. The use of two different versions of the Tier.net database in the integrated and non-integrated zones, the improved version (Tier.net 14) being only in the pilot phase of implementation in the integrated zones, limits the availability of certain data; the version Tier.net 10 used in the non-integrated zones does not allow to encode all the data, especially those of PMTCT.

Evaluators did not have access to age and gender disaggregated data, and this type of information is essential to better analyze and understand the results achieved by supporting decentralization.

With regard to indicators, it should be noted that the indicators monitored over the years do not allow for monitoring of developments and comparison of the progress of certain indicators. These include the indicator on stock-outs whose monitoring was abandoned while this indicator had not improved, before removing it from monitoring, this leading to questions.

Note that some CBO and other indicators, including UNAIDS, that could help to better assess the availability and functionality of services in decentralized structures, are not monitored by the project. These indicators include:

- Percentage of health facilities dispensing antiretrovirals that have experienced stock-outs of at least one of the requested antiretroviral drugs in the past 12 months [disaggregated by sector public, private] – UNAIDS indicator;
- Percentage of women whose HIV status is unknown and who were tested for HIV at the first antenatal visit – MSF indicator;
- Percentage of pregnant women who have been tested for HIV and know the outcome (disaggregated by type of service (antenatal, labor and delivery, postpartum)) - UNAIDS indicator;
- Percentage of infants born to HIV-positive mothers on cotrimoxazole prophylaxis within two months of birth – UNAIDS indicator.

Overall, indicators of the quality of PMTCT services have not been monitored in decentralized health facilities, while current HIV priorities in the DRC focus on PMTCT, pediatric HIV care, and access to viral load. Standard CBO indicators are also very little used in the monitoring of decentralization, whether they are global indicators of HIV services or specific PMTCT indicators.

At the end of MSF support, some structures or providers resume charging patients certain fees, including consultation, and some PLHIV prefer to change their structure to follow MSF in the new structures supported. This could lead to a lot of bias in the statistics of health facilities deserted after MSF's disengagement, with potentially a significant number of people lost but who in reality would end up in the new structures supported by MSF. In these new facilities that would receive patients who already know themselves PHAs, we could wrongly appreciate a high efficiency when a lot of new patients would not really be.

3.5 Conclusion on effectiveness

The decentralization initiative of the AIDS project has been effective mainly in reducing the number of people lost to follow-up over the period evaluated, maintaining an overall high retention rate in care in all health care facilities and a remarkable increase in access to viral load testing. However, there are still shortcomings in the indicators for initiating routine prophylactic treatment in HIV-negative PLHIV and the availability of ARVs in decentralized facilities. The quality of the data and the monitoring of indicators to

better assess their effectiveness nevertheless remain a point of attention, both in terms of completeness and compatibility of databases, and in the choice and longitudinal monitoring of indicators.

The contribution of the SAMU teaching and learning unit to support decentralization was assessed in terms of organization and activities carried out, but it was not possible to assess the improvement in the skills of the mentee staff, due to a lack of data.

Although decentralization seems to have had positive effects on the extension of HIV care and quality to decentralized health facilities, it appears that the available data, the indicators monitored and the duration of support are not sufficient to assess all these effects on health structures and beneficiaries of HIV care services.

3.6 Suggestions for improving efficiency

- Extend the duration of support to health structures to 5 years (achieving objectives takes time and changing practices is a process: risk of withdrawal too early or even backtracking when support stops 2 years later);
- The project should also be able to better define the objectives of decentralization and the end-of-support criteria: aim to obtain and maintain a high level of quality rather than dispersing itself in several structures by leaving those that have not yet acquired managerial and financial maturity;
- Extend the deployment of the improved version 14 database Tier.net all structures for the collection of the same information (do not lose some quality monitoring data in health structures);
- Consider accelerating the decentralization of second-line ARV treatment also to other structures (in addition to CHK) which would be a second step in decentralization by also making other care structures centers of excellence that can offer a complete package of HIV care services (viral load achievement, second-line processing, etc.) ;
- Dedicate sufficient time to the support of health structures (5 years) by working on clinical mentoring as well as on the improvement of governance and management, as well as the improvement of professional practices. Indeed, some indicators that can confirm the performance of care activities can only be evaluated over time, such as retention at 12 months, 24 months, 36 months, 48 months, and 60 months. The project collects data from retention in care up to 120 months (10 years).
- Include some indicators for monitoring activities in decentralized structures in order to better assess effectiveness, especially on high-risk groups such as pregnant women and children;
- Try to maintain the same indicators to assess improvements in decentralized structures, if not accompany changes with explanations.

4. EFFICIENCY

4.1 Definition of the criterion

Extent to which the intervention is producing, or is likely to produce, results economically and in a timely manner. The aim here is to assess how resources and inputs (funds, expertise, time, etc.) are converted into results.

4.2 Evaluative Question(s)

The analysis of efficiency involves answering the following evaluative question :

EQ 6: What resources were needed, were they available, could they have been mobilized more effectively or sustainably?

4.3 Financial Efficiency

- *Financial data required for financial efficiency analysis*

The evaluation team asked the project team to share the following data:

- Budget requests related to the HIV project for the years 2018, 2019, 2020 and 2021;
- The approved budget for the HIV project for the years 2018, 2019, 2020 and 2021;
- Actual project expenditures against the approved budget for the years 2018, 2019, 2020 and 2021.

The evaluation team also requested a refined presentation of costs to allow for an analysis of expenditures in the integrated and non-integrated models of project decentralization. In particular, to present the above categories using a detailed approach, i.e. by breaking down demands, budget and expenditure by service area (laboratory, clinics, training, management, etc.) or by investment costs (equipment, medicines, training, salaries, etc.) as appropriate. In addition, the evaluation team sought details on the funds invested by health zone or partner structure in order to be able to group them and compare integrated and non-integrated areas. The evaluation team found it difficult to obtain such data in a structured manner that could inform the evaluation of the project. One of the main challenges highlighted in the financial management of project activities was the difficulty of making a clear and detailed financial analysis of the expenditures incurred on each structure. However, through this evaluation, the project team noted the need to allocate costs to each supported structure by specifying the expenses in order to be able to estimate the cost of decentralization.

- *Analysis of the financial implementation rate and management costs*

Although the project team shared the budget forecast sheets, analysis of financial data was not possible due to the limitation in the presentation of data provided to evaluators. The project team was unable to assess financial implementation rates for decentralization activities. For example, the "actual" amount recorded under decentralization was recorded as zero for several years. According to the evaluation team, this does not necessarily mean that there have been no expenditures related to decentralization. However, it was apparently not possible (under the current coding system) to distinguish between the direct and indirect costs of decentralization.

- *Stakeholder perceptions of project efficiency*

Given the nature of the project, the evaluators recognized that the level of criticality of success regarding project efficiency is directly related to the specific requirements and priorities of the different project stakeholders (mainly the Ministry of Health). The interviews confirmed that all stakeholders have favorable views on the efficiency of implementation. The project team considered that the project was able to demonstrate the proper use of financial resources, through adequate control and a validation circuit respected at all levels.

The planning and control function of any project aims to ensure the proper coordination and success of the project. The time spent on planning helps to raise awareness of the challenges among all relevant stakeholders. Despite the age of the project, the evaluation team could not clearly determine what the long-term financial plan of the project was (as well as the long-term vision of the decentralization strategy). This lack of financial visibility is likely to affect the chances of a successful stable transition for the transfer of responsibility for the project to another partner, whether national or international. Indeed, the resumption of an activity requires sufficient information on its assembly, its operation at the technical level, and its cost of implementation. The absence of this kind of information could be a source of reluctance for a potential buyer.

- *Budget allocation*

The evaluation team wanted to see if there were differences in the type of expenditure (or budget allocations) among the different types of health facilities supported by the project. From the reactions gathered during the evaluation, it is clear that such differences exist, depending on the needs of each health structure supported by the project, and the specificities of the decentralization support put in place for each structure. Thus, it was not possible to establish standard costs to support decentralization support by health structure.

- *Funding factors that influenced project performance*

The project team observed some differences in the financial resources allocated to project activities (support to CHK, support costs for the operation of the MSF office, and total budget allocated to decentralization). For example, in 2017, a budget of 553 773 euros was allocated to decentralization without details of the distribution of this budget to the various activities related to decentralization or even the distribution by health structure or health zone.

The project team also believes that it is very important to improve the description of resource allocation by structure to allow for a good analysis of financial results and risks (i.e. developing a standard way of allocate resources to health structures supported by MSF to decentralization).

The feedback from the project team on the factors that affected or influenced the implementation of decentralization indicates the importance of granting the operating envelope for each structure composed

of 3 levels of premiums: (1) fixed operating premium, (2) basic standing premium, and (3) performance bonus. These amounts depend on the outcome of the performance evaluation carried out in relation to the quality of care offered to beneficiaries. The evaluators believe that this allocation should be more detailed and not limited to the precision of premium amounts. Without knowing the actual expenditure made to achieve the results of support for decentralization in the various health structures, it is impossible to say today whether the overall budget allocated to decentralization was sufficient, nor whether it was used efficiently to meet the priorities in decentralized structures.

4.4 Efficiency in relation to human resources

For the provision of care in the structures supported in the context of decentralization, the project was based on the local workforce of these structures to which it provided support in terms of capacity / skills building. This is indeed a positive point of non-substitution for local actors. It should be noted, however, that financial incentives in the form of performance bonuses, particularly for psychosocial workers carrying out therapeutic education, are not a sustainable form of motivation for human resources if measures have not been taken to ensure that these incentives continue to be distributed after MSF has withdrawn. Indeed, in the structures where MSF has disengaged, either these people no longer do the activities properly, or the care has become paid again for the patients with the explanation that it is necessary to generate income to pay and maintain the motivation of the staff.

4.5 Efficiency in relation to time resources: speed of decentralization

Two years as a period of support for a structure does not seem to be sufficient to achieve and maintain the objectives of support for decentralization. The change in professional practices involves a reflective dynamic of one's own action and integrating the collaborative dynamics and aspects of the care relationship into the work of providers. However, this takes more time than traditional training or clinical mentoring. MSF's presence can mask inappropriate practices that will re-emerge and lower the quality of care after its disengagement.

4.6 Conclusion on Efficiency

To assess the success of project management, the relative efficiency of project management must be defined. For this evaluation, the evaluation team could not identify MSF's internal standards (and/or external benchmarks) that could be used for this purpose. Despite this shortcoming, the results of the evaluation under other criteria indicate that the resources invested in the HIV project (human resources, thematic capacity-building interventions) are sufficient to achieve the originally planned results. The recording of project expenditures did not make it possible to highlight the costs incurred in supporting decentralized structures with disaggregation by health structures in order to estimate the cost-benefit of the investment made by supporting decentralization. The use of the local human resources of the supported structures was appreciated, but the incentives given as performance bonuses could have a perverse effect by discouraging providers from providing free care to PLHIV after disengagement from MSF. Finally, the time MSF remains in a health facility seems insufficient to bring about lasting changes and the reduced chances of sustainability could be considered as a factor in the low efficiency of the intervention on decentralization.

4.7 Suggestions for improving efficiency

- Improve the recording of expenditure to highlight what is spent on the various headings (training, laboratory, purchase of medicines, staff bonuses for decentralized structures, etc.) with disaggregation by health structure.

5. IMPACT

5.1 Definition of the criterion

Extent to which the intervention has produced, or is expected to produce, significant and far-reaching effects, positive or negative, intended or unintentional. Impact in the context of the decentralization component of the HIV project refers to the difference that decentralization makes in the context of HIV services. It defines the extent to which decentralization has generated or is expected to generate significant positive or negative effects, intended or unintentional, at a higher level.

5.2 Evaluative Question(s)

The impact analysis involves answering the following evaluative question:

QE 7: What is the impact of the decentralization component?

Specifically, the following sub-questions are answered:

- What are the effects of decentralization as perceived by patients and peers?
- What are the observed negative and positive consequences (expected or unexpected) of decentralization?

5.3 Importance of decentralization and extent of its impact

MSF's intervention on decentralization has had an impact on improving the quality of care and especially on reducing the number of people lost to follow-up, which is one of the major issues in HIV care in the DRC and specifically in Kinshasa. PNLS has also included decentralization in its strategic plan and plans to extend decentralization elsewhere in the country through the creation of new HIV services within health facilities that currently lack them. The decongestion of the CHK followed by the extension of quality to other supported structures has been consistent with a decrease in mortality rates for PLHIV, possibly related to the increase in HIV care coverage (testing in decentralized structures). Nevertheless, these results should be interpreted with caution because severe cases are not treated there but at the CHK (referral hospital for unstable patients). In terms of impact, it should be noted that no differences are currently detectable between integrated and non-integrated areas.

5.4 Incremental and Unintended Effects

- *Impact of decentralization as perceived by beneficiaries*

Caregivers who have benefited from clinical mentoring services say that MSF's intervention at the level of decentralized structures has allowed them to increase their skills and increase their personal confidence in managing HIV infection. PHAs have seen their quality of life improved by bringing services closer together, especially for ARV supply by avoiding long lines if they all have to go to CHK and saving money for patients living far from CHK. Nevertheless, PLHIV deplore the decline in the quality of the caregiver-patient relationship following the return to payment of certain fees after MSF has withdrawn from certain structures.

- *Unintended effects of decentralization*

The model of decentralization with free care and a high quality of care (MSF technical platform) creates a dependence of patients on all levels (desertion of structures from which MSF disengages to go to the new structures supported by MSF, because some services such as consultation become paid). Some actors do not like the fact that MSF decides to leave health facilities to go to others before consolidating the gains and this creates a feeling of low participation in decision-making compared to disengagement. The low geographical coverage of MSF support is also poorly perceived, but this could be due to the fact that actors have not been sufficiently informed that MSF is not in coverage mode. This is a rather unprecedented approach to some structures in an area that should be taken up by the other actors or duplicated by MSF if it shows convincing results.

5.5 Impact Conclusion

The impact of the decentralization of the quality of care and free to peripheral structures has been mainly on improving the quality of life of PLHIV satisfied with no longer travelling long distances or spending a lot of money in search of quality care at CHK. The CHK has also benefited from the extension of the quality of care to decentralized structures because it has allowed it to be relieved. The fact that MSF remains in a structure for a relatively short time would not allow to consolidate the gains made and when MSF leaves there would be a feeling of being neglected at the level of providers and patients.

5.6 Suggestions for improving impact

- Extend the duration of the intervention in a structure beyond 2 years;
- Advocate for the inclusion of financial support (incentives) for psychosocial / therapist educators in Global Fund grants (other providers could be taken over by the NLP or the public service);
- Work on the non-clinical professional practices of providers (support on issues of patient relations and analysis of professional practices).

6. SUSTAINABILITY

6.1 Definition of the criterion

Extent to which the net benefits of the intervention/project will continue or are likely to continue. Sustainability refers to the ability of the effects of decentralization to exist and/or continue beyond the end of initial support by MSF, through the mechanisms that have been used to design and implement this component. In terms of ongoing benefits, this means that programming is not negatively affected by the cessation of AIDS project support and activities.

6.2 Evaluative Question(s)

The analysis of sustainability involves answering the following evaluative questions:

- EQ 8: Are the benefits or changes brought about by the decentralization of HIV care by the AIDS project sustainable?
- EQ 9: What capabilities has the project created that can help ensure sustainability?

6.3 Technical durability

The equipment received from MSF at the level of health facilities and the technical skills acquired by those trained through clinical mentoring can continue to be used for a long time in decentralized structures, but this faces the challenges of maintenance, depreciation and replacement of equipment as well as the mobility of trained staff, or low supply capacities, especially for laboratory reagents.

6.4 Economic or financial sustainability

It should be noted that the resumption of payment for care by the patient after MSF disengages from the health structures supported remains difficult, questioning the relevance of free health care as organized today in a context of the DRC where most of the care services are paid for with a low participation of the State. The situation of the health system with poorly paid human resources or sometimes without salary means that MSF's intervention remains relevant until a reform of the health system allowing autonomy in the management of HIV care services. Currently, the national program to combat AIDS (PNLS) does not have sufficient resources to cover the gap after MSF has withdrawn.

No standard sustainability strategy has been defined clearly explaining how MSF will leave and transfer responsibility (to which actor and under what conditions).

6.5 Conclusion on sustainability

The technical skills acquired can continue to be used even after MSF's withdrawal from decentralized health facilities, as well as some equipment. Nevertheless, good practices and the level of quality of services do not seem to be very likely to be sustainable after exit. The duration of MSF's support of 2 years within a health structure also seems insufficient, since some indicators of the success of decentralization, such as detention in the premises, can only be calculated when MSF is already preparing to leave or has already left.

It should therefore be concluded that sustainability seems unlikely today with the setting up of MSF's commitment and disengagement in support of decentralized structures.

6.6 Suggestions for improving sustainability

- Establish ad hoc follow-up mentoring on the clinical and organisational practices of the structures where MSF has disengaged (pearl support);
- Advocate with the PNLS for the resumption of health structures formerly supported by MSF, including mentoring;
- In the structures currently supported by MSF, extend the support for at least 5 years to work on non-clinical practices also (management) and increase the probability of being able to sustain the results achieved;
- Train mentors at the PNLS level (identified early enough when MSF joined the structure) to continue supporting health structures with the same principles of quality of care;
- *Develop a gradual exit strategy with disengagement from one* category of activities at a time rather than an instant break in support after 2 years.

ANALYSIS OF CROSS-CUTTING THEMES: GENDER AND DIVERSITY, ENVIRONMENT

INTEGRATION OF GENDER AND DIVERSITY INTO THE STRATEGY OF THE PROJECT ON DECENTRALIZATION

Gender has not been specifically integrated into decentralization and the indicators are not gender-specific. Nevertheless, it should be recalled that some HIV services are more in demand by women and that some interventions are specifically targeted at women; these include PMTCT services. Indeed, PMTCT could be taken into account in a specific way in the decentralization of care services or the extension of the quality of care at the peripheral level. In general, support for decentralization should take greater account of the specificities of different types of patients and their needs, and work towards data disaggregation. Particular attention must be paid to particularly vulnerable groups in the design and implementation of support for decentralization.

CONSIDERATION OF ENVIRONMENTAL PROTECTION IN THE DECENTRALIZATION

The environmental theme is taken into account in the project and in the decentralization at the level of hygiene and management of healthcare waste. There are no specifically defined activities or specific indicators on environmental protection in the context of decentralization. Awareness-raising measures should nevertheless be introduced on environmental protection, since the increase in the activities of decentralized structures may generate a greater carbon footprint (incineration, more frequent use of electricity generators, etc.).

CONCLUSION

MSF's support for decentralization as part of the AIDS project in Kinshasa aimed to relieve congestion in the CHK's central structure by extending free access to HIV care services and the quality of care to decentralized structures. As part of this approach to support the improvement of the quality of HIV care services, MSF intervened in health structures already operational by deploying a zonal approach with work in several health structures within the same health zone.

The decentralization of quality has solved the problem of insufficient quality of care in peripheral structures, marked mainly by high rates of PLHIV lost sight of, thus confirming the relevance of the intervention on decentralization.

The intervention at the different levels of the pyramid of care within a health zone with evolution from the non-integrated model to the integrated model, the multi-stakeholder dynamic initiated with the collaboration of the PNLS at the national and provincial level but also of the other actors show the coherence of MSF's intervention logic with the configuration of the health system of the DRC but also with the organization of the HIV response in the Congolese context.

The effectiveness of support for decentralization was assessed by the high overall performance rates for decentralized structures, the decrease in loss of follow-up rates, and high retention rates in care confirming the effectiveness of MSF support for decentralization, although the issue of sustainability of effects remains a major challenge. However, decentralization has focused efforts on supporting the clinical component (clinical mentoring) and I have focused on aspects of caregiver-patient relationships, which are an important determinant of adherence to care and thus retention in care.

It was difficult to assess the financial efficiency of the project because of expenditure recording processes that did not correspond to the analyses required by the evaluation, and it did not allow details to be reached in relation to the use of decentralization budgets. Nevertheless, changes in quality of care and the use of local human resources seem to confirm that the decentralization approach was efficient. Compared to time, it was found that two years of MSF's presence in a health facility was not enough to achieve the quality improvement objectives and increase the chances of sustainability.

The impact of decentralization has been much greater on relieving CHK congestion (ultimately focusing only on cases of unstable patients), and allowing an increase in the quality of care and quality of life of PLHIV as a whole through the extension of quality care in decentralized structures. It should nevertheless be noted that the experience of care by PLHIV after MSF disengaged from certain structures has been a source of dissatisfaction because the quality of the care relationship is impacted by a demotivation of care providers, losing performance bonuses, and a return to payment for care by patients, after a period of free care during MSF's presence. The impact of decentralization was therefore perceived differently by beneficiaries depending on whether MSF was still present or had already disengaged.

Technical sustainability, particularly in relation to the skills acquired by health care providers, is possible because they can continue to use these skills even after MSF's disengagement, but economic sustainability does not seem to be possible in the absence of cost-recovery mechanisms, as HIV services are theoretically free. Early disengagement after two years of support also does not seem to offer the chances of appropriating good practices within the decentralized structures supported.

RECOMMENDATIONS

=> Recommendation 1: Extend support for decentralization to other health facilities in non-integrated areas. Specifically:

- Enlist new structures to have support at different levels of the reference chain within the same health zone (if MSF supports a health centre and a hospital centre, enrol a general referral hospital);
- Do not go to new health zones without consolidating the package and the zonal approach in health zones where MSF is already active with the AIDS project on decentralisation (avoid a dispersion of efforts and resources).

=> Recommendation 2: Strengthen support for health structures through long-term technical support. Specifically:

- Extend support to health facilities to 5 years rather than 2 years to allow better integration of good practices in structures where MSF is still active;
- Establish pearl/ad hoc support in the form of clinical and management mentoring for structures where MSF has disengaged.

=> Recommendation 3: Improve project data and information management. Specifically:

- Organize the classification of expenditure on decentralization according to the care structures supported and the different areas supported (training, laboratory, pharmacies, etc.) and extract estimates of the cost of quality decentralization for future projects or scale-up needs;
- Extend the use of the Tier.net database to non-integrated areas and engage in a discussion with the PNLS on which digital tool to remember between the Tier.net database and the DHIS2 parameterized with patient information.

=> Recommendation 4: Improve the preparation of MSF's disengagement to increase the chances of sustainability of the results obtained by supporting quality improvement in decentralized structures:

- Develop a strategy or guidelines on the organization of decentralization with the different possible standard approaches and the activities they include;
- Include in the decentralization strategy guidance on the process of disengagement and transfer of responsibility from structures formerly supported by MSF to other actors.

=> Recommendation 5: Advocate for the inclusion of quality improvement aspects in the process of decentralization of HIV care in the DRC. Specifically:

- Stimulate a reflection on technical assistance from the Global Fund on the quality of care;
- Include qualitative indicators in the assessment of the quality of decentralized care for Assess the satisfaction of beneficiaries and collect their feedback regularly.

ANNEXES

1. Evaluation Matrix
2. Maintenance Guide
3. Performance and quality of care indicators – decentralized structures
4. Tools for calculating overall performance indicators and quality of care in health facilities

Appendix 1. Evaluation Matrix

Evaluation Criteria and Questions	Sub-questions	Indicators	Data sources
Relevance EQ 1: Were the objectives relevant given MSF's observed and expressed needs, context and priorities?	1.1 What are the priorities and needs of stakeholders identified on the decentralization component of the project? Have they been independently evaluated? 1.2 How did the project address the expressed needs of HIV patients and their families for decentralization?	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 congruence between project objectives/activities and identified needs for decentralization of HIV care services.	▪ Literature review ▪ Key Informant Interviews (CIRTs)
Coherence EQ 2: Was the strategy, design and implementation consistent given the context and existing resources? How could the approach have been more coherent? EQ 3: To what extent have past experiences (including the previous evaluation) been taken	2.1 How are the activities of the decentralization component adapted to the priorities and needs of stakeholders, including patients? 2.2 Has decentralization been adequately designed taking into account the context of the DRC / Kinshasa (National Strategic Plan to Combat AIDS)? 2.3 Has the decentralization strategy deployed been able to adapt over time to changes in context?	C. Stakeholders' views on the link between the design of the decentralization strategy and the local context, and its ability to adapt to contextual change. D. Stakeholders' views on increasing project coherence on the decentralization component.	▪ Literature review ▪ Key Informant Interviews (CIRTs)

Evaluation Criteria and Questions	Sub-questions	Indicators	Data sources
into account in the definition and implementation of the 2017-2022 decentralization strategy?			
Participation QE 4: Have the different actors and counterparties been sufficiently taken into consideration?	3.1 Was the decision to decentralize a concerted one? 3.2 Who are the persons/entities involved in decentralization decision-making? 3.3 Have patients' opinions and wishes been particularly taken into account in decentralization decision-making? 3.4 At what precise level of the organization of decentralization were the different actors involved and what was their role?	E. Stakeholder documentation at the 2020 roundtable; F. Documentation on other decision-making moments on decentralization and the decision-making mechanism	▪ Literature review ▪ Key Informant Interviews (CIRTs)
Effectiveness EQ 5: Has the decentralization component achieved its expected results?	3.5 What are the predefined objectives and expected results of the decentralization component? 3.6 To what extent has the project achieved its general and specific objectives?	G. Documentation of the results of the decentralization project and comparison with the expected results in the logical framework (specific indicators on decentralization). H. Perception of different stakeholders on the effectiveness of	▪ Literature review ▪ EIIC ▪ Field visits ▪ Medical data

Evaluation Criteria and Questions	Sub-questions	Indicators	Data sources
	3.7 What were/are the main opportunities and constraints that have led/are leading to the achievement or non-achievement of results? 3.8 Has the project defined specific indicators on decentralization? What is the level of achievement of these indicators? 3.9 What is the most effective decentralization approach (integrated or non-integrated and why?)	decentralization by comparing the operational efficiencies of integrated and non-integrated zonal approaches.	
Efficiency EQ 6: What resources were needed, were they available, could they have been mobilized more effectively or sustainably?	4.1 What resources (human, logistical, financial, advocacy, etc.) have been allocated to achieve the above results? 4.2 How has MSF coordinated and collaborated with other actors in the DRC, including to strengthen existing capacities on decentralization and the HIV response in general? 4.3 Could resources have been used more efficiently?	I. Document review to assess resources (human, logistical, financial, advocacy, etc.) allocated and trends over time. J. Documentation of collaboration with other actors (MoU). K. Stakeholder perceptions of the most cost-effective/cost-effective decentralization models. L. Stakeholders' views on the effective use of resources allocated to decentralization over the life of the project.	▪ Literature review ▪ EIIC ▪ Field visits

Evaluation Criteria and Questions	Sub-questions	Indicators	Data sources
	4.4 In what ways is the decentralization component of the project efficient in achieving objectives? 4.5 How could efficiency be improved in the implementation of the decentralization component of the project?		
Impact QE 7: What is the impact of the decentralization component?	6.1 What are the effects of decentralization as perceived by patients and their peers? 6.2 What are the expected or unexpected negative and positive consequences of decentralization?	M. Document review to assess the impact on patient retention, adherence to treatment, etc.; N. Perception of stakeholders, especially patients, on the facilities provided by decentralization or more generally on their quality of life.	▪ Literature review ▪ EIIC ▪ Field visits
Durability EQ 8: Are the benefits or changes brought about by the decentralization of HIV care by the AIDS project sustainable? EQ 9: What capabilities has the project created that	6.3 Has the project developed a strategy for exiting and transferring decentralization management to another partner? 6.4 Was the exit strategy coherent and planned for the transfer of skills to the partner who will take over the project? 6.5 Did the exit strategy take into account potential	O. Document review to map the exit strategy / transfer of project management; P. Stakeholders' perception of the exit strategy and transferability to another partner, including implementation, modification/adaptation, communication and problem solving.	▪ Literature review ▪ EIIC ▪ Field visits

Evaluation Criteria and Questions	Sub-questions	Indicators	Data sources
can help ensure sustainability?	challenges, including the economic sustainability of care services in decentralized structures after exit, and how were they addressed? 6.1 What local capacities and resources have been identified? How did the project link with them to ensure the sustainability of results after MSF's withdrawal? 6.2 Are there factors that facilitate/prevent decentralization, specifically related to the Congolese context? 6.6 What general elements could be replicated in other contexts for better decentralization of HIV services to the peripheral level?		

Appendix 2. Maintenance 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; e.g. beneficiaries will not be asked about project history/context, etc.)
- In addition, surveys will be used to obtain more in-depth information as needed.

Introduction and request for consent

Hello, my name is [YOUR NAME] and I am part of a team conducting an evaluation of the decentralization component of the MSF NGO AIDS project in the DRC. 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.

The interview will last approximately 40 minutes and all your answers will remain completely confidential and will only be transmitted to MSF in aggregated form without the possibility of linking your answers to your person. I will not record the interview and 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 do not hesitate to contact me [PROVIDE YOUR CONTACT INFORMATION].

Are there any questions I can answer for you now?

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

Date of interview:	Interviewer: Léon / Théophile / Amjad
Role of the interviewee in the project:	Dates (from/to):

Key interview questions

Questions to the MSF cell and the SAMU

1.Has an assessment of the needs of the population been carried out before launching the decentralization models? If not, why not?
2. Do you think that the objectives of decentralization correspond to the needs identified? What for?
3. Was the vision of the decentralization approach plausible? What for?
4. Has the team fully understood how the desired change by decentralization could occur in the DRC context? Can you describe it in simple terms?
5. What processes of change are already underway in the HIV care ecosystem in Kinshasa following the introduction of decentralization of HIV care, and how do they influence the outcomes of each decentralization model?
6. Regarding the overall context or environment of the project: What were the main factors for and against the achievement or non-achievement of the objectives of decentralization? How has the project responded to these challenges?
7. What were the key assumptions or prerequisites to ensure the desired outcomes of decentralization models? What could make these models sustainable and long-term?
8. Can you give me an example of a similar HIV project whose decentralization model works very well in the DRC or elsewhere? Why is this the case? What do you think makes it work well?
9. How would you describe the performance (successes & weaknesses / failures) of the transfer strategy for the decentralization component? Describe this in relation to the decentralization objectives set by the project. ?
10. What could have been done better or should have been done differently in the next period?
11. What made decentralization work optimally and what didn't work so well? Why was this the case?
12. How do you rate the performance of integrated and non-integrated zonal approaches to decentralization of HIV care? Which approach seems to work best and best suited to meet the identified needs? What for?
13. Do you think there is a question I should have asked you that I did not ask or that there is additional information to provide me essential to this assessment? If so, what is it exactly?

Questions to MSF coordination (MedCo and other senior staff)

1. What is the structure (HR and hierarchy) of the project to fulfil its mission (e.g. information on activities at central, intermediate, primary health care, community level)? How is the decentralization component specifically structured? Why did you choose this structure?
2. Did the team understand how the desired change could happen in the context? Can you describe it in simple terms?
3. How have the guidelines and protocols for implementing decentralization models been implemented and monitored?
4. Were you satisfied with the "process"? And are you convinced that the activities will achieve the specified results and that the quality will be as good in the decentralized structures as in the parent structure? What for?
5. What change processes are already underway in your "ecosystem", and how do they influence the outcomes the intervention was intended to achieve?
6. What were the key assumptions or preconditions that will ensure that the desired outcomes or changes on decentralization are sustainable and long-term?
7. Did the approach you used capture the effects of policy influence and evidence assimilation by government counterparts? How?
8. Have you looked at which other actors are working in the same field as MSF in HIV programs and especially on decentralization? And have you assessed how they might influence your results? Did you work together? Or are they opposed to what you do?
9. What is the nature of collaboration and coordination methods with HIV partners in the DRC in general and more specifically on decentralization?
10. What are the roles of the different partners involved in the decentralization of HIV services and activities?
11. What specific outcomes would the collaboration focus on?
12. What risks did the project face in successfully decentralizing HIV services? How were these risks managed?

13. Regarding the overall context or environment of the project: What were the main factors in favor and against the achievement or non-achievement of the decentralization objectives? How has the project responded to these challenges?
14. How would you describe the success of decentralization models? What does it mean for the intended beneficiaries if this project has worked well?
15. What could have been done better or done differently during the project period to make decentralization successful and more beneficial to PHAs?

Questions to other project staff

1. What was your role in the implementation of the project and its decentralization component?
2.How were the guidelines and protocols of the decentralization intervention operationalized and followed? How did you contribute to that? What are the specific indicators that would make it possible to measure the performance of decentralization? Are these indicators included in the standard list of CBO indicators?
3. To what extent has the project been well integrated within the health system and in the different sectors related to HIV services? And for the decentralization component, do you think it has been well integrated into the national HIV strategy in the DRC?
4. Of the different levels of the PLHIV care cascade, which services have been decentralized? Do you think other services should have been decentralized? If so, which ones?
5. What are the linkages and continuity of shared programs across sectors/services, including between decentralized structures and the higher baseline? How does the referral between PODI and health centers work, if it exists?
6. To what extent has decentralized HIV services been integrated into primary health care at the health center level? Have the teams of the decentralized structures taken ownership of the new activities? If not or partially, what are the causes and challenges identified?
7. What is the place of the decentralization of HIV services in the DRC's national HIV strategy?
8. What is the nature of collaboration and coordination methods with partners involved in the management of HIV programs?

Questions to stakeholders and government counterparts

1. As a key stakeholder, what do you think of the design, implementation and results of the models and interventions for decentralization of care implemented by MSF's AIDS project? How do you see added value in the local context?
2. To what extent has the MSF AIDS project been well integrated within the health system and across sectors, especially with its decentralization component?
3. What are the linkages and continuity of shared programs across sectors/services? Especially between centralized structures and maternal or higher level health structures in the health system?
4. Do the objectives of the decentralization of HIV care in Kinshasa correspond to the needs identified? If so, what needs has this decentralization made it possible to meet?
5. Was MSF's overall strategy on decentralisation appropriate to achieve its objectives?
6. How would you describe the success of this project on the decentralization component? What does it mean for the intended beneficiaries if this project has worked well?
7. What could have been done better or differently during the project period to improve the performance of decentralization or better meet the needs of PHAs and the local health system?

Questions for patients

1. MSF's AIDS project extended care services to peripheral health facilities, whereas they were initially concentrated at the Kabinda General Referral Hospital. Would you like to continue to be treated at Kabinda HGR or in a decentralized structure? What for?
2. What differences do you make in the quality of care (reception, availability and ease of access to treatment and follow-up examinations, caregiver-patient relationship, etc.) between Kabinda HGR and your new care structure?
3. Can you tell me who made the decision to assign you to another care facility for the continuation of your treatments? What are the advantages and disadvantages, if any, of finding yourself followed-up in a peripheral health structure?
4. Do you still attend your old care facility despite the fact that you are normally followed-up in this peripheral structure? If so, for which services do you continue to go to your old care facility?
5. Are you in an ARV drug recovery program from another patient providing community distribution? What do you think of this community distribution of ARVs?

6. When you are seriously ill, are you always referred to your old care structure? For which cases / exams, tests, or problems are you obliged to be referred to them?
7. If you have never changed your care structure and you are followed-up at the Kabinda General Hospital, would you like to be followed-up in another structure? If so, what would be your expectations in this new health structure in terms of available services, distance to get there, etc.

Appendix 3: Performance and quality indicators of care – centralized structures

1. CS Saint Clement

Duration	Values	2017	2018	2019	2020	2021
6						
	Originally started in cohort	**45**	**33**	**20**	**32**	**56**
	First line regimen	11	19	13	15	37
	Second line regimen	0	0	0	0	0
	Third line regimen	0	0	0	0	0
	In care but not on drugs	8	1	3	6	1
	Second line %	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	Third line %	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	Transferred out (cumulative %)	2.2%	3.0%	0.0%	0.0%	3.6%
	Remaining in care %	**45.2%**	**62.5%**	**84.2%**	**65.6%**	**70.4%**
	LTF (cumulative %)	40.5%	34.4%	15.8%	34.4%	25.9%
	Interrupted (cumulative %)	9.5%	3.1%	0.0%	0.0%	1.9%
	Mortality (cumulative %)	4.8%	0.0%	0.0%	0.0%	1.9%
	Viral loads done	1	10	7	7	32
	Viral loads <400 copies/ml	1	7	6	7	28
	Viral load suppression %	100.0%	70.0%	85.7%	100.0%	87.5%
	Viral load completion %	**9.1%**	**52.6%**	**53.8%**	**46.7%**	**86.5%**

Duration	Values	2017	2018	2019	2020	2021
12						
	Originally started in cohort	**44**	**32**	**20**	**32**	**21**
	First line regimen	7	11	11	9	13
	Second line regimen	0	1	0	0	0
	Third line regimen	0	0	0	0	0
	In care but not on drugs	6	5	1	7	0
	Second line %	**0.0%**	**5.9%**	**0.0%**	**0.0%**	**0.0%**
	Third line %	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	Transferred out (cumulative %)	0.0%	0.0%	0.0%	0.0%	4.8%
	Remaining in care %	**31.7%**	**54.8%**	**63.2%**	**50.0%**	**65.0%**
	LTF (cumulative %)	53.7%	38.7%	31.6%	46.9%	35.0%
	Interrupted (cumulative %)	9.8%	0.0%	5.3%	0.0%	0.0%
	Mortality (cumulative %)	4.9%	6.5%	0.0%	3.1%	0.0%
	Viral loads done	5	7	8	7	9
	Viral loads <400 copies/ml	3	4	6	7	7
	Viral load suppression %	60.0%	57.1%	75.0%	100.0%	77.8%
	Viral load completion %	**71.4%**	**58.3%**	**72.7%**	**77.8%**	**69.2%**

Duration	Values	2017	2018	2019	2020	2021
24						
	Originally started in cohort	**44**	**32**	**19**	**11**	
	First line regimen	10	8	11	4	
	Second line regimen	1	1	0	0	
	Third line regimen	0	0	0	0	
	In care but not on drugs	3	2	0	0	
	Second line %	**7.1%**	**9.1%**	**0.0%**	**0.0%**	
	Third line %	**0.0%**	**0.0%**	**0.0%**	**0.0%**	
	Transferred out (cumulative %)	0.0%	6.3%	0.0%	0.0%	
	Remaining in care %	**34.1%**	**37.9%**	**61.1%**	**36.4%**	
	LTF (cumulative %)	56.1%	55.2%	38.9%	63.6%	
	Interrupted (cumulative %)	2.4%	0.0%	0.0%	0.0%	
	Mortality (cumulative %)	7.3%	6.9%	0.0%	0.0%	
	Viral loads done	7	7	10	4	
	Viral loads <400 copies/ml	5	5	9	3	
	Viral load suppression %	71.4%	71.4%	90.0%	75.0%	
	Viral load completion %	**63.6%**	**77.8%**	**90.9%**	**100.0%**	

Duration	Values	2017	2018	2019	2020	2021
36						
	Originally started in cohort	**44**	**31**	**7**		
	First line regimen	9	4	3		
	Second line regimen	1	2	0		
	Third line regimen	0	0	0		
	In care but not on drugs	1	0	1		
	Second line %	**9.1%**	**33.3%**	**0.0%**		
	Third line %	**0.0%**	**0.0%**	**0.0%**		
	Transferred out (cumulative %)	4.5%	0.0%	0.0%		
	Remaining in care %	**28.2%**	**21.4%**	**66.7%**		
	LTF (cumulative %)	59.0%	71.4%	33.3%		
	Interrupted (cumulative %)	5.1%	0.0%	0.0%		
	Mortality (cumulative %)	7.7%	7.1%	0.0%		
	Viral loads done	8	6	3		
	Viral loads <400 copies/ml	7	5	3		
	Viral load suppression %	87.5%	83.3%	100.0%		
	Viral load completion %	**80.0%**	**100.0%**	**100.0%**		

2. CH Mokali

Duration	Values	2017	2018	2019	2020	2021	2022
6							
	Originally started in cohort	**16**	**12**	**14**	**17**	**22**	**182**
	First line regimen	15	9	14	15	13	144
	Second line regimen	0	0	0	0	0	0
	Third line regimen	0	0	0	0	0	0
	In care but not on drugs	0	0	0	0	0	1
	Second line %	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	Third line %	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	Transferred out (cumulative %)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Remaining in care %	**93.8%**	**75.0%**	**100.0%**	**88.2%**	**65.0%**	**80.6%**
	LTF (cumulative %)	0.0%	8.3%	0.0%	0.0%	35.0%	5.0%
	Interrupted (cumulative %)	0.0%	16.7%	0.0%	11.8%	0.0%	13.9%
	Mortality (cumulative %)	6.3%	0.0%	0.0%	0.0%	0.0%	0.6%
	Viral loads done	0	0	0	2	10	12
	Viral loads <400 copies/ml	0	0	0	1	9	10
	Viral load suppression %				50.0%	90.0%	83.3%
	Viral load completion %	**0.0%**	**0.0%**	**0.0%**	**13.3%**	**76.9%**	**8.3%**

Duration	Values	2017	2018	2019	2020	2021	2022
12							
	Originally started in cohort	**16**	**11**	**14**	**17**	**1**	**160**
	First line regimen	14	9	13	13	1	128
	Second line regimen	0	0	0	0	0	0
	Third line regimen	1	0	0	0	0	1
	In care but not on drugs	0	0	0	0	0	0
	Second line %	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	Third line %	**6.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.8%**
	Transferred out (cumulative %)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Remaining in care %	**93.8%**	**81.8%**	**92.9%**	**76.5%**	**100.0%**	**80.6%**
	LTF (cumulative %)	0.0%	0.0%	0.0%	23.5%	0.0%	3.1%
	Interrupted (cumulative %)	0.0%	18.2%	7.1%	0.0%	0.0%	15.6%
	Mortality (cumulative %)	6.3%	0.0%	0.0%	0.0%	0.0%	0.6%
	Viral loads done	2	0	0	0	1	3
	Viral loads <400 copies/ml	2	0	0	0	1	3
	Viral load suppression %	100.0%				100.0%	100.0%
	Viral load completion %	**13.3%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**2.3%**

Duration	Values	2017	2018	2019	2020	2021	2022
24							
	Originally started in cohort	**16**	**11**	**14**	**11**		**153**
	First line regimen	14	9	8	0		110
	Second line regimen	0	0	0	0		0
	Third line regimen	0	0	0	0		1
	In care but not on drugs	0	0	0	0		1
	Second line %	**0.0%**	**0.0%**	**0.0%**			**0.0%**
	Third line %	**0.0%**	**0.0%**	**0.0%**			**0.9%**
	Transferred out (cumulative %)	0.0%	0.0%	0.0%	0.0%		0.0%
	Remaining in care %	**87.5%**	**81.8%**	**57.1%**	**0.0%**		**73.2%**
	LTF (cumulative %)	6.3%	0.0%	42.9%	90.9%		11.8%
	Interrupted (cumulative %)	0.0%	18.2%	0.0%	0.0%		13.7%
	Mortality (cumulative %)	6.3%	0.0%	0.0%	9.1%		1.3%
	Viral loads done	0	0	3	0		7
	Viral loads <400 copies/ml	0	0	3	0		6
	Viral load suppression %			100.0%			85.7%
	Viral load completion %	**0.0%**	**0.0%**	**37.5%**			**6.3%**

Duration	Values	2017	2018	2019	2020	2021	2022
36							
	Originally started in cohort	**16**	**11**	**2**			**130**
	First line regimen	14	6	0			100
	Second line regimen	0	0	0			0
	Third line regimen	0	0	0			1
	In care but not on drugs	0	0	0			0
	Second line %	**0.0%**	**0.0%**				**0.0%**
	Third line %	**0.0%**	**0.0%**				**1.0%**
	Transferred out (cumulative %)	0.0%	0.0%	0.0%			0.0%
	Remaining in care %	**87.5%**	**54.5%**	**0.0%**			**77.7%**
	LTF (cumulative %)	6.3%	45.5%	100.0%			6.9%
	Interrupted (cumulative %)	0.0%	0.0%	0.0%			14.6%
	Mortality (cumulative %)	6.3%	0.0%	0.0%			0.8%
	Viral loads done	1	1	0			4
	Viral loads <400 copies/ml	0	1	0			3
	Viral load suppression %	0.0%	100.0%				75.0%
	Viral load completion %	**7.1%**	**16.7%**				**4.0%**

3. CS Saint Joseph

Duration	Values	2017	2018	2019	2020	2021	Total général
6							
	Originally started in cohort	**51**	**35**	**69**	**47**	**50**	**369**
	First line regimen	43	25	46	25	31	245
	Second line regimen	0	0	0	0	0	0
	Third line regimen	0	0	0	0	0	0
	In care but not on drugs	3	1	3	0	1	10
	Second line %	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	Third line %	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	Transferred out (cumulative	0.0%	0.0%	2.9%	4.3%	10.0%	2.4%
	Remaining in care %	**90.2%**	**76.5%**	**75.4%**	**64.1%**	**76.2%**	**73.3%**
	LTF (cumulative %)	2.0%	17.6%	6.2%	20.5%	21.4%	8.3%
	Interrupted (cumulative %)	7.8%	5.9%	6.2%	7.7%	0.0%	14.9%
	Mortality (cumulative %)	0.0%	0.0%	12.3%	7.7%	2.4%	3.4%
	Viral loads done	9	5	14	13	26	68
	Viral loads <400 copies/ml	8	4	13	13	22	61
	Viral load suppression %	88.9%	80.0%	92.9%	100.0%	84.6%	89.7%
	Viral load completion %	**20.9%**	**20.0%**	**30.4%**	**52.0%**	**83.9%**	**27.8%**

Duration	Values	2017	2018	2019	2020	2021
12						
	Originally started in cohort	**51**	**35**	**69**	**47**	**18**
	First line regimen	41	20	32	20	10
	Second line regimen	0	0	0	0	0
	Third line regimen	0	0	0	0	0
	In care but not on drugs	0	2	1	4	0
	Second line %	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	Third line %	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	Transferred out (cumulative	0.0%	2.9%	2.9%	2.1%	11.1%
	Remaining in care %	**80.4%**	**66.7%**	**52.4%**	**63.2%**	**66.7%**
	LTF (cumulative %)	11.8%	24.2%	23.8%	26.3%	26.7%
	Interrupted (cumulative %)	7.8%	9.1%	9.5%	2.6%	0.0%
	Mortality (cumulative %)	0.0%	0.0%	14.3%	7.9%	6.7%
	Viral loads done	19	6	15	13	8
	Viral loads <400 copies/ml	15	6	13	12	5
	Viral load suppression %	78.9%	100.0%	86.7%	92.3%	62.5%
	Viral load completion %	**46.3%**	**30.0%**	**46.9%**	**65.0%**	**80.0%**

Duration	Values	2017	2018	2019	2020	2021
24						
	Originally started in cohort	**51**	**35**	**69**	**14**	
	First line regimen	36	19	21	4	
	Second line regimen	0	0	0	0	
	Third line regimen	0	0	0	0	
	In care but not on drugs	1	0	0	0	
	Second line %	**0.0%**	**0.0%**	**0.0%**	**0.0%**	
	Third line %	**0.0%**	**0.0%**	**0.0%**	**0.0%**	
	Transferred out (cumulative	0.0%	0.0%	2.9%	14.3%	
	Remaining in care %	**72.5%**	**57.6%**	**34.4%**	**44.4%**	
	LTF (cumulative %)	11.8%	36.4%	49.2%	33.3%	
	Interrupted (cumulative %)	15.7%	3.0%	0.0%	0.0%	
	Mortality (cumulative %)	0.0%	3.0%	16.4%	22.2%	
	Viral loads done	13	11	17	3	
	Viral loads <400 copies/ml	12	11	16	3	
	Viral load suppression %	92.3%	100.0%	94.1%	100.0%	
	Viral load completion %	**36.1%**	**57.9%**	**81.0%**	**75.0%**	

Duration	Values	2017	2018	2019	2020	2021
36						
	Originally started in cohort	**51**	**34**	**17**		
	First line regimen	36	10	2		
	Second line regimen	1	0	1		
	Third line regimen	0	0	0		
	In care but not on drugs	0	0	0		
	Second line %	**2.7%**	**0.0%**	**33.3%**		
	Third line %	**0.0%**	**0.0%**	**0.0%**		
	Transferred out (cumulative	0.0%	5.9%	0.0%		
	Remaining in care %	**72.5%**	**33.3%**	**20.0%**		
	LTF (cumulative %)	23.5%	60.0%	66.7%		
	Interrupted (cumulative %)	3.9%	3.3%	0.0%		
	Mortality (cumulative %)	0.0%	3.3%	13.3%		
	Viral loads done	25	10	2		
	Viral loads <400 copies/ml	25	10	2		
	Viral load suppression %	100.0%	100.0%	100.0%		
	Viral load completion %	**67.6%**	**100.0%**	**66.7%**		

4. CS Sainte Anne

Duration	Values	2017	2018	2019	2020	2021
6						
	Originally started in cohort	**53**	**21**	**54**	**34**	**24**
	First line regimen	53	18	53	3	17
	Second line regimen	0	0	0	0	0
	Third line regimen	0	0	0	0	0
	In care but not on drugs	0	0	0	0	0
	Second line %	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	Third line %	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	Transferred out (cumulative	0.0%	4.8%	0.0%	0.0%	0.0%
	Remaining in care %	**100.0%**	**90.0%**	**98.1%**	**9.4%**	**77.3%**
	LTF (cumulative %)	0.0%	0.0%	0.0%	50.0%	13.6%
	Interrupted (cumulative %)	0.0%	5.0%	1.9%	28.1%	4.5%
	Mortality (cumulative %)	0.0%	5.0%	0.0%	12.5%	4.5%
	Viral loads done	3	0	0	0	4
	Viral loads <400 copies/ml	2	0	0	0	3
	Viral load suppression %	66.7%				75.0%
	Viral load completion %	**5.7%**	**0.0%**	**0.0%**	**0.0%**	**23.5%**

Duration	Values	2017	2018	2019	2020	2021
12						
	Originally started in cohort	**53**	**20**	**54**	**23**	**10**
	First line regimen	53	19	44	0	6
	Second line regimen	0	0	0	0	0
	Third line regimen	0	0	0	0	0
	In care but not on drugs	0	0	0	0	0
	Second line %	**0.0%**	**0.0%**	**0.0%**		**0.0%**
	Third line %	**0.0%**	**0.0%**	**0.0%**		**0.0%**
	Transferred out (cumulative	0.0%	0.0%	0.0%	0.0%	0.0%
	Remaining in care %	**100.0%**	**95.0%**	**81.5%**	**0.0%**	**66.7%**
	LTF (cumulative %)	0.0%	0.0%	13.0%	36.4%	33.3%
	Interrupted (cumulative %)	0.0%	0.0%	3.7%	50.0%	0.0%
	Mortality (cumulative %)	0.0%	5.0%	1.9%	13.6%	0.0%
	Viral loads done	5	0	0	0	5
	Viral loads <400 copies/ml	2	0	0	0	5
	Viral load suppression %	40.0%				100.0%
	Viral load completion %	**9.4%**	**0.0%**	**0.0%**		**83.3%**

Duration	Values	2017	2018	2019	2020	2021
24						
	Originally started in cohort	**53**	**20**	**54**	**10**	
	First line regimen	53	9	0	3	
	Second line regimen	0	0	0	0	
	Third line regimen	0	0	0	0	
	In care but not on drugs	0	0	0	0	
	Second line %	**0.0%**	**0.0%**		**0.0%**	
	Third line %	**0.0%**	**0.0%**		**0.0%**	
	Transferred out (cumulative	0.0%	5.0%	5.6%	40.0%	
	Remaining in care %	**100.0%**	**47.4%**	**0.0%**	**50.0%**	
	LTF (cumulative %)	0.0%	42.1%	90.2%	33.3%	
	Interrupted (cumulative %)	0.0%	5.3%	7.8%	0.0%	
	Mortality (cumulative %)	0.0%	5.3%	2.0%	16.7%	
	Viral loads done	2	0	0	2	
	Viral loads <400 copies/ml	2	0	0	2	
	Viral load suppression %	100.0%			100.0%	
	Viral load completion %	**3.8%**	**0.0%**		**66.7%**	

Duration	Values	2017	2018	2019	2020	2021
36						
	Originally started in cohort	**53**	**20**	**11**		
	First line regimen	31	0	3		
	Second line regimen	0	0	0		
	Third line regimen	0	0	0		
	In care but not on drugs	0	0	0		
	Second line %	**0.0%**		**0.0%**		
	Third line %	**0.0%**		**0.0%**		
	Transferred out (cumulative	3.8%	0.0%	0.0%		
	Remaining in care %	**60.8%**	**0.0%**	**33.3%**		
	LTF (cumulative %)	37.3%	94.7%	66.7%		
	Interrupted (cumulative %)	2.0%	0.0%	0.0%		
	Mortality (cumulative %)	0.0%	5.3%	0.0%		
	Viral loads done	0	0	2		
	Viral loads <400 copies/ml	0	0	0		
	Viral load suppression %			0.0%		
	Viral load completion %	**0.0%**		**66.7%**		

5. CS Tshimungu

Duration	Values	2017	2018	2019	2020	2021
6						
	Originally started in cohort	**15**	**11**	**33**	**16**	**13**
	First line regimen	15	10	30	16	12
	Second line regimen	0	0	0	0	0
	Third line regimen	0	0	0	0	0
	In care but not on drugs	0	0	0	0	0
	Second line %	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	Third line %	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	Transferred out (cumulative %)	0.0%	0.0%	0.0%	0.0%	0.0%
	Remaining in care %	**100.0%**	**90.9%**	**90.9%**	**100.0%**	**92.3%**
	LTF (cumulative %)	0.0%	0.0%	6.1%	0.0%	7.7%
	Interrupted (cumulative %)	0.0%	0.0%	3.0%	0.0%	0.0%
	Mortality (cumulative %)	0.0%	9.1%	0.0%	0.0%	0.0%
	Viral loads done	0	0	0	0	4
	Viral loads <400 copies/ml	0	0	0	0	3
	Viral load suppression %					75.0%
	Viral load completion %	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**33.3%**

Duration	Values	2017	2018	2019	2020	2021
12						
	Originally started in cohort	**15**	**11**	**33**	**16**	**5**
	First line regimen	14	10	30	16	2
	Second line regimen	0	0	0	0	0
	Third line regimen	0	0	0	0	0
	In care but not on drugs	0	0	0	0	0
	Second line %	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	Third line %	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	Transferred out (cumulative %)	6.7%	0.0%	3.0%	0.0%	0.0%
	Remaining in care %	**100.0%**	**90.9%**	**93.8%**	**100.0%**	**40.0%**
	LTF (cumulative %)	0.0%	0.0%	6.3%	0.0%	60.0%
	Interrupted (cumulative %)	0.0%	0.0%	0.0%	0.0%	0.0%
	Mortality (cumulative %)	0.0%	9.1%	0.0%	0.0%	0.0%
	Viral loads done	0	0	0	3	1
	Viral loads <400 copies/ml	0	0	0	3	0
	Viral load suppression %				100.0%	0.0%
	Viral load completion %	**0.0%**	**0.0%**	**0.0%**	**18.8%**	**50.0%**

Duration	Values	2017	2018	2019	2020	2021
24						
	Originally started in cohort	**15**	**11**	**32**	**1**	
	First line regimen	8	8	21	0	
	Second line regimen	0	0	0	0	
	Third line regimen	0	0	0	0	
	In care but not on drugs	3	1	0	0	
	Second line %	**0.0%**	**0.0%**	**0.0%**		
	Third line %	**0.0%**	**0.0%**	**0.0%**		
	Transferred out (cumulative %)	0.0%	0.0%	0.0%	0.0%	
	Remaining in care %	**78.6%**	**81.8%**	**65.6%**	**0.0%**	
	LTF (cumulative %)	7.1%	9.1%	28.1%	100.0%	
	Interrupted (cumulative %)	14.3%	0.0%	3.1%	0.0%	
	Mortality (cumulative %)	0.0%	9.1%	3.1%	0.0%	
	Viral loads done	0	0	1	0	
	Viral loads <400 copies/ml	0	0	0	0	
	Viral load suppression %			0.0%		
	Viral load completion %	**0.0%**	**0.0%**	**4.8%**		

Duration	Values	2017	2018	2019	2020	2021
36						
	Originally started in cohort	**15**	**11**	**8**		
	First line regimen	8	7	2		
	Second line regimen	0	0	0		
	Third line regimen	0	0	0		
	In care but not on drugs	0	0	0		
	Second line %	**0.0%**	**0.0%**	**0.0%**		
	Third line %	**0.0%**	**0.0%**	**0.0%**		
	Transferred out (cumulative %)	0.0%	0.0%	0.0%		
	Remaining in care %	**57.1%**	**63.6%**	**25.0%**		
	LTF (cumulative %)	42.9%	27.3%	62.5%		
	Interrupted (cumulative %)	0.0%	0.0%	0.0%		
	Mortality (cumulative %)	0.0%	9.1%	12.5%		
	Viral loads done	0	3	1		
	Viral loads <400 copies/ml	0	2	1		
	Viral load suppression %		66.7%	100.0%		
	Viral load completion %	**0.0%**	**42.9%**	**50.0%**		

Appendix 4: Tools for calculating overall performance indicators and quality of care in health facilities

Performance evaluation grid for health structures supported by MSF in the care of HIV/AIDS in the City of Kinshasa - Version of 19 November 2019

MSF Belgium (MSF-B) supports several primary and secondary school structures in the City of Kinshasa in the fight against HIV/AIDS.

In these facilities, MSF-B offers a comprehensive package of support in terms of skills building (through a *mentoring* program), medicines for major opportunistic infections, laboratory equipment and inputs for biological monitoring, logistical support to achieve the standard of hygiene standards and control of nosocomial infections, and financial support. The latter is based on the concept of payment by performance, i.e. a premium additional to the basic premium, and which is determined according to the results achieved.

The results depend on the predetermined objectives in consultation with the management team of the supported structure. These objectives are translated into measurable indicators, and will be verified during an external evaluation, monthly or quarterly, carried out by an MSF-B team specifically dedicated to this exercise, and in the presence of members of the health structure concerned, identified in advance for this task.

The analysis of Tier-Net data will refer to the previous month.

This document brings together the evaluation grids, including criteria by department and expected results. The sum of the results obtained by department measures the performance of the staff in charge of the activities (in %). The result of the evaluation thus makes it possible to determine the performance bonus.

Indicators of Support (OPD)

Performance evaluation Support for Health Centers of Decentralization

STRUCTURE: …… Date: …./…./…….Evaluator:……..

No.	SUPPORT INDICATORS	QUOTATION INDICATION	POINTS OBTAINED	SCORE MAX	EXPLANATION/ COMMENT
1	DCIP OPD: 90% of patients consulted and of unknown status targeted are screened.	< 69% = 170 – 89 = 2≥ 90%=4		4	DCIP – Number of patients with known status/total consultations (DCIP registry + consultation register)

2	Average time from positive screening date + enrolment to initiation date < 14 Days (PPDV excluded) for stage 1 and 2 patients	<14 j = 4≥14 j – 20 j =2> 20 j = 1		4	Team Data
3	90% ARV patients of active thread over 6 months have at least one CV available	< 69% = 170 – 89 = 2≥ 90%=4		4	Team Data NB: if input breakdown, note Not Applicable (NA)
4	> 95% of women who test positive for CPN1 are initiated to ARVs	< 69% = 170 – 95% = 2> 95%=4		4	Team Data
5	90% of CVs of pregnant women on ARVs over 6 months of age made their CV during	< 69% = 170 – 95% = 2> 95%=4		4	Team Data
6	> 95% of exposed children had PCR between 0-6 weeks of life	< 69% = 170 – 89 = 2> 90%=4		4	Team Data
7	80% of patients and adolescents (0-18 years) on ARVs are in the active queue after 12 months	< 50% = 150 – 69 = 2> 70%=3		3	Team Data
8	80% of adult patients (19+) on ARVs are in the active queue after 12 months	< 50% = 150 – 69 = 2> 70%=3		3	Team Data
9	90% of TB patients have their HIV status documented in the TB registry	< 69% = 170 – 89 = 2> 90%=3		3	Register TB
10	100% of patients diagnosed TB 12 months rather have their results filled in the registry (the fate of patients)	< 69% = 170 – 89 = 2> 90%=3		3	REGISTER TB
	Grand total			36	

PERCENTAGE RESULT =

(Score obtained*100)/32

STRUCTURE: …… Date: …./…./…….Evaluator:……..

Consultation Indicators (OPD)

No.	CONSULTATION ROOM	QUOTATION INDICATION	POINTS OBTAINED	SCORE MAX	EXPLANATION/ COMMENT
1	Correct completion of the dossier (OPD dossier evaluation sheet, Annex 2)	< 69% = 1 70 – 79 = 2 80-89= 3 ≥ 90%= 4		4	Evaluation to be made on 10 files
2	Correct prescription of ARVs (combination therapy, pediatric dosage),	< 69% = 170 – 79 = 2 80-89= 3≥ 90%= 4		4	Evaluation to be made on 10 files
3	Correct prescription treatment of IO and other common pathologies, according to the diagnosis made.	< 69% = 170 – 79 = 2 80-89= 3≥ 90%= 4		4	Evaluation to be made on 10 files
4	100% of patients with CD4 counts < 200 had reported AML and CRAG TB	< 69% = 170 – 79 = 2 80-89= 3≥ 90%= 4		4	CD4, TBLAM and CRAG lab registry
	Grand total			16	

PERCENTAGE RESULT =

(Score obtained*100)/ 16

Performance Evaluation Hygiene of Health Centers of Decentralization

STRUCTURE: …… Date: …./…./…….Evaluator:……..

OPD hygiene indicators

No.	EVALUATION CRITERIA	RESULT OBTAINED	SCORE MAX	EXPLANATION/COMMENT

1	WATER	Yes =1	Not = 0		
	Handwashing device at the indicated places:				
	Yard entry (reception)			1	
	Consultation Office			1	
	Nurses' room			1	
	Observation room			1	
	Laboratory			1	
	Pharmacy			1	
	Latrines			1	
	PSE			1	
	S/ Total			8	
2	ADEQUATE PERSONAL PROTECTIVE EQUIPMENT	Yes =2	Not = 1		Yes= everyone wears correctly; No= no staff or some do not wear their outfit properly
	Hygienists: reusable gloves + boots + glasses			2	
	FFP2/95 respiratory protection masks are available and worn if necessary			2	
	S/ Total			4	
3	LATRINE	Yes = 2	Not = 1		
	functional and clean			2	
4	COURTYARD	Yes =2	Not = 1		
	Clean (no grass, plastic bag, standing water)			2	
	Trash can for household waste in the yard at pre-identified locations (at least 2)			2	
	S/ Total			4	

5	WASTE SORTING				
	Correct separation of waste (solids, glass, TC)	Yes =2	Not = 1		
	Consultation room			2	
	Treatment room			2	
	Observation room			2	
	Laboratory			2	
	PSE			2	
	S/ Total			10	
6	WASTE AREA	Yes = 2	Not = 1		
	clean and used			2	

PERCENTAGE RESULT = (Score*100)/ 30

Performance evaluation Laboratories of Decentralization Health Centers

STRUCTURE: …….. Date: …./…./…….Evaluator:……..

1. Hygiene indicators

	YES (4)	NOT (0)
Precautions		
- Are the benches clean, well cleaned and less cluttered?		
- Waste sorting is done correctly: are the needles/lancets thrown into a cutting container, the tips used in a container with tips, and is the glass thrown into a cutting container?		
Subtotal 1:	/08 to %	

2. Performance quality indicators, quality controls and maintenance

Test supervision	YES (4)	NOT (0)
-A quality control is carried out at the opening of a new test box and each day of use of the devices (Sysmex, Biochemistry, CD4, TB Lam, CrAg) *Check if according to the opening date of the latest kits, a check has been made and recorded.		

Quality control verification and maintenance	YES (1)	NOT (0)
1. PoC créatinine (New StatSensor Express)		
- Are the checks done and documented EVERY WEEK (or 2 weeks MAX)?		
2. Hémocue		
- The Hemocue is maintained and documented at least 2x the month		
- Are the checks done and documented EVERY WEEK (or 2 weeks MAX)?		
3. Glucomètre (New StatStrip)		
- Are the checks done and documented EVERY WEEK (or 2 weeks MAX)?		
4. Pima		
- Are the checks done every day of use?		
- Are all controls documented and are they within standards?*		
-The control cartridges are used within the required 6 months and opening date noted?		
5. VISITEC		
- Are the checks done every day of use?		
- Are all controls documented and are they within standards?		
Subtotal 2:	/09 to %	

* QC standards are usually indicated in/on control kits

3. Reporting indicators, samples sent to the CHK lab and data recording

	YES (4)	NOT (0)
1. Reporting		
- The monthly report is sent on time (before the 5th), well written and contains all the necessary data?		
	YES (2)	NOT (0)
2. Samples sent to the CHK lab		
Samples sent to CHK are of good quality (< 10% rejections/non-conformities)		

-The results of the analyses sent to the CHK are returned within a reasonable time (CV </= 2 weeks; Blood cultures </= 1 week; CD4, Biochemistry, TB </= 24 h)		
3. Registers		
- Are the results of laboratory tests properly encoded in the register? *Evaluator must check (depending on the presence of a few vouchers) the consistency between the data in the register and the result encoded.		
Subtotal 3:	/10 to %	

4. Indicators on stock management

	YES (1)	NOT (0)
Consumption and order tracking sheets are available and up to date		
- Consumption and order tracking sheets are available and up to date		
- Consumption is consistent with statistics.		
- Pre-breaks are anticipated and reported in real time. *To be checked according to the number of exceptional orders		

FEEDBACK

CONCLUSION

No.	EVALUATION CRITERIA	RESULT OBTAINED			SCORE MAX	COMMENTS/RECOMMENDATIONS
	STOCK / PHARMACY	Yes = 2		Not = 1		
1	Storage of pharmacy stock					
	Products are arranged by family or alphabetical order on shelves and labeled				2	
2	Register or consumption record					
	Presence of register/stock sheet/daily tracking sheet of movements of medicines and other materials, well maintained and up-to-date				2	
3	Internal controls (random verification of 5 products)	>80% (=4)	60-79% (=3)	<60% (=1)		Choose 10
	For more than 80% of tracer products (Annex 5: CS list), the physical stock corresponds to the theoretical stock				4	
4	Compliance with the order schedule:	Prompt (= 2)	Delay 2-5 days (= 1)	Delay >5 days (= 0)	2	Taking MSF planning into account
A	The IO order was developed, validated and transmitted to MSF					

	according to the schedule set up by the latter.					
B	ARV and Anti TB commands have been developed, validated and transmitted and monitored to the health zone set up by the latter.	Prompt (= 2)	Delay 2-5 days (= 1)	Delay >5 days (= 0)	2	Consider Health Zone planning only for HCs and not Hospitals (not applicable for DPIs)
5	Monitoring Pre-rupture and Ruptures of ARVs and IO	> 90% (= 4)	70 – 89% (= 3)	< 69% (= 1)		Compare out sheet with stock sheets.
	More than 90% of the tracer products in rupture were registered in the rupture follow-up sheet/register and communicated to the health zone or to MSF (Annex 6)				4	
6	Cleanliness of the Pharmacy	Yes =2		Not = 1		
	Hygiene of surfaces, floor, furniture				2	
7	Expired management	Yes=2		Non=0	2	
	Expired products not lying around in the pharmacy with other medications. The return form of expired products available and filled out at the end of each month.					
	TOTAL GENERAL				20	

PERCENTAGE RESULT =

(Score obtained*100)/22

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Performance Evaluation Pharmacy of Decentralization Health Centers

STRUCTURE: …….. Date: …./…./…….Evaluator:……..

PHARMACY INDICATOR

PSE Performance Evaluation of Decentralization Health Centers

STRUCTURE: …….. Date: …./…./…….Evaluator:……..

Indicators of PES activities (OPD)

No.	INDICATORS	QUOTATION INDICATION	POINTS OBTAINED	SCORE MAX	EXPLANATION/ COMMENT
1	The therapeutic education sheet is present and inform in >90% in patients referred and received to the PSE last month.	< 69% = 170 – 89 = 2≥ 90%=4		4	Number of new patients referred to PSE with the completed therapeutic education sheet, out of the total number of patients referred for therapeutic education during the month. Evaluation on 10 files
2	At least three awareness sessions in the waiting room were conducted per week.	< 12/ month = 112-16/month = 217-20/month = 4		4	Awareness Register
3	An individual adherence plan is present and duly completed in > 90% of patient records during the period	< 69% = 170 – 89 = 2≥ 90%=4		4	Number of patients referred to EPS with the adherence plan completed, out of the total number of patients referred for adherence during the month.
4	100% search-eligible PPDV are searched by the phone call strategy and/or VAD are reported in the registry	< 69% = 170 – 89 = 2> 100%= 4		4	Number of VDPs searched during the period / number of SLDCs in the period
5	50% of PPDV searches came back	< 30% = 130-		4	Number of income PPDVs / Number of PPDVs sought (tracing register)

		45%=2≥ 50= 4			
6	90% of patient records have a checked/updated address card	< 30% = 130- 45%=2≥ 50= 4		4	. Evaluation on 10 files
	Grand total			24	

PERCENTAGE RESULT =

(Score obtained*100)/24

7. Composition of the Evaluation Team

ACTIVITIES TO BE EVALUATED	NAMES OF EVALUATORS	
	POUR MSF	FOR SC
Consultation (OPD)	1. Medical Referral 2. MSF doctors 3. Decentralization Manager	1. 2.
Supporting Indicators (OPD)	1. Encoder Supervisor 2. Epidemiologist	1. 2.
Protocol Compliance and Tool Maintenance (OPD)	1. Medical Referral 2. MSF doctors 3. Decentralization Manager	1. 2.
Pharmacy	1. Pharmacy Manager 2. Decentralization Manager	1. 2.
Laboratory	1. Laboratory Support 2. CHK Lab Supervisor	1. 2.
Water, Hygiene and Sanitation	1. Logistics Decentralization 2. Car Manager 3. Decentralization Manager	1. 2.

Nursing	1. Director Nursing 2. MSF Nurse	1. 2.
PSE	1. Support PSE Decentralisation 2. Support PSE CHK / Supervisor PSE CHK	1. 2.

ATTENTION: all persons must sign their evaluation grid to agree on the result obtained.

8. Summary of points obtained

Structure evaluated: ..... Evaluation Date: .....

CATEGORY OF INDICATORS	PERCENTAGES OBTAINED
Indicators of Support (OPD)	
Consultation Indicators (OPD)	
Hygiene indicators	
Laboratory Activity Indicators	
Pharmacy Indicators	
Indicators of PES activities (OPD)	
OVERALL AVERAGE	

This average percentage will be applied to calculate the amount of the performance bonus.

This percentage will be applied to the amount agreed in the agreement.

All departments are subject to the overall percentage and not to the individual result.

9. ANNEXE 2: Check-list dossier OPD

Date: ..... **Health Center:** ..... **Supervisor:** .....

	Criteria	Folder 1	Folder 2	Folder 3	Folder 4	Folder 5	Folder 6	Folder 7	Folder 8	File 9	Folder 10	Observations
1	Patient details											
2	Date of visit and Name of responsible consultant readable											
3	Next appointment date											
4	Vital signs plus Weight and height											
5	Current complaints											
6	Physical examination											
7	Current drugs											
8	Differential/probable diagnosis											
9	Treatment Plan/Action											
10	Examinations requested											
11	Test results received, read, signed, dated											

12	Background											
13	Allergies											
14	TB Active Research Fact Sheet											
15	PSE Tracker											
16	Reference HGR/PODI/CR made if necessary											
17	CR/PODI Consent Form											
18	Readable notes											
	Total points obtained											
	Denominator											

Legend: 1 = Data not present or incomplete; 2 = Present and complete data; NE = not assessable (write the reason in the observations)

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

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