EVALUATION OF

HANDOVER OF THE KIAMBU PROJECT, KENYA

Consolidated learning and insights after the second project visit

JANUARY 2025

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

All evaluators contracted by the SEU are subject to the SEU Ethical Guidelines for Evaluations.

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DISCLAIMER

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

Table of Contents

Introduction

This report provides a snapshot of the handover process as of November 2024. It builds on earlier findings (Phase One internal report), which captured the experiences and perspectives of key stakeholders during the final months of MSF's tenure as the transition was being finalized (May and June 2024, with the handover happening in July).

Handover is more than just completing tasks or passing over procedures. It is a process of transition that reshapes relationships, shifts cultures, and ensures continuity. It's about building on achievements while staying true to core principles and vision. A successful handover balances the ability to adapt to new conditions with the capacity to preserve and apply the knowledge and experiences of the past.

The first report was comprehensive and detailed, which posed a challenge for this follow-up. How do you build on something so extensive without repeating or duplicating it? At the same time, it was important to maintain continuity and connect the two phases. To do this, the current report:

- **Reuses the Key Drivers framework:** The first report was developed through a systematization process, where evidence was organized into themes that emerged from stakeholder input. While the content and evidence were initially derived from addressing the evaluation questions, it became clear that the emerging findings could be better framed under the "core drivers of good handovers". These drivers provided a higher-level synthesis of the learning itself. For instance, the evaluation question; "*What could be the best approach to a handover process for such a project?"* could be answered with; "*Consider the Key Drivers, and here is how they played out in this specific handover, with its strengths and weaknesses".* This shift in perspective turned the Key Drivers into actionable insights that could guide future handovers. It's also worth noting that the first report produced additional tools and frameworks for use in the handover process. These are referenced in this report but are not the main focus. Instead, this follow-up report relies on the Key Drivers as the primary framework to streamline and structure the findings.

- **Summarizes Phase One findings and presents the state of the art.** For each Key Driver, this report provides a **concise** summary of findings from Phase One to connect the insights gathered during the final months of MSF's involvement. These summaries are concise and might risk losing some nuance and do not capture the full richness of the first report, which remains an essential reference. The idea is to tease readers into revisiting it, not to replace it. It then **presents new findings** based on observations since the handover, offering a snapshot of the situation 5 months after the handover. Together, these elements ensure that the drivers provide a comprehensive view of the handover as a process—one that evolves over time, with strengths, weaknesses, and opportunities emerging along the way.

Why this structure?

Integrating Phase One findings and revisiting them in this report aligns with the evaluation's vision: Understanding handover as a dynamic process that evolves over time. It also reinforces the coherence of the systematization process. The second report provided an opportunity to verify whether the findings from the second visit could be effectively analyzed through the same framework, further validating the robustness of this approach.

Methodological note from the evaluator and the SEU

When reading this piece:

- **It is important to keep in mind it is based on state of things as of the end of 2024** and hence does not consider any further developments past that date.
- **This report reflects the efforts to explore a different approach (for the SEU) while carrying out this evaluation.** The focus has been on being very participative from early on (i.e. confirming the scope with the evaluator and the stakeholders, in Kenya), adaptive and real-time (evaluator onboard early, with no set plan), and anchored in Kiambu, its context and its people (i.e. visit during scoping, no consultation group as such, relationship building, co-creation of findings and tool). We aimed for the process itself to be a learning moment, and this report should be read with that in mind.

Thanks for your interest in this evaluation process, and thanks to everyone who contributed to it!

EVALUATION PROCESS

Following are the different phases in the evaluation process:

Preparation	The preparation phase involved conversations with key stakeholders, a review of relevant literature, and participation in learning events conducted by MSF Kenya.
First project project trip	The first project trip took place from May 23 to June 5, 2024.
Reporting	The first report was submitted in July 2024. It was followed by a remote presentation of preliminary findings to key MSF staff, both in Kenya and internationally. This presentation was valuable for gauging their interest in the process and for incorporating feedback to generate insights and materials relevant to their needs.
Preparation	The second project trip was informed by findings from the first one, with preparatory meetings held with the Stockholm Evaluation Unit (SEU) and Nairobi-based teams to define the evaluation focus of Phase Two.
Second project trip	The second visit took place from November 10 to 15, 2024, covering all clinics in Kiambu County (Karuri, Thika, Ruiru) and the MSF office in Nairobi. Activities included: • In-depth conversations with key stakeholders (MSF, Ministry of Health staff, government officials, partners, clients). Some of these stakeholders had been engaged during the first trip, allowing for follow-up discussions. • Participant observation during activities and events, including the open day of the Empowerment Center in the Karuri clinic. • Routine debriefs with management. • Setup of a Participatory Assessment Tool in collaboration with HACK. We developed the structure, set up data collection tools, and piloted them, and ran an initial test analysis. HACK continued collecting interviews through November and early December, and the evaluator then processed the results in a comprehensive report.
Reporting	The second project trip resulted in:

	• This report, capturing updated findings. • A Participatory Assessment Tool co-authored with HACK. • A presentation of findings to key stakeholders, which is forthcoming.

All these activities were detailed in a **working blog** (https://kiambuevaluation.wordpress.com/) which was made accessible to evaluation managers to generate transparency in the process and opportunities for real-time feedback.

AI was creatively used – always following guidelines from MSF – in supporting evaluation activities. This included transcriptions, summarisation, tests of generation of preliminary findings, and support for editing write-ups – as well as more creative "experiments".

KEY QUESTIONS REMAPPED

To compare findings across the two project trips more efficiently—and to better articulate the evaluation process—the original evaluation questions have been reorganized and addressed through the "key driver" framework. This framework, developed during the first report, provided a comprehensive and coherent structure for analyzing handovers. It not only captures the specific content of the questions but also reflects the temporal dynamics of the handover process—what happened, what shifted, and what remained stable.

While the questions remain at the core of this work, they are no longer explicitly structured in the report. Instead, they are woven into the analysis of the drivers. This approach preserves the essence of the questions, which continued to guide the work, knowing these are what stakeholders most need to understand. At the same time, it became clear that the questions could be addressed through a more coherent and practical tool. The framework itself became an outcome, offering a way to not only analyze this handover but also to inform questions about methodology and what makes a good handover.

It is not just about "having done this or that" during the process but about whether the key factors that truly matter in a handover were carefully considered. The drivers provide a structured lens to evaluate these factors and, in doing so, offer a replicable tool for future handovers.

Is the handover designed to sustain the project's achievements? ○ What could be the best approach in terms of handover process for such project? ○ Was the methodology used adapted to the concept? ○ What could we define in the initial MoU / Project Specific Agreement for the handover process in terms of engagement with stakeholders? ○ What could partners pick from the starting of the process till the end?	These questions guided the creation of the "handover drivers"—a set of then critical factors identified during the first report. The second project trip confirmed the relevance of these drivers, which are now central to the report's structure. Each driver addresses these questions through specific insights and updates, integrating both the process and the outcomes of the handover. Specifically on stakeholders, the first report explored stakeholder attitudes in detail, dedicating standalone sections to various dynamics. In this report, these insights are consolidated under Key Driver 5 (stakeholder engagement), illustrating how the framework aligns with the original evaluation focus while streamlining the analysis.

Is the handover successful and sustainable? ○ How do the stakeholders view the process (county MOH and other partners)? ○ What could have been done better? ○ Did we achieve our set initial objectives for the handover processes? ○ What impact has the handover process had on the continuity of service three months and six months after MSF's departure?	These questions were central to the second project trip, which focused on understanding "what happened" after the handover - as this trip now took place after the transition. The evaluation assessed progress, continuity, and sustainability. The introductory section provides an overview of the handover status, while the Key Drivers highlight successes, challenges, and lessons for sustaining progress.
What can be learnt for future handovers? ○ Is it replicable as a handover process, and in which context? ○ What could we consider replicating as part of the methodology for other settings?	The approach of organizing the findings around the Key Drivers has already provided valuable lessons for future handovers. It's not about creating a fixed model but about identifying critical factors that truly matter and ensuring they are addressed. The framework highlights systemic learning—what makes a good handover—and offers practical insights that can guide future transitions. These considerations can be adapted to different contexts, ensuring that the essential dynamics are not overlooked and making the handover process replicable in various settings.

THE STATE OF THE ART AS NOVEMBER 2024

The second visit happened in November 2024, in the 5th month past the handover (July 2024). The transition was a big challenge for all those involved, yet the foundations laid by MSF ensured continuity. While challenges remain, there is much to appreciate in how the services have adapted and persisted during these critical first five months.

Core services

One of the most striking outcomes of the handover is that **core services have continued uninterrupted**. The MAT clinics remain operational, supported by the government's commitment to supplying methadone and buprenorphine. The **pharmacy**, stocked by MSF with additional supplies to ease the transition, has ensured that essential medications are still available. As a clinic manager noted: "*The program has been running, as you could say, smoothly, probably much like before. There hasn't been much of a difference […] We're still not short of those commodities donated by MSF. We're still running on that*".

Physical infrastructure

The physical infrastructure provided by MSF, including clinic buildings and equipment, has been instrumental in sustaining operations. The clinics are busy, the pharmacies remain stocked, and the premises visibly maintain their original purpose. However, some spaces, such as the former MSF offices in Karuri, now lie largely unused, occasionally hosting Ministry of Health meetings.

Empowerment Center

The Empowerment Center attached to the clinic, managed by HACK, continues to play a vital role, hosting activities and supporting patients. However, no formal agreement about its long-term ownership has been made, leaving HACK uncertain about its future; "*We rely on the Empowerment Center's setup—things like the pool table, the computers, and internet access. If the county takes back these assets, it'll be tough to keep people engaged. We don't know if we have ownership, so it feels shaky*".

Technical assistance

MSF's presence was also still felt through **post-handover technical assistance, which lasted three months and was highly valued.** Stakeholders described this support as critical for addressing initial challenges, though its discontinuation was a concern. At the same time, MSF was finalizing a comprehensive **capitalization report** to document the program's experience, a lasting resource with potential for reflection and learning.

Collaboration

The handover process showcased **strong collaboration between stakeholders**, particularly the county government, which played a pivotal role in ensuring stability. The appointment of a strong and well-received **MAT coordinator** – with extensive knowledge of the service and strong leadership capacities - added much-needed oversight, contributing to continuity, and improving operational management.

Staffing

Most staff were retained, a key success of the handover, ensuring that technical expertise and relationships with patients were not lost. However, LVCT, which absorbed much of the **community-level staff** previously supported by MSF, was unable to retain all the substance use counsellors**.** This placed additional pressure on the remaining staff and reduced the program's capacity to provide specialized support.

The **sense of pride** among stakeholders was palpable. While the handover was tough, it was viewed as a **valuable learning experience** – also for future handovers – and an opportunity to strengthen local ownership.

MAT service

The MAT service proved to be resilient and maintained its core functions, but **some gaps emerged.** A **Participatory Assessment Tool,** co-generated and run with the clients during the evaluation (see *Key Driver 10* for more) revealed notable **declines in resource-intensive and decentralized services**, such as referrals and home visits. These services, which MSF had heavily subsidized, are now more difficult for patients to access; "*When MSF was here, they'd cover transport costs and some of the treatment fees for referrals to other hospitals. Now, clients have to pay their own way, and many can't afford it, so they miss out on care"*.

They also rely on the support of NASCOP, which is currently refraining from making a formal decision on whether **take-home doses** can continue under LVCT's management. Auxiliary services, such as hygiene supplies and childcare, have also diminished, disproportionately **affecting the most vulnerable**. Patients noted these changes: "*We're seeing a drop in service quality. It's not just the big things, like medicine and counselling—it's also the little stuff. Before, you'd have soap and tissue available; now, you might come in one day and it's not there".*

These changes reflect the realities of transitioning from MSF's comprehensive, high-standard model to a public health system with more limited resources. The good news is that most stakeholders' **fears about catastrophic service disruption did not materialize**. However, anxieties about the transition still impacted attendance, with **some patients relapsing** due to uncertainty, "*Honestly, fear is the main issue. People are scared they'll wake up and methadone won't be there. That uncertainty is pushing some people back into relapse".*

Social Health Insurance Fund

A major challenge during the handover was the concurrent **transition to the Social Health Insurance Fund** (SHIF). MSF's plans to support patient registration in the previous national insurance system were disrupted, leaving many—especially vulnerable groups like inmates—without clear access to care. "*With SHIF, we're required to register the facility for supplies, but the process is so tedious that we're not sure if we'll get them in time".* These broader systemic issues have exacerbated the strain on the program's resources and contributed to uncertainty about its long-term sustainability.

HACK and the Empowerment Center

HACK, the PWUDs community-based organization, proved to be a vital element of the program's legacy and was still supported by MSF (until end of December). The **Empowerment Center** consistently received the highest satisfaction scores in the Participatory Assessment Tool, reflecting its importance to patients. However, its future is uncertain due to a lack of formal agreements and funding for ongoing activities. "*My main worry is what happens if we lose the Empowerment Center. This place is critical for the patients and for us. Even without funding, we might manage some activities, but keeping the center open and maintained will be hard without resources*". HACK's ability to provide community engagement and patient support is clear, but its potential role in **accountability and service assessment** remains underutilized. The organization has shown leadership and innovation, but without formal inclusion in accountability processes, its impact remains limited.

The handover has been a major achievement, ensuring continuity in services despite the challenges of transition. However, the **process is not yet complete**. MSF's phased withdrawal, including the cessation of technical support and financial assistance for HACK by December 2024, leaves significant questions about the next stage. LVCT's expanded role has yet to take full shape, and its ability to fill existing gaps remains uncertain.

The sense from stakeholders is that, for MSF, this is largely a "done" project, and it is unclear **where this experience will lead next**. Will the trust and expertise developed during the program be leveraged in advocacy to address persistent gaps in the national system? Will MSF proactively continue to share learning and expertise from the initiative? Will it remain a point of contact and support for PWUD and the organization it nurtured?

The project visit highlighted resilience and commitment but also areas of fragility. The service remains functional in most areas, supported by dedicated staff and strong county leadership. However, questions persist, as MSF steps back further, about its long-term capacity to maintain its status as a **centre of excellence**[1] rather than merely a MAT service.

Key drivers of good handover

The initial project visit highlighted that while there may not be a single "best approach," we can identify what makes a handover good. Through a systematization process, we uncovered **Key Drivers of successful handovers**. The result is a practical framework that reveals crucial, often overlooked factors rather than imposing existing managerial models, based on the experience of Kiambu, but applicable more broadly. For each driver, we provide a summary of the key findings from the first phase and present findings from the second phase.

[1] The project is referred as a centre of excellence in many documents (i.e. project reports) and by many stakeholders (MSF and non-MSF), see more on this page 11.

Box 1 - Key Drivers of good handovers (as emerged from the Kiambu experience)

Pinpointing what matters

Identifying what makes the MSF-run clinic excellent and what needs to be preserved is crucial for maintaining quality care post-handover.

Reality check

An honest assessment of achievable standards - measured against reality (contextual challenges, different capacities, priorities, perspectives).

Strategic Foresight and Phasing

Looking ahead to future transitions while planning a gradual handover process helps ensure continuity and prepares for long-term sustainability.

Adaptiveness

Building flexibility into the handover process allows for necessary adjustments as circumstances change.

Stakeholder Engagement and Ownership Transition

Transferring ownership and responsibility to local stakeholders is essential for the long-term success of the MAT clinic.

Cultural and Operational Alignment

Addressing the challenges of aligning MSF's culture and management/ operational style with those of the receiving organizations, is crucial for a smooth transition.

Performance Monitoring for Handover

Setting up clear targets and indicators specific to the handover process improves accountability and helps track progress.

Knowledge Management and Learning

Capturing and sharing key learnings from the project safeguards knowledge and can inform future MAT clinic operations and handovers.

Post-Handover Influence and Support Strategies

Defining MSF's ongoing role after the handover ensures continued support and maintenance of standards.

Clarity of Commitments and accountability mechanisms (with PWUDs at the centre)

Establishing clear expectations and agreements helps guide the handover process and sets the foundation for future accountability, and for systems that empower PWUDs to hold service providers accountable.

KEY DRIVER 1: PINPOINTING WHAT MATTERS

Identifying what makes the MSF-run clinic excellent and what needs to be preserved is crucial for maintaining quality care post-handover.

MSF is not just handing over a project—it is transferring an entire approach and model represented by the MAT clinic. This requires a careful examination of what constitutes the essence of the project and what truly matters in the transition. Is it the mere sustainability of a functioning clinic? Is it the working culture it embodies? Or is it the broader ambition of enhancing MAT practices and harm reduction nationwide? These questions are critical for ensuring that what truly matters is neither lost nor overlooked.

SUMMARY OF PHASE ONE EVALUATION FINDINGS

The first evaluation phase insisted on this aspect and explored it at length:

Why understanding what is worth handing over matters: While projects are extensively documented through reports, these often fail capture the project's essence beyond listing activities. A project is a complex, interconnected system, and in its true workings, dynamics, and learnings can be challenging. Project staff and managers engaging daily with a project might take its functioning and added value for granted. However, if not explicitly captured, important dimensions can be lost in the handover.

Capitalization as an opportunity: The capitalization process could be an excellent opportunity to explicitly identify what is worth handing over in a shareable way with other actors. However, MSF's current approach to capitalization (internally focused, end-of-project, report-oriented) means that significant investments in learning are not fully utilized.

Sharing the perspective of future owners: The most effective way to share what is worth handing over is to look into the perspective of future owners. Aligning the project's learning and experience with MAT guidelines would ensure that the handover process not only allows for the continuation of activities in Kiambu but also passes on MSF's full experience to other clinics. When viewed through the lens of MAT guidelines, it becomes apparent that MSF has transformed often aspirational guidelines into shareable, visionary practices. Understanding what constitutes “excellence” within this will be essential to preserve it as much as possible. Yet the narrative is still very project-centric, potentially reducing uptake.

Pinpointing what matters: MSF challenges and achievements

Finding	Summary
Be more explicit about what matters.	The project's core values and elements of excellence were not formally or collectively defined. Focus was placed on practicalities, risking the neglect of key cultural and management aspects.
Leverage the capitalization process.	The capitalization process can help define "what matters," but its current design is limited to internal documentation, reducing its strategic value.
Not everything can be handed over as a project.	Some achievements, like those requiring national policy changes, cannot be handed over. Linking the handover to continued advocacy is crucial to sustaining these gains.

PHASE TWO FINDINGS

The introductory chapter of the Phase One report delved deeply into the challenge of "pinpointing what matters". While the findings are summarized above, they were explored in much greater depth in the original report, with detailed references and actionable points. These findings remain relevant, particularly the suggestions for making capitalization more effective.

Phase two findings:

- **Capitalization: Strong process, but limited impact on handover and transition.** The capitalization process engaged with the challenging task of documenting the structure of a highly complex project and did so effectively, resulting in a strong, detailed report. However, it came too late to meaningfully influence the handover, as it was not yet finalized at the time of the visit. Additionally, its focus was primarily internal, conceived as an MSF asset rather than a resource tailored to the needs of the project or its future stakeholders. [See more about this in the → *Learning section*]

- **Experimentation in capitalization: A path to better learning tools:** The capitalization process demonstrated a welcome openness to experimentation, incorporating ideas from the first evaluation phase, such as the use of AI, complexity mapping, and visualizations. These innovative approaches suggest promising avenues for improving the efficiency and effectiveness of documenting learning – and doing so more deeply. Insights gained from this experimentation could provide valuable support to those engaged in future capitalization efforts, enhancing their ability to translate complex project dynamics and deep insights into knowledge. [See more about this in the → *Learning section*]
  Through long conversations with the thoughtful staff who built the project, it became clear that what truly mattered wasn't just operational routines or resources. It was the harder-to-see elements—the culture of care, the focus on dignity, and the commitment to continuity—that defined the MAT clinic's excellence. Yet, as many of these staff moved on, much of this knowledge moved with them. These were not things easily captured in documents or handover notes; they were ways of thinking and working that now risk being lost.
  If someone visited the project now with no pre-existing knowledge, much of its history and specifics would be invisible. The insights gained through privileged conversations with staff are largely gone, as are many of the people who carried them. For some county staff, the experience still resonates, but their focus has shifted toward integrating the service into the broader health system rather than striving for "excellence per se". Meanwhile, feedback from people who use drugs (PWUD) suggests that the satisfaction on care, especially in less tangible aspects like dignity and holistic support, is already in decline.

- **Services declined, disproportionately, in key areas**: The Participatory Assessment conducted with PWUDs offered invaluable insights into what mattered most about the clinic. Rather than focusing solely on services and deliverables when designing the tool, PWUDs emphasized less tangible but highly significant aspects such as the continuum of care, trust, and dignity. These elements were paramount to them, shaping their experience and the clinic's identity as a center of excellence. However, it is precisely these less operational and more distinctive aspects that have proven most vulnerable over time. Their users' perceived quality seems to be declining disproportionately compared to more routine operational practices. This highlights the challenge of not just sustaining a functional clinic but preserving the deeper values that made it truly impactful.

- **"What was worth handing over" means more than "operations":** The challenge of handing over the MAT clinic was never just about keeping it operational. The real question was how to preserve and pass on the deeper values and insights that made it exceptional, by the organizational culture that allowed built excellence [→ *Key Driver 6*, Cultural] and its untold standards [→ *Key Driver 7*, Performance

assessment]. How do you sustain excellence when the foundations that made it work are no longer present to guide the way? The process of surfacing and preserving these defining qualities was limited by the lesser focus on the “deepest parts of handover”.

What is “excellence” really all about? Is it simply about having resources? Or about a clear vision and ways of working embracing deeper values of client care? The handover iceberg provides a metaphor for what is at stake and can be combined with the Key Drivers framework – also emerged in this evaluation, offering a more operational perspective. Above the surface are operational practices and resources, visible and tangible but not the full story. Beneath lie the less tangible aspects: cultural values, relationships, and tacit knowledge, which are harder to articulate but essential for the clinic’s identity and quality. These hidden elements are often the first to erode and the hardest to pass on. They are critical for guiding stakeholders through transitions while keeping the essence of what made these projects exceptional intact.

KEY DRIVER 2: REALITY CHECK

An honest assessment of achievable standards - measured against reality (contextual challenges, different capacities, priorities, perspectives).

A crucial step in the handover process is an honest, comprehensive assessment of what is achievable and sustainable post-transition. This is particularly vital for projects regarded as a “center of excellence," where standards often surpass current practices. The project document, the learning events presentation, the capitalisation report – as well as stakeholders from MSF, the service and the county - all highlighted this excellence as a valued and distinctive feature. Such high standards are a double-edged sword: while they inspire admiration and support, they also raise legitimate concerns about long-term sustainability, especially in resource-constrained environments.

The reality check serves a dual purpose: it clarifies expectations around these standards and measures aspirations against practical realities. This process is essential for identifying and prioritizing the fundamental elements of excellence that must be preserved, while also confronting the hard question of what may need adaptation. Crucially, this is not a one-time discussion but a conversation that must take place throughout the project.

The tension lies in MSF’s role: to inspire and push the boundaries of what can be achieved, while remaining mindful of the risk of overstretching beyond what is realistically feasible in the given context. Balancing ambition with grounded pragmatism ensures that the program can remain impactful, even as it transitions to new hands.

SUMMARY OF PHASE ONE EVALUATION FINDINGS

Reality check from past handover experience: The former Kibera project provided important warning signs, but learning from it was difficult due to staff turnover and no formal post-handover monitoring. When experiences rely on personal memories rather than institutional knowledge, valuable insights get lost.

The “original sin” of high ambitions: proactive co-planning for sustainability.

Setting up a center of excellence creates inherent sustainability challenges: MSF sets high standards with substantial resources - when the money, cars, management and logistics are no longer there, significant challenges emerge.

What is "Good Enough Excellence"? Balancing ambition with local reality: Some project components (like drug testing and home deliveries) may face continuation challenges. In this complex project, all elements interconnect - even small changes trigger significant consequences throughout the system. MSF faces a critical tension: guiding decisions about what to maintain while advocating for the full package. Local health administrators must balance specialized services against basic care in weak health systems. MSF must provide clear guidance on service adjustments, as cost-focused actors may miss these complexities - even when MSF prefers to discourage changes.

Reality checks on capacity and adaptive strategies: The evaluation showed that MSF sometimes expected achievements from peers that didn't match their actual capabilities. While MSF could flexibly provide resources when needed, more structural support was needed for long-term sustainability.

Risk discussions often become the "elephant in the room": during handover negotiations, risk discussions were avoided to maintain optimism. For excellence models, higher standards increase risks - especially for vulnerable PWUDs who could lose trusted services. While it's awkward to plan for problems when leaving, MSF can still provide consultative support and monitoring systems. This helps protect service quality and MSF's reputation, while supporting partners without requiring direct management.

Checking on political will (and generating buy in): Beyond resources, sustained political commitment proved essential. While the prestige of a "centre of excellence" provided initial momentum, maintaining support for care of stigmatised populations will require ongoing championship.

Reality check: MSF challenges and achievements

Finding	Summary
Awareness of Previous Handovers	Lessons from Kibera project remained tacit rather than explicit. While some lessons were applied (like MoH staffing from start), the full handover experience wasn't openly shared.
Resource disparity	Clear gap existed between MSF and peers in both tangible (finances, logistics) and intangible resources (expertise, management, systems).
Balancing standards	Staff struggled to discuss which standards might not be achievable in resource-constrained settings, given deep commitment to quality.
Capacity reality checks	While MSF provided targeted assistance to LVCT Health, some performance concerns remained an "elephant in the room" and a potential transition risk.
Research opportunity	Failed to turn collected data into evidence demonstrating which elements of excellence mattered most.
Political support handover	Successfully advocated through government transitions, but questions remained about who would champion MAT after MSF's departure.
Context monitoring	Showed good ability to track handover rumors and their community impact.
Technical support	Included a 3-month technical support post-handover for early risk identification.
Optimism vs realism	Hesitated to discuss reduced service scenarios, limiting risk assessment and understanding of impact on PWUDs. A “decision making matrix” confronting desired standards (must have, should have, nice to have) and operational realities (guaranteed support, possible support, unlikely support) was proposed.

PHASE TWO FINDINGS

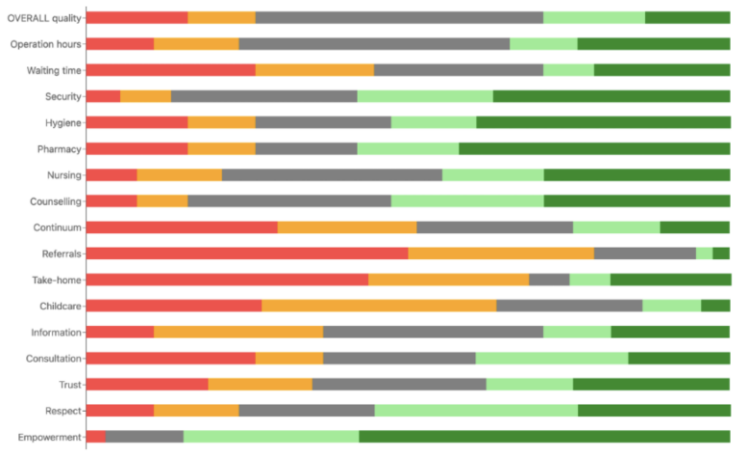
The first visit highlighted the tension between MSF’s high ambitions—excellence in MAT care—and the practical realities of handing over the project to local stakeholders. The second visit sheds light on how these aspirations have unfolded, exposing achievements, gaps, and lessons about **what is sustainable** in resource-limited settings.

Overall, the key elements of the service are there, and good enough.

The key elements of the MAT clinic’s services remain intact, ensuring continuity of services for patients—a significant achievement given the challenges of the handover. Continuity of service was not a given. As a county officer reflected; "*I had **specific targets** I really wanted to meet. One of them was just to ensure **continuity of service**. The quality might not be where it was, but keeping the **service** as we always knew it was essential*”. This consideration is echoed by MSF staff, recalling that; "*The continuum of care is intact, so*

they can continue providing services to patients. Honestly, that's excellent, although it did require tough conversations to keep certain services in place". This steadfast commitment is commendable, especially as staff are now more stretched than ever. The role of clinic coordination, for example, was done by MSF through a dedicated staff. Now the coordinator balances her administrative and management duties with her primary role as a pharmacist – and no salary increase matching the responsibilities. Her motivation stems from the fulfilment of fostering a supportive and effective team environment – a testimony of the dedication of staff in maintaining service delivery.

The permanence of service is also recognised by the Participatory Assessment Tool by Hack, showing that MAT services have largely maintained basic acceptability levels, with more than 70% of clients finding them at least satisfactory across most domains.



The Participatory Assessment Tool selected key services and concerns relevant to assess clients' perception of the MAT service and scored them on a scale from 1 to 5. It also asked participants to rate if services had improved or worsened following the handover, to capture changes in perceived quality. The full report is available as a separate document.

Where was the drop felt?

The good news is that services have largely remained "acceptable," as confirmed by the Participatory Assessment Tool developed and deployed with HACK. However, users have reported a decline, particularly in the most resource-intensive and nuanced aspects of care—areas where MSF previously excelled. Referrals and take-home doses experienced the most significant drop, while operational aspects tended to remain more stable. Vulnerable groups, including women, economically disadvantaged users, and those living further from the clinic, reported disproportionately lower satisfaction and reduced access to critical services like hygiene and referrals.

- **Challenges in Resource-Intensive Services:** The findings from the Participatory Assessment Tool validated concerns expressed by PWUDs, MSF, county officers, and clinic staff regarding the maintaining service standards. While the clinic continues to operate and deliver core services, several critical areas have experienced significant declines due to resource constraints. For example, the provision of take-home doses—one of the program's most innovative components—is at risk of being discontinued due to the lack of in-person verification trips. As one staff member noted; "*The clinic is running, but there are gaps—no hygiene supplies, fewer home visits. It's not quite MSF anymore*". Similarly, also the provision of hygiene products in the center is being discontinued.

- **Reduced Mobility and Outreach:** The withdrawal of vehicles has severely impacted outreach efforts and home visits, which are essential for verifying patient progress and engaging their families—a crucial component of the care model. With these resources withdrawn, "*follow-ups are limited to phone calls, and we can't always verify client statements. Previously, MSF provided vehicles for in-person home visits, which helped validate data and assess patient stability post-treatment. Now, we lack this mobility*". This

creates a significant gap, threatening services. An ambulance transfer, which could alleviate some of these issues, has been delayed due to bureaucratic hurdles, exacerbating the strain on mobility and patient care.

- **Impact on Counselling and Social Support:** Counselling services, a cornerstone of patient support, have also been compromised. Previously, counsellors were paired with social workers to provide individualized care. However, the reassignment of two social workers to other facilities has reduced this support, leaving no clear replacements. This has disrupted the continuity of care, with clients expressing frustration over the difficulty in building strong, consistent relationships. As one MSF staff member observed; "*Services are continuing, though not quite at MSF standards. There's a willingness to keep going, even if it's different from MSF's desired quality*".

- **Jeopardized Transition Plans:** Reduced support for PWUDs, particularly in referrals and treatment, remains a critical issue. MSF's efforts to facilitate client access to health insurance were undermined by systemic changes that disrupted the planned transition. This not only affected clients' ability to secure necessary treatments but also highlighted the fragility of continuity planning. This aspect will be examined in greater depth later in this chapter.

Where will be the drop felt?

The transition period and temporary measures have smoothed, and perhaps delayed, some of the challenges associated with the handover. MSF's technical support (to be discussed under *Key Driver 9*: Post-Handover Engagement) has been instrumental in mitigating management difficulties, ensuring a management role was established and widely recognized—a significant accomplishment given the complexities of the transition.

However, lingering staff dissatisfaction, particularly regarding pay, poses a serious risk (→ *Key Driver 6*). This dissatisfaction culminated in a strike during the transition, an unprecedented event for the MAT clinic. "*Another surprising development: when there's typically a strike, MAT clinic staff usually don't join in. But this time, the clinic was closed for two weeks, except for the pharmacy. That didn't happen under MSF, and it's impacted the sense of continuity*".

The following are components at risk to be compromised, or issues that might impact on quality of the programme. Unfortunately, some were also among the innovative and defining characteristics of the approach.

- **Medication Supply Challenges:** To address resource constraints, MSF provided a stopgap measure by supplying medications, which has temporarily offset the county's resource strain. Efforts are ongoing to integrate these drugs into the county's procurement system, but there is concern that stocks will soon reduce to only essential medications, with more expensive options potentially shifted to patients. Additionally, county procurement processes have not yet been tested, raising concerns about potential gaps. The fragmented supply chain further complicates matters, with supplies like vaccines sourced from separate county systems (e.g., Nairobi vs. Kiambu), creating logistical and coordination difficulties.

- **Decentralization Under Threat**: Decentralized approaches, particularly the flexibility offered through home doses, are at risk of being discontinued. With NASCOP yet to provide formal approval, the continuation of this patient-centered innovation remains uncertain. LVCT and county stakeholders are preparing for a possible halt to home doses but lack clear directives, complicating efforts to maintain patient adherence and engagement.

- **Prioritization of Services:** As resources dwindle or challenges arise, it will become increasingly difficult to prioritize what must be retained. While the Phase One of the evaluation suggested developing a transparent system to categorize services into "must-have," "should-have," and "nice-to-have," such a system has not been implemented. This absence leaves decisions to a reactive "cross your fingers and see what lasts" approach, lacking strategic foresight.

- **Capacity of the Incoming Partner:** LVCT, the incoming partner, has taken on additional challenges in transitioning to overall management. At the time of the visit, LVCT had not yet assumed full control, as its financial year did not align with the July handover. This created a gap in leadership and planning. Compounding this, the sudden death of a key staff member closely connected to the project may further impact continuity and the transition's pace. Outreach gaps already noted during the project have persisted, with MSF staff observing; "*LVCT's lack of outreach means heavily dependent users and those experimenting with drugs remain underserved, particularly those in dens who do not actively seek care".*

- **Uncertainty Around the Empowerment Center:** The Empowerment Center, a day-center linked to the Karuri clinic, faces an uncertain future. Run under the supervision of Hack, it provides PWUDs with a safe space and social activities, a setup beneficial for both users and the local community, which initially opposed the MAT clinic. Currently operated by volunteers receiving minimal transport benefits from MSF, the center is deeply valued. "*The Empowerment Center is still functioning well—they're deeply committed and passionate. For them, that $30 mainly covers transport and is a way to keep themselves focused on work rather than looking for ways to make ends meet on the streets*," the county staff noted – referring to their estimated operational costs. However, MSF support to Hack is set to end in December, and there were no concrete plans for sustaining the center's operations at the time of the visit. "*We depend on the transport reimbursements to come in and run activities […]. If that funding stops, things like travelling to other clinics or organizing cleanups become really difficult - and for bigger events, like the tournaments and cleanups, transport reimbursements make a huge difference".* Activities are likely to continue, but it will be hard to continue keeping the empowerment centre open as it is now.

- **Monitoring Moving Forward:** Sustained monitoring of services remains crucial. The evaluation was an opportunity to co-design and pilot with Hack a Participatory Assessment Tool to track clients' perceptions of the service. Its future relevance will depend heavily on the organization's future stability and the establishment of robust accountability platforms involving other stakeholders. Participatory monitoring tools offer a valuable foundation for maintaining standards, but their utility will require ongoing institutional support and follow-through.

Relapse and retention challenges

Retention has emerged as a significant challenge following MSF's exit. While comprehensive data on relapse and retention could not be accessed by the evaluator, insights from various informants confirm that some patients left the system upon hearing of MSF's departure. LVCT reported that, as of August, approximately 50 patients were lost to follow-up[2], a smaller drop than initially feared but still considerable. In MSF's final weeks, community rumours about potential clinic closures or service interruptions contributed to the decline. A lack of trust in the clinic's sustainability under government management also led some clients to accelerate their treatment in less-than-optimal ways.

[2] Note: as per the capitalization draft report, by end of June 2024, 1619 PWUD had been enrolled across the three MAT clinics Of these, 63% were active in care. MSF in Kiambu defined lost to follow up **"**patients who missed opioid substitution therapy (OST) doses for more than 30 consecutive days".

As noted in the first report, MSF acted promptly to counter these rumours, launching outreach initiatives to reassure patients that core services—such as methadone availability and psychological support—would remain intact. This message was echoed by county officers following the handover. However, reconnecting with patients remains an ongoing challenge. LVCT has not yet fully integrated into the program, and the existing difficulties in community outreach have persisted without MSF's support. And as a county staff mentioned "*MSF's robust follow-ups and contact tracing have been hard to replicate, resulting in patient dropouts".* This was further compounded by the limited engagement of community health workers during the programme by MSF. They received some training towards the end of the project, but a stronger connection with the MAT clinic could have been useful, in providing them with stronger stills and exposure to the service.

While precise figures were unavailable, it was reported that overall numbers have declined further due to fewer new patients joining the program and the potential disruption of key components like take-home doses. The Ministry of Health, through NASCOP, has raised concerns about the sustainability of take-home dosing, with county officers expressing fears that this could significantly impact retention. Reduced mobility for home visits and inconsistent follow-ups exacerbate these issues, limiting engagement with patients at higher risk of relapse.

As retention declines, the importance of proactive measures to sustain patient trust and engagement becomes evident. Enhanced communication, targeted outreach, and addressing logistical barriers will be essential to reversing this trend. However, these efforts are undeniably more challenging for institutions with fewer resources than MSF.

And, as retention is increasingly a challenge, so is enrolment, Beside the aforementioned challenges by LVCT in reaching out PWUDs, Hack members pointed out; "*It's rough for new clients. Some don't even come in because they've heard that things are different now. They're the ones who really need support, and they're not getting it the way they would have before".*

Expectations

Under MSF's leadership, client experiences were characterized by smooth operations and comprehensive care. The continuum of care was a cornerstone of the approach, ensuring patients had seamless access to integrated services that met all their treatment needs under one roof. However, this continuum relied not only on service integration but also on MSF's ability to remove financial barriers. The transition disrupted this foundation, fragmenting services and creating challenges for patients—particularly the most vulnerable—to navigate a system that no longer guarantees the same accessibility or cohesion. As Hack members noted; "*The transition has been a lot. Without MSF, it's been challenging, but we're making progress in connecting with patients and the community. But, for example, meds are now harder to get. We're sent to the pharmacy, and it's just not as smooth as before, where you'd get everything right there".*

- **The Ethics of Patient Engagement vs. Risk of Abandonment**: This shift has been particularly difficult for patients with limited means, who feel the absence of previously free medical supplies as a significant "let-down". It raises the question: could MSF have ensured a "soft landing" for patients and community partners post-exit? The intensity of MSF's engagement built deep trust, but the abrupt transition has left many patients grappling with unmet expectations and gaps in care.

- **The Double-Edged Sword of Free Services:** While free services under MSF ensured accessibility, they also created expectations that have proven difficult to sustain post-handover. Patients, accustomed to receiving free care, now face a system where payment is required for most health services. As a county

officer observed; *"If patients contributed something small, they'd feel more responsibility for their health, and it might help sustain services. But now, they're not used to paying, and it's tough to find a sustainable balance".* Preparing patients for this change earlier—through gradual phasing out of free services and engagement with families—could have mitigated some of the challenges – a strategy now attempted by the county. However, this opportunity was not fully utilized, leaving a stark contrast between MSF's accessible care model and the current system's expectations.

- **Focus on the vulnerable vs universal care:** PWUDs emphasized the importance of prioritizing the most vulnerable clients rather than providing universal free care. As one noted; "*Maybe instead of setting up full services for everyone, the focus could have been on the most vulnerable cases. If we could've targeted services, maybe clients would've been better prepared".* Another added; "*MSF created a system that was reliable, so people got comfortable. But now, they're facing the reality, and it's hard. If MSF had focused more on the people who really couldn't afford the meds on their own, maybe we'd have been better prepared for this transition".* This perspective highlights how universal free services sometimes led to unintended behaviours, such as patients bringing family and friends or parents refusing to pay for their children's treatments. A more targeted approach could have better prepared both patients and the system for the transition. As one stakeholder reflected; "*It's like babying people. We need to learn to take responsibility for ourselves. If we'd known from the start that not everything would be covered forever, it would've been easier".*

MSF's approach set a high benchmark for care, fostering trust and creating a system where patients felt secure. However, in a resource-poor environment, the universal free care model proved challenging to sustain. While universal care is an admirable aspiration, in a resource-strained system, the ability to target support for the most vulnerable is crucial. MSF could have used its influence to emphasize this balance, advocating for both universal care as a long-term goal and immediate strategies to protect the most vulnerable. Without such a plan, the transition risks dismissing universal care without ensuring adequate support for those who need it most.

The dilemma of high standards

The dilemma of balancing MSF's high standards with future sustainability has been central to discussions and was extensively explored in the first report. MSF's approach set a high benchmark for care, aiming to fill gaps and deliver the level of service beneficiaries deserve. However, as anticipated, maintaining these standards in a resource-limited environment has proven challenging post-handover; *"Without proper resources, even small problems—like printing paper—become big obstacles".*

Local stakeholders captured this tension; *"It's a dilemma, really. High standards are great in principle, but given our environment—a low-middle-income country—we sometimes have to ask what's feasible".* Similarly, others noted; *"The high standards MSF set were hard to sustain without their resources".* Even MSF staff acknowledged the challenge; "*On the one hand, it fills the gap that brought MSF into the project. We aim to lift care to a level that beneficiaries deserve. On the other hand, when MSF transitions out, there's an inevitable drop in standards because the county cannot maintain the same level of resources or quality. This drop often results in dissatisfaction".*

Dissatisfaction was indeed felt, particularly by the most vulnerable users, and had repercussions on care. This underscores the importance of embedding sustainability into project planning from the start and accepting the limitations of the local system. Earlier integration with the county's supply chain could have helped avoid the current gaps in basic patient expectations, such as medicine availability and service accessibility.

Operating within these resource constraints requires adjusting ambitions to align with care levels that can realistically be sustained. "*While MSF's standards provide a benchmark, they often exceed the public system's capacity*", a county officer suggested, hinting that the answer is to be found in continuous adaptation and dialogue, where MSF can indeed have a role in pushing the boundaries and vision, but also be aware of not overstretching.

Integrating locally available resources into project design and aligning standards with the system's capacity could bridge the gap between high aspirations and practical feasibility. A structured transition, including formal agreements with the county, would have supported continuity and mitigated gaps in care. As a county officer observed; "*MSF set a high-quality model that's hard to sustain. I think it's a lesson for future projects to consider sustainability from the beginning*".

Concluding thoughts

The MAT clinic's transition reveals a tension; the desire for excellence versus the realities of maintaining high standards in limited-resource environments. MSF established a high benchmark, building trust and providing comprehensive care, but sustaining these standards after the handover has been difficult. This emphasizes the need for a practical balance between aspirations and realities feasibility.

A "reality check" is crucial, not to lessen ambition but to ensure it aligns with actual capacities. Involving local stakeholders early via co-management, phased transitions, and candid assessments of MSF standards against local conditions may help reconcile high expectations with achievable outcomes. The challenge lies not only in maintaining high standards but also in acknowledging the importance of focused care for those who are most vulnerable.

While universal care is a commendable goal, without adequate resources to support it, MSF could have increased efforts to promote a balanced strategy—prioritizing vulnerable groups while simultaneously laying the groundwork for wider access. Failing to do so risks the total rejection of universal care, which could result in overlooked needs for those who are most at risk. Future projects can learn from this experience; excellence must be defined not only by high standards but also by their adaptability to local contexts. Sustainable transitions require embedding realistic planning from the start, maintaining ambition without overstretching, and involving local partners in co-creating models that blend aspiration with operational feasibility.

KEY DRIVER 3: STRATEGIC FORESIGHT AND PHASING

Looking ahead to future transitions while planning a gradual handover process helps ensure continuity and prepares for long-term sustainability.

A phased handover **ensures continuity** and **mitigates the risk of an abrupt transition**. Adopting a **long-term view** and **anticipating future challenges** can significantly **improve sustainability**. All this relies on a **strong strategic vision** and a balanced **management approach that combines control** (maintaining standards and achieving goals) **and letting go** (allowing other actors to take on responsibilities, fostering ownership and capability). Achieving this balance **depends on the buy-in of the handover recipients.**

SUMMARY OF PHASE ONE EVALUATION FINDINGS

Start a project with the end in mind

Handover planning should begin from day one, integrated with implementation from the MoU stage.

A modular design, within an integrated project

While phased handovers work better with modular components, integrated projects present unique challenges. The key is finding standalone elements while maintaining essential connections, particularly when transitioning management structures.

Think long-term

Future scenarios must shape current decisions - like LVCT Health's expected transfer to government and declining donor support. This affects how responsibilities and capacities are built during handover.

Gradual, steady involvement of future owners

Success requires incremental transfer of responsibilities, specific task assignments, mutual accountability, and adaptation capacity during transition.

Deadlines: balancing strictness with flexibility

Multiple "mini-deadlines" work better than single endpoints, creating urgency while avoiding rushed handovers. However, gradual transitions risk creating dependency.

From MoU to Handover - track the process

Beyond the MoU, live documents should track progress and changing circumstances, ensuring continuous alignment and accountability.

Handover should not add more workload but aim to reduce it

Staff face dual burdens of program management and handover activities - gradual transition should reduce, not increase, workload.

Strategic foresight and phasing: MSF challenges and achievements

Finding	Summary
Abrupt transition	Kiambu faced a short timeframe while still gaining momentum.
Early planning	Mid-term roundtable started the handover planning, but ideally needed a handover framework from project inception.

Stakeholder buy-in	Securing participation was difficult - partners clarified intentions late, county representatives postponed meetings, and MSF lacked leverage.
Expectation management	Previous long handovers (Kibera) created assumptions of extended transition, potentially delaying partner commitment.
Project interconnection	Integrated nature made traditional phasing difficult, though opportunities existed (like procurement handover).
Handover chain	Late discovery of LVCT Health's planned transfer to the government complicated long-term planning.
CBO Support Phaseout	Insufficient clarity on PWUD CBO's goals and future role after the support ends.

PHASE TWO FINDINGS

Although the second evaluation visit was intended to assess the post-handover phase, it became evident that several components were still in transition. Technical support had recently ceased, the pharmacy was still relying on the transitional stock provided by MSF, and HACK continued to receive some support (planned end: December). It is only in the coming months that the impact of MSF's departure will be fully realized.

A gap in management: challenges in the handover process

The handover process faced notable challenges due to a gap in management, as the new partner, LVCT Health, was not set to fully assume its new role until autumn. While LVCT had already been part of the project in a different capacity, focusing on community outreach, this delayed transition created a disconnect. Negotiations during the handover primarily occurred between MSF and the county government rather than directly with LVCT as the incoming lead partner. This had both advantages and limitations. On the positive side, the focus on the county aligns with the long-term vision for MAT services, as they will ultimately belong to and be managed by the local health system. Building the county's ownership and responsibility for the program was an essential step in ensuring sustainability. However, the lack of structured engagement with LVCT in its future management role meant that key elements of the transition, such as outreach efforts and operational continuity, were not sufficiently addressed in advance. Adding to the complexity was the absence of formal guidelines or agreements that clearly delineated responsibilities for both the county and LVCT during and after the transition. This lack of a comprehensive transition plan created risks for continuity, especially for innovative or resource-intensive services

Transition was too short. The right time to start? Before the programme.

Everyone felt that the transition period was far too short and rushed. Most of the handover planning happened in the last six months—despite MSF's efforts to start earlier, beginning with the mid-term revision of the project. On one side, participants were relieved to have managed the handover within the deadline. But on the other, there was a consensus that the timing was – as county officers mentioned - "*insufficient for comprehensive planning and adjustments, impacting sustainability efforts*".

The main lesson is that the right time to prepare for a transition is not during the project's final stages but from the outset. And yet, even with foresight, time may still feel insufficient—especially for a program as complex as this one, which aimed to demonstrate a model of care and excellence for government adoption. No length of transition will ever truly feel "enough" unless programs are designed with sustainability embedded from the start. The point is not just about extending timelines but about fundamentally rethinking

how programs are conceptualized. As a county officer insightfully noted; "*The discussion on sustainability should begin from the get-go. As early as a program is starting, you should already be planning for the exit of whoever is supporting, so that there's that sustainability*".

As discussed under → *Key Driver 2*, a reality check is essential to ensure that whatever is put in place aligns with the capacities and priorities of local stakeholders. Starting with co-creation, rather than making adjustments later, would have better ensured that the program could integrate seamlessly into the local health system. Another county officer highlighted; "*MSF largely set up the program independently. Future programs should be co-created with county governments to better align with local systems".*

While the independence with which MSF established this program achieved high standards of care, it also created operational challenges to be solved during the handover. However, where strong agreements were established early—such as retaining staff—they ultimately held firm and strengthened sustainability. MSF was certainly aware of the need for a well-phased and prepared handover, and staff in Kenya had learned lessons by witnessing handovers for Kibera and Embu. Compared with them, Kiambu demonstrated improvement due to **early planning**. "*For instance, the MOU outlined responsibilities at the project's inception, making the transition smoother. The document specified MSF's responsibilities, the county's obligations, and what would happen at the end of the project. This provided a* ***roadmap*** *that was invaluable during negotiations. Referring back to the MOU helped keep both parties accountable*". The takeaway is clear: no transition period can compensate for a lack of early planning and alignment. Effective handover starts with sustainability as a core element of program design.

Making the Transition Real: Overcoming Denial

Despite MSF's commitment to ensuring a smooth handover, a pervasive sense of denial among key stakeholders delayed critical preparations. This denial stemmed from lingering hopes that MSF might extend its stay, which undermined the urgency to prepare fully and wasted valuable time that could have been used for a more incremental transition.

Accepting the reality of transition was hard. One of the pivotal moments came when MSF leadership made it clear that the transition was non-negotiable. As one staff member recalled; "*I remember… [a MSF manager] was categorical, saying, 'No, we have to close out.' That's when it hit me—this is real*". This definitive stance served as a wake-up call, pushing the team to shift their mindset and begin preparing both mentally and operationally.

For many, this realization came late in the process, limiting the effectiveness of planning efforts. "*We didn't fully take it seriously—probably because we'd never done it before,*" noted another participant. The perception of having "extra time" from previous experiences in other projects contributed to complacency, with some admitting they only grasped the complexity of taking over once MSF stepped back. "*MSF made it look easy, but actually taking over showed us the real complexity".*

The experience underscores the importance of creating a sense of urgency and clarity from the outset. Transition plans should include regular updates, clear milestones, and efforts to make all stakeholders feel actively involved. As one participant reflected; "If we'd started earlier with the mindset that this was a real transition, we'd have been better prepared". Early, collective ownership is key to making transitions both effective and sustainable.

Delays Amplified by Administrative Complexity

The transition process was significantly slowed by the inherent complexity of mobilizing a broad spectrum of stakeholders within the county administration. MSF's efforts to initiate handover discussions had to navigate

through the partnership coordinator, who acted as a bridge to the broader system. However, this layered structure—and the inertia it often produced—added delays. Even when the coordinator acted swiftly, the process of identifying the right individuals to involve and bringing them to the table was neither straightforward nor quick.

Reflecting on the challenges, a MSF staff shared; "*Personally, I was involved in the transition actively for one year, and that helped me get a full picture. But if the whole team, including county leadership, had been engaged, it would have felt more like a collective effort*". This insight underscores not just the logistical challenges but also the sense of isolation felt by those tasked with driving the transition forward. The experience highlights the need for realistic expectations about the pace of engagement in complex administrative systems. This is not about an idealized simultaneous engagement but rather a pragmatic recognition of the time required to align diverse actors and interests within a large system. Engaging leadership early, while recognizing the iterative nature of administrative processes, could help reduce delays. A phased approach also provides opportunities to address resistance and ensure that no single bottleneck hinders overall progress. While ideal solutions are elusive in such contexts, starting earlier and with clearer strategies for stakeholder mapping and engagement would likely have eased the burden of last-minute mobilization.

Importance of Supporting the Transition

Post-handover support is a critical stage in the transition process, distinct from the immediate handover, as it involves addressing remaining gaps and securing the sustainability of key components. This phase will be explored in more detail under Key Driver 7, emphasizing MSF's potential role in ensuring continuity for targeted components, advocacy efforts, and broader system improvements even after the organization formally exits.

In this case, MSF effectively managed the immediate post-handover transition, particularly given the delays in LVCT Health's readiness to fully assume operations. The gap between July and October, when LVCT Health could formally take over, was bridged by MSF through the provision of essential commodities, equipment, and licensures. This ensured the MAT clinic remained open daily without interruptions, safeguarding patient care during a critical period.

The transition period also provided an opportunity to address loose ends that ideally should have been resolved earlier. For instance, LVCT Health took charge of human resource management with Kiambu County's support, while MSF supplied vital equipment and drug stocks. This phased approach to transferring responsibilities helped LVCT build the HR infrastructure necessary to sustain operations long-term.

Who to involve?

The handover succeeded in aligning key stakeholders like LVCT Health, MSF, CDC, and Kiambu County through early coordination, with meetings starting in December. This groundwork was crucial for ensuring shared understanding and preparation. However, while county staff were heavily involved, some stakeholders, including patients and community officers, were sidelined, limiting the inclusivity of the process. A major lesson was the importance of engaging the community and patients early. When services shifted from free to paid, insufficient preparation led to shock and disruptions in care. Proactive communication and managing expectations could have eased this transition, as one team member noted:

"*For patients used to receiving everything for free, this change is difficult*". Early engagement builds trust and ensures smoother adaptation to changes, especially for key populations. MSF staff reflected that "O*ne lesson we've learned is the need for early community engagement and handover planning. Starting these processes*

sooner would make these transitions smoother. For projects dealing with key populations, exit strategies should be part of the original planning". A more inclusive approach is essential and need to be planned throughout the handover process. Early involvement of all stakeholders—including patients and community representatives—ensures transitions are not only technically sound but also build trust, reduce disruptions, and better address the needs of vulnerable populations.

Optimizing resource utilization through phased handover

Effective resource management is crucial during the transition of healthcare projects. A phased handover approach can help balance resource allocation and prevent underutilization or neglect of assets.

In the Kiambu case, certain resources, such as transportation vehicles, were abruptly withdrawn, leading to operational challenges. Conversely, facilities like the clinic's adjacent offices, constructed by MSF, remain largely unused. These spaces, now quiet except for occasional use of a warehouse, kitchen, and boardroom, could have been repurposed for integrated programming or other beneficial activities. However, restricted access—only through the MAT clinic—poses logistical issues, as clinic administrators have offices elsewhere within the hospital, making these isolated spaces less practical for alternative uses. A phased handover strategy might have allowed for gradual resource reallocation, providing time to address such logistical challenges and repurpose facilities effectively. This approach ensures that all assets are optimally utilized, supporting the sustainability of healthcare services post-transition.

Stepwise transitions: learning through implementation

A more staged transition could have significantly eased the challenges of handing over such a complex program. Several areas stand out as opportunities where a phased approach would have been particularly effective. While some of these were highlighted in the first phase of the evaluation, others emerged during the transition itself:

- **Procurement systems:** To prevent interruptions during the transition, MSF provided extra stock of medicines and essential supplies—a commendable effort to ensure continuity of care. However, the long-term sustainability of procurement remains uncertain, as the county's systems have yet to fully take over these responsibilities. A phased transition of procurement, initiated earlier, could have allowed the county to gradually build capacity, test processes, and address gaps before the handover. This would minimize risks and better prepare the county to manage stock independently.

- **Staff Management and Joint Planning: "***Starting small and transferring a few staff to the county payroll each year would make the transition easier"*, said a county officer. Developing joint work plans and involving the county in co-managed hiring processes from the outset could have ensured a smoother handover. As observed; "*Creating joint work plans and hiring together with the county ensures seamless transitions later. By developing co-created work plans, the county can step in without disruptions, because the transition would be more like a natural handover*". While MSF attempted to engage in co-management, limited responsiveness from some stakeholders slowed progress. Earlier and more structured collaboration could have fostered greater ownership among local actors and reduced reliance on MSF leadership during the critical transition phase.

- **Realignment of services and public expectations:** Recognizing early that post-handover services could not maintain MSF's high standards might have allowed for a more gradual realignment of expectations. For instance, MSF could have focused on serving the most vulnerable populations or scaling back additional services while still overseeing operations. Counties often struggle to sustain the "extras" provided by MSF—such as free medicines, transportation, hygiene kits, and additional diagnostic tests. The sudden absence of these enhancements has, in some cases, led to public frustration and diminished

trust in county services. As one MSF staff noted; "*A more gradual transition in standards might mitigate this shock*". Such an approach could have prevented the government from bearing the brunt of public dissatisfaction. MSF's phased involvement in scaling back services would have allowed for clearer communication, shared accountability, and reduced the perception of an abrupt decline in care quality.

- **Financial management:** A gradual transition of services and staff could have clarified the linked budgetary demands early on, making it easier for the county to plan and allocate resources effectively. As one stakeholder noted; "*The same goes for budget planning—if we know the resources required early, we can better advocate for consistent funding".*

The importance of calendar alignment in transition planning

A key challenge in the handover process was the misalignment of operational calendars between MSF and its partners, particularly LVCT Health. MSF planned the transition according to its project timeline, but LVCT Health's fiscal year meant their new budget would only activate in October. This gap left LVCT operating with limited resources during critical transition months, putting strain on logistics and human resources when stability was crucial.

County health officers echoed this issue, emphasizing the broader importance of aligning calendars in transition planning. They noted that budgetary alignment across fiscal years could ensure smoother implementation, allowing transitions to be integrated into existing financial frameworks. This proactive approach would provide the stability needed to support long-term services and prevent gaps during handovers. By recognizing the impact of differing organizational calendars, future transitions could avoid such disruptions and improve outcomes for all stakeholders involved.

HACK: falling through the cracks of transition

The Empowerment Center, managed by HACK, stands as a critical yet precariously supported element of the MAT project. HACK, an organization comprised of PWUDs, plays a pivotal role in providing a safe space and essential services to a highly vulnerable population. Despite widespread acknowledgment of its value, the support for HACK appears to have fallen into the cracks of transition planning.

LVCT, while expressing intent to support HACK, has yet to take concrete steps. As of November, no formal agreements or funding strategies were in place to ensure the continuation of the Empowerment Center, even with MSF's funding set to end in December. LVCT is awaiting a concept note from HACK to explore potential avenues for collaboration, but no tangible commitments have been made, leaving the future of this crucial service uncertain.

MSF, too, might have had options to provide light accompaniment or transitional support, but discussions around this remained absent as the handover deadline loomed. Staff close to the organization gauged that support should have continued for at least one year. HACK now faces not only the daunting task of securing its own funding—hampered by basic gaps such as not yet having a dedicated bank account—but also the responsibility of sustaining the Empowerment Center. This center, which provides vital services to a population already grappling with drops in care and continuity, remains without a strategy for long-term sustainability.

The Empowerment Center was a commendable and innovative initiative by MSF, but it was never deeply integrated into the core of the MAT program or the handover process. Crucially, no commitments were secured from other stakeholders to sustain it post-MSF. This oversight jeopardizes the significant investment made in HACK and, more critically, risks further marginalizing a vulnerable group that the MAT program was designed to support.

Without a strategy to ensure HACK's survival and the continuation of its services, the initiative risks being reduced to a missed opportunity. The situation underscores the need for more robust transition planning, with clear roles, commitments, and support mechanisms for all key components of a program—especially those addressing the vulnerabilities the program seeks to alleviate.

KEY DRIVER 4: ADAPTIVENESS

Building flexibility into the handover process allows for necessary adjustments as circumstances change.

The topic of adaptiveness could have been addressed in the previous discussions about phased handovers, but it is crucial to highlight it further here, as a standalone driver of good handovers.

SUMMARIZED FINDINGS FROM PHASE ONE OF THE EVALUATION

Adaptive management vs. phased handover planning

MSF demonstrated adaptability in their project operations by adjusting staffing models and developing innovations at the clinic over time. While MSF was flexible, partner organizations often have more rigid organizational cultures that resist change. The challenge is to design handover processes that allow for exploration and changing goals while maintaining the structure.

Identification of ready-to-handover elements

Project managers need to continuously assess which components (like standalone systems or individual clinics) are ready for transition, based on their self-sufficiency and local readiness. The ideal timing is when these elements are stable enough to operate independently but can still adapt under new management.

Adaptive co-management

The handover process could have gradually shifted responsibilities from MSF to partners through "adaptive co-management". This approach would have included early shared ownership, with partners taking increased leadership under MSF guidance, clearly defined roles that are regularly reviewed, improved understanding of role responsibilities, and strengthened accountability for roles and responsibilities through a clear governance structure.

Capacity to consider plan B's - and dynamic options for support

MSF lacked adequate planning for scenarios where initial handover plans don't succeed. The organization needs better monitoring tools and hasn't fully explored the space between actively running programs and completely exiting them, which is crucial for sustaining their care models.

Responsiveness and adaptation to post-handover challenges: what role for technical support?

MSF provided three months of technical support after the handover to monitor quality, and to advise the new management. This creates a dilemma: while open communication helps identify and address problems, it may lead partners to seek continued MSF involvement, potentially undermining the goal of complete ownership transfer.

Adaptiveness: MSF challenges and achievements

Finding	Summary
Inflexible handover deadline	The non-negotiable deadline successfully brought stakeholders to discussions but resulted in unresolved issues

Absence of contingency planning	MSF needs to develop clear approaches for situations where sustainability is at risk after handover

PHASE TWO FINDINGS

This chapter examines the importance of embedding adaptiveness into the handover process. The first evaluation visit, conducted during the final stages of handover discussions, captured many of the ongoing adaptations and highlighted ways the handover could have been more flexible. For instance, a phased strategy involving co-management could have allowed more overlapping responsibilities, fostering continuity while co-generating insights for service adaptation This chapter now explores three different areas of adaptiveness:

- **Aspects already requiring adaptation:** The program's current operations highlight areas where services are already needing adjustments to maintain their relevance and effectiveness. This reinforces the earlier recommendation for phased co-management, which would have allowed for greater continuity and smoother transitions.

- **Last-minute challenges that precluded adaptation:** Some challenges, such as late-emerging shifts in policies or external conditions, surfaced too late in the handover process for the program to respond effectively. This reminds that sometimes it might simply not possible to anticipate potential disruptions.

- **Programmatic adaptations beyond the handover:** Certain emerging issues, such as changing patterns in drug use, would have called not simply to diverse handover strategies, but to broader shifts in the program's design to strengthen potential for long-term sustainability.

The handover benefitted from an overall stable context

The handover occurred under relatively favourable conditions, marked by the **stability and commitment of the government institutions** assuming responsibility. While not without challenges, this stability provided a strong foundation for transition. As noted in the previous evaluation, stability was somewhat relative—there were changes in management across institutions from the time the Memorandum of Understanding (MoU) was signed, **requiring MSF to re-establish relationships with county leadership throughout the program**. Nonetheless, the **final phase of the handover benefitted from a close and steady partnership with the county**, characterized by strong relationships and commitment from **key personnel**, which significantly eased the process.

No **imminent leadership changes are anticipated**, particularly at the county level, providing the MAT clinic with a window of stability to consolidate operations without the disruption of political turnover. This stability is crucial, especially when agreements leave room for interpretation and accountability remains dispersed among multiple stakeholders (a point discussed further in section 10). The **personal buy-in of individuals involved** often proves as important as the agreements themselves. Each person brings its own style, priorities, and approach, which can influence the program's trajectory. As one interviewee noted; "*Yes, everything depends on the incoming leadership. New bosses come every two to three years, and each one has a different budget outlook*. *For instance, the new boss here has indicated the prison budget is stretched, so he's reached out to headquarters to see if they can allocate additional funds*". While upcoming political elections are still a few years away, potentially allowing the MAT clinic time to stabilize, these periodic changes remain an inherent risk.

Despite the relative stability at the county level, some challenges emerged, particularly with NASCOP. **Leadership turnover at NASCOP** (two heads within a single year) disrupted efforts to define roles and responsibilities, creating **gaps in coordination between LVCT and HACK**. As one stakeholder remarked;

"*Frequent leadership changes stalled plans and created uncertainty, especially regarding inter-agency collaboration*".

Challenges ahead, requiring post transition adaptation

Several challenges in the program's current operations already point to need for ongoing adaptation. Addressing these issues proactively could have been eased through a co-management approach, fostering greater continuity and smoother transitions.

- **Staff turnover and retention**: One of the primary concerns is staff retention. Although measures have been taken to ensure staff continuity, turnover remains a potential issue as personnel express interest in exploring new roles or transferring to other facilities. As one interviewee noted; "*Some of the staff absorbed from the county have expressed interest in transferring to other facilities, as MAT is more specialized and might not appeal to everyone. But for now, continuity has been ensured. The county needs to train more clinicians in MAT services so that there's flexibility in transfers".* Issues of internal mobility, already mentioned in other chapters, are also examples of this challenge.

- **Re-engaging dropouts:** Another challenge involves re-attracting patients who dropped out of the system during earlier phases. Recognizing this risk, LVCT implemented a faster follow-up protocol for missed doses to improve retention; *"Social workers now contact patients within two days of missed doses, demonstrating LVCT's commitment to patient-centred care"*. This points to the importance of measures to mitigating dropout rates and rebuilding patient trust in the system – affected by too abrupt of a transition.

Last-minute changes in national policy left no space for adapting

The transition faced a significant hurdle due to an abrupt change in the national health insurance system, complicating efforts to ensure continuity of care post-handover. MSF had provided comprehensive healthcare services, addressing a broad spectrum of health needs for vulnerable populations. This approach was critical in a context where universal free healthcare access was not guaranteed, and individuals relied on health insurance to receive care.

To address this gap, MSF explored providing insurance support to patients during the transition, aiming to integrate them into the national system while negotiating with the government to ensure coverage for the most vulnerable groups. However, these plans were disrupted when the government replaced the National Health Insurance Fund (NHIF) with the Social Health Insurance Fund (SHIF). This policy shift occurred during the handover process, creating significant challenges. The handover period started with the change announcement in November 2023, but the system was not yet in operation. Initially planned for March 2024, implementation was postponed to July 2024 and fully rolled out in October 2024—precisely as MSF was handing over.

The transition was marked by glitches and widespread public confusion. This sudden change severely impacted MSF's transition strategies and forced the discontinuation of efforts to secure insurance coverage for patients. It also created hurdles for clinics; "*Now, with this **transition to the new Social Insurance Fund**, every facility is supposed to **register** so it can get an **allocation** from the county. But it's such a **tedious process** that we're not sure about. Usually, we'd expect supplies **quarterly**, but we've only been getting about **half**. We anticipated new **commodities** in January, but because of this new Social Insurance Fund program, our facility might not get any because there are **issues,** we need to address, like **licensing** the facility".*

Under the SHIF, registration became mandatory for access to healthcare, including referral-level services. Unlike the NHIF, which allowed for free treatment at lower-level facilities, SHIF excludes unregistered

individuals - a major challenge for vulnerable populations, such as those in prison. As a clinic manager said; *"I even tried to register an inmate yesterday, but the requirements are so rigid that no inmate can meet them. Unless they change the system to allow for inmate-specific registration, it's impossible under the current setup".*

This sudden policy shift left no time to adapt transition strategies, leaving significant gaps in access to essential services. Advocacy efforts to ensure the new system accommodates key populations—such as prisoners and those unable to pay—remain critical. But will MSF continue to engage in this effort? While the transition to SHIF was a planned policy change, the practical uncertainties and implementation challenges created a limbo period, complicating forward planning for healthcare providers. Navigating this was exceptionally difficult.

Strategic adaptations for sustainability: the case of polydrug use

Discussions with stakeholders highlighted significant shifts in drug use within the community, posing challenges for the MAT program's sustainability and relevance. LVCT observed that changes in the aggregation and behaviours of people who use drugs (PWUD) complicate community outreach, necessitating restructuring to effectively engage this evolving population. Stakeholders also noted a shift from opioid use to other substances, such as cocaine, alongside a persistent and growing issue of polydrug use, particularly involving alcohol. Some PWUDs even suggested that the handover may have exacerbated these risks; "*Patients feared methadone will disappear... some have relapsed, turning to alcohol instead".* These trends, already visible during MSF's tenure, demand a reconsideration of the clinic's model. However, no concrete plans exist to adapt services beyond methadone treatment, leaving the clinic at risk of losing relevance within the community.

Addressing polydrug use was discussed by several stakeholders, not only as a future challenge for the center but as a missed opportunity for post-handover sustainability. Some MSF staff reflected that adapting the MAT project to integrate polydrug use services into the clinic's offerings could have strengthened community buy-in and expanded the clinic's role as a comprehensive care provider—ultimately bolstering its post-handover resilience**.** As one noted; "*We could have been more strategic in integrating alcohol addiction services. Rather than building a new alcohol detox unit, we could have added wards to the existing facility and created a small rehabilitation unit for alcohol addiction alongside opioid treatment. Patients could transition seamlessly between services, maximizing existing infrastructure and staff".* Such an approach might have better utilized valuable existing resources handed over by MSF, including office spaces currently underused.

Such an approach aligns not only with MSF's desire for integration, but with the Ministry of Health's emerging vision for integrated care. A representative shared; "*Across all departments, we're now moving toward a 'one-stop-shop' approach where clients can receive all necessary services at a single location. For example, instead of sending clients to multiple locations, we'd like a methadone patient to receive comprehensive addiction support in one place. I foresee that integrated cross-addiction services will eventually be part of our model".*

MSF's earlier incorporation of polydrug use services could have strengthened the handover's push for integration.

Alcohol-related issues carry different stigmas, often viewed as broader public health concerns, which might have drawn additional support for sustaining the clinic. Incidentally, the inclusion of alcohol treatment could have made the clinic less intimidating for patients who feared being labelled solely as drug addicts. As one

MSF staff member noted; "*Many MAT patients refused to visit level-four facilities due to fear of judgment. If we had addressed this early on, we might have been able to create smaller, less intimidating spaces for care".* By broadening its scope, the clinic could have attracted more county resources and built stronger community acceptance. Polydrug use, instead of being solely a risk to patients, could have been transformed into an opportunity to strengthen support for the clinic.

MSF was not blind to the fact that opioid users often also use cannabis, alcohol, benzodiazepines, and tobacco, reflecting the complexity of substance use profiles. However, the response did not formalize or institutionalize comprehensive support for polydrug use. MSF staff acknowledged that integrating addiction services alongside core health initiatives—possibly linking with other government initiatives targeting alcohol abuse—could have facilitated deeper engagement and additional resources; *"Adding an addiction component to our programming might have attracted more county resources and facilitated deeper community engagement".*

Of course, time was a challenge. While the timeframe of the project helped establish a center of excellence, it was not long enough to make it fully adaptive to emerging challenges; *"MSF's focus on creating a center of excellence within a short timeframe meant limited room for flexibility or additional components. While this approach delivered high-quality services, it might have been beneficial to align the project more closely with community needs, such as addiction support".* Ultimately, building greater flexibility into program design could have positioned the clinic as a pioneer in this approach. And, handover-wise, might have contributed to the MAT clinic's long-term sustainability, by enhancing its impact on the community.

KEY DRIVER 5: STAKEHOLDER ENGAGEMENT AND OWNERSHIP OF TRANSITION

Transferring ownership and responsibility to local stakeholders is essential for the long-term success of the MAT clinic.

This driver recognizes that a successful handover fundamentally depends on people and their relationships. Ensuring a smooth transition requires a deep understanding of the stakeholder ecosystem, along with the application of tools and frameworks to analyze power dynamics and relational structures.

SUMMARIZED FINDINGS FROM PHASE ONE OF THE EVALUATION

The importance of a stakeholder ecosystem: The previous report highlighted the importance of understanding the entire stakeholder ecosystem during the handover of a complex project. It's not just about individual relationships but how all participants interact. MSF has been a key player, serving as the glue that kept everything together. However, as MSF steps back, the network seems less cohesive—at least from MSF's perspective. This raises an important question; are there other connections in the ecosystem that could be strengthened or leveraged? A prototype stakeholder network map was introduced as part of the evaluation, which captured the interest of MSF staff and government officers. This indicated the need for a tool to better identify existing links and opportunities for collaboration.

Ownership, leadership, responsibility, and answerability in handover: The evaluation highlighted four key concepts to consider during a handover: 1) *Ownership*: A sense of connection and commitment to the initiative, independent of formal roles or decision-making authority. 2) *Leadership*: The ability to guide and inspire, based on respect and competence rather than official roles. 3) *Responsibility*: The tasks assigned to individuals or groups (the "doers"). 4) *Answerability*: Final accountability for outcomes—clarifying "where the buck stops". To ensure a smooth transition, it is essential to maintain clear responsibilities and accountability while fostering leadership and ownership among stakeholders in a collaborative environment. Challenges identified included:

- **Challenges on answerability:** With MSF stepping back, accountability is now shared, leading to fragmented answerability. Decisions may slow, coordination could weaken, and conflicts might arise without clear accountability.
- **Confusion of responsibility and answerability:** Multiple doers without clear final accountability can lead to blame-shifting and poor coordination. Defining answerability first is crucial to ensure effective action.
- **Reduced spaces for leadership:** MSF's departure risks a shift to hierarchical, risk-averse management, reducing opportunities for shared leadership and innovation. A "just-mind-your-business" culture may emerge if leadership is not fostered.
- **Fragile ownership:** Ownership is the backbone of a project, reflecting the sense of pride and connection it inspires in stakeholders. This shared commitment creates a critical mass of support that can sustain the project through challenges and keep it prioritized. Currently, ownership and pride in the project are strong, but without MSF's advocacy and promotion, this vital yet fragile asset risks being weakened.

Adaptiveness: MSF challenges and achievements

Finding	Summary
Stakeholder analysis	Stakeholder analysis was included but lacked depth. Interactive mapping tools could improve clarity, document relationships, and address weak links.

Navigating administrational changes	MSF successfully rebuilt commitment after staff turnover, using strong MoUs and personal relationships. Maintaining this post-handover is a challenge.
Strength of partnership with LVCT Health	Capacity challenges weakened the partnership with LVCT Health, creating an imbalance that affected both the project and the handover process.
Working groups	Technical Working Groups were valuable but lacked strong feedback loops to decision-makers. Their resilience post-handover without MSF remains uncertain.
A RACI Matrix?	Using a RACI matrix could have clarified roles and responsibilities, reducing ambiguity and improving coordination during the handover.
Perception of project ownership	The project is still seen as "MSF's", which may hinder loyalty to the new management and sustain the belief that MSF's standards are unattainable.
Early engagement vs procrastination	Early handover discussions faced delays in active participation. Hard deadlines enforced urgency but risked leaving loose ends. Creative post-handover support is crucial.
Who was left out?	Some departments and stakeholders were engaged too late in the project or missed in the handover, limiting their impact on administrative and strategic decisions.
Layers of coordination and engagement	Coordination across county and national levels required strong facilitation, but turnover and gaps in partnerships posed challenges.
Leadership capacities of MAT clinic staff	Staff received technical training but lacked leadership development. Post-handover, they may struggle to adapt to less responsive management structures.

Additional insights on stakeholders

The report also emphasized the importance of stakeholder engagement and mutual accountability throughout the handover. This topic was addressed in a dedicated chapter due to its importance. The key findings have now been condensed and integrated into this framework, where they rightfully belong. The report highlighted key stakeholders, their contributions, and factors that shaped the process, providing a foundation for improving future transitions.

Stakeholders in the handover process: The previous report examined key stakeholders involved in the Kiambu handover process, providing insights into their roles and challenges. The analysis highlighted a tendency to focus on high-level actors while community stakeholders were less actively engaged. Below is a summary of key stakeholders:

Stakeholder	Key Highlights
MSF	Led the project and early handover planning; extended timelines but lacked a post-handover strategy.
MAT Clinic staff	Medical staff was recruited through MoH but faced unclear roles during handover, this causing anxiety.
Peers	Played a role in sensitization but faced job losses post-handover due to county readiness issues.
Community health workers (CHWs)	Critical for outreach but engaged late, limiting their mediation and sensitization impact.
MoH staff	Early engagement with leadership, but broader MoH staff had limited involvement with MAT clinic.
County staff	Essential for long-term buy-in; engagement was strong but required effort to rebuild after turnover.
Prison service	Effective partner for decentralized clinics but preferred oversight through county for coordination.

LVCT Health	Partner for harm reduction services; faced capacity gaps and uncertain long-term engagement.
Community and PWUDs	Minimal involvement in decision-making, though critical for sustainability.

Factors for good engagement: The evaluation identified factors critical for stakeholder engagement and mutual accountability. These factors provide a framework for building relationships and ensuring effective handover processes:

Factor	Key highlights
Timeliness	Early engagement is ideal but can be delayed by turnover or slow buy-in. The handover felt rushed for many.
Approachability	MSF was praised for accessibility, though challenges remained in reaching key stakeholders.
Brokerage	Key actors (e.g., county governor) were vital in bringing diverse stakeholders to the table.
Understanding	Gradual exposure and capacity building increased comprehension, but some aspects remained superficial.
Connection	Working groups and training sessions built trust but did not extend strongly to community actors.
Goodwill	Positive impacts generated pride and support, though maintaining quality post-handover will be critical.
Continuity	Turnover in partner institutions disrupted relationships; onboarding and capacity building are essential.
Cultures	MSF values, like patient-centred care, need careful transition to a more bureaucratic environment.
Politics	Navigating approvals at various political levels was essential but slowed decision-making.
Contractual obligations	MoUs ensured commitments but required flexibility for adaptation and unexpected developments.
Communication	Informal agreements complicated clarity; documentation and transparency need strengthening.
Power	Imbalances limited marginalized voices; expertise must be valued alongside formal authority.

Engagement of community stakeholders: the previous report emphasized the importance of engaging a wide range of community stakeholders, including political representatives, traditional and religious leaders, CHWs, peers, local volunteers, and families of PWUDs. While these actors were on the radar, their involvement varied significantly. For instance, **CHWs** were supported and trained but not engaged consistently, leaving gaps in their potential contributions. During the handover, apart from **government representatives**, most community stakeholders had no clearly defined roles or outlined support for the post-handover phase. This lack of clarity has raised concerns about the sustainability of community engagement and the ability of stakeholders, particularly PWUDs, to contribute to support services.

The engagement of PWUDs: The report examined the role of PWUDs and their organisation, HACK, in depth, emphasizing their potential to drive the sustainability of harm reduction services. Initially regarded as patients or clients, PWUDs were later recognised as critical stakeholders capable of representing their interests and advocating for their rights. MSF's support for the formation of HACK in 2023, the county's first PWUD-led CBO, marked a transformative step towards representation (providing PWUDs with a formal platform to express their needs and advocate for their rights); advocacy (challenging stigma, discrimination, and criminalisation of PWUDs); accountability (monitoring MAT services and demanding adherence to

commitments); and community engagement (fostering a sense of service ownership among users, thus supporting sustainability).

However, challenges remain. HACK is a young organization, still building its legitimacy and capacity. It was not involved in the handover process, limiting its ability to establish credibility and advocate effectively. Moreover, while HACK members are motivated, their roles post-handover remain unclear, and their exclusion from key discussions has hindered their ability to hold stakeholders accountable.

Findings	Summary
Handover: an opportunity to build legitimacy	Excluding PWUD representatives during the handover missed a chance to build legitimacy for both PWUDs and HACK. Overlapping roles and unclear future support further complicated HACK's position.
HACK: an opportunity for MSF for "having a foot in the door"	HACK allows MSF to stay connected to MAT services post-handover. A long-term partnership with shared objectives and participatory processes is key to success.
Rethink support, from administration to participation	Overemphasis on administrative tasks risks distracting HACK from its mission. Support should focus on participatory, community-driven approaches to empower PWUDs.
Thinking support at the time of AI	AI can simplify bureaucracy, freeing HACK to focus on engaging communities, service providers, and decision-makers effectively.
Accountability is power	Empowering PWUDs to demand accountability can make them active rights-holders. The handover must include measurable commitments and community-led monitoring platforms.
Disentangle accountability and advocacy	Separating advocacy (what could happen) from accountability (what must happen) helps HACK build clearer goals and strategies, enhancing its legitimacy.
A realistic (time)frame for support	Building a sustainable CBO like HACK needs time. A rushed transition risks harming its members. Phased, adaptive support ensures stability and success.
Failure of HACK, or of its handover, poses significant human risk	Failure would harm both HACK's members and the progress made. Support must prioritize the human element and address vulnerabilities with flexibility.

The framework for appreciating network dynamics, introduced in the previous report, highlights the intricate and often invisible processes of stakeholder engagement during a project handover. It emphasizes that handovers are not static but dynamic, requiring ongoing adjustments to relationships, group dynamics, and role formalizations. The framework outlines three interconnected elements: exploring and maintaining relationships, forming structured groups and clusters, and formalizing roles and responsibilities. However, the arrows connecting these elements are just as crucial, reflecting the iterative nature of stakeholder management. These linkages ensure that agreements, once formalized, can still be revisited and adjusted to meet evolving needs or address gaps. This approach underscores the importance of leadership, inclusiveness, and mutual accountability in sustaining transitions.

This model revealed that the handover process in Kiambu relied heavily on these dynamics. Relationships with key stakeholders—such as the county government, community organizations, and health providers—were actively maintained, ensuring continuity of services. Structured working groups facilitated dialogue and decision-making but required ongoing leadership to stay relevant and avoid stagnation. Formalized agreements, while helpful, lacked specificity in areas such as resource allocation and role definitions, highlighting the need for "living documents" that evolve with the project. The framework illuminated how successful transitions depend not just on clear agreements but on the ability to revisit, renegotiate, and adapt roles and relationships in response to emerging challenges. This iterative process was critical to navigating the complexities of the Kiambu handover and ensuring its continued resilience.

Sentiment analysis: The first part of the evaluation also analyzed stakeholder sentiment on key handover aspects. It revealed widespread concerns about financial sustainability, continuity of services, and clarity of roles, with MSF, staff, government,

and community actors expressing varying degrees of anxiety and caution. Optimism was noted regarding the comprehensive care model, stakeholder engagement, and continuous training, which were widely appreciated. However, logistical challenges, integration with hospital services, and job security were significant areas of uncertainty. Community actors expressed hope for strengthened ownership and engagement but remained concerned about sustaining key services and non-medical components post-handover.

PHASE TWO FINDINGS

The first evaluation report provided an in-depth analysis of stakeholders and their dynamics, highlighting the critical importance of focusing on these relationships and leveraging innovative tools and approaches, such as interactive stakeholder mapping and sentiment analysis.

At this stage, it is **challenging to add new insights without repetition**, as the project is currently in a state of limbo. The relationships outlined in the first report remain relevant, and there have been no significant shifts in stakeholder roles—such as the onboarding of LVCT or the conclusion of support for HACK—that would introduce new dynamics.

The **relative stability of the stakeholder landscape** during this phase is noteworthy, particularly given the program's history of navigating diverse institutions and frequent changes in county leadership. In the past, leadership turnover required repeated renegotiation and reestablishment of contacts. However, during the transition, the program benefited from an unusually stable political and institutional environment (with the exception of NASCOP, which posed some challenges).

Another key strength during this period was the presence of **strong gatekeepers**. These individuals played a crucial role in navigating the complexities of the stakeholder landscape, ensuring that issues were addressed and connections were maintained. Their efforts were instrumental in sustaining progress and mitigating the risks often associated with such transitions.

The county role: political commitment drives handovers

Ownership by county stakeholders was a key factor in the success of the handover. As a MoH high officer said; "*Support from leadership, including the Governor, has been instrumental in sustaining the program*". County leadership demonstrated a strong sense of responsibility for the MAT program, investing resources for employing staff on permanent contracts and appointing a dedicated MAT coordinator to oversee the clinics. As an MSF staff noted; "*One thing that surprises me is how the county has taken to the MAT clinic. They even pushed for appointing a MAT coordinator*". This level of ownership ensured that the program's key structures were institutionalized within the county's operations, setting a strong foundation for sustainability.

At the time of the handover, the county also benefited from a period of relative stability, in contrast to earlier phases marked by leadership changes. Previous disruptions—such as the transition from one governor to an interim deputy and then to a newly elected governor—had required repeated renegotiations and rebuilding of trust. By comparison, the stable leadership during the handover allowed the county to commit fully to the program, demonstrating how essential it is to consider the stakeholder landscape when planning transitions. Where relationships with stakeholders were less developed, such as with NASCOP, the challenges were more apparent. As one county stakeholder explained; "*Now we're dealing with a **new leadership** that's coming in with a different approach. A gap in advocacy has meant that take-home dose policies weren't cemented early on, leaving us vulnerable to these changes now*". Strong relationships and consistent communication are critical to ensure smoother handovers, even in complex environments.

The importance of gatekeepers

Strong gatekeepers played a crucial role in navigating the complexities of stakeholder ecosystems during the handover. These individuals acted as connectors, bridging gaps between different stakeholders and ensuring that issues were brought to the table and addressed. As one county stakeholder noted; "*Identifying a key entry point—someone like [key stakeholder], who was instrumental in pushing negotiations forward—can make a significant difference. Without [this stakeholder's involvement], progress would have been much slower. Future projects should prioritize finding such individuals early on".* Gatekeepers of this kind were vital in managing executive matters and facilitating negotiations, ensuring that critical decisions could be made even in challenging environments. Their ability to join the dots and motivate others made them indispensable in a process that required interfacing with a complex public administration.

However, gaps in leadership engagement sometimes left those on the ground to handle matters without adequate authority. As one county staff member reflected; "*At one point, I found myself in meetings, negotiating on behalf of the team, which was challenging because I didn't have the authority to make decisive calls. I would tell them, 'I'll consult and get back to you,' but it would've been easier if the county leadership had been involved from the beginning".*

This highlights the importance of involving senior leaders early in the process to strengthen coordination and ensure buy-in from all levels. While ground-level staff often understood the issues, decision-making power remained concentrated at higher levels, leading to delays and missed opportunities for stronger alignment.

The lesson is clear; gatekeepers with the right connections and authority are essential for navigating complex ecosystems.

The critical role of a MAT coordinator

The role of a MAT coordinator proved essential in bridging the gap between facilities and the government after MSF's departure. During MSF's tenure, the clinics benefitted from centralized oversight, which allowed for greater flexibility in managing resources—such as reallocating staff, sharing learning, and addressing gaps quickly. This coordination ensured smooth operations across the clinics and fostered innovation in problem-solving. As the handover approached, the absence of a clear MAT coordinator role posed a significant risk. Without a designated leader to provide oversight, communication and coordination among clinics could have deteriorated, creating inefficiencies and leaving gaps in care. Fortunately, this potential challenge was mitigated with the appointment of a MAT coordinator, whose combination of strong relationships, leadership skills, and familiarity with the system made her an ideal fit for the role.

The MAT coordinator's prior role had allowed her to build a wide network of trust among staff and external partners, which became a critical asset during the transition. As she explained; "*My previous role helped me build my network, which has strengthened my leadership now. Familiarity with the team and external partners allows me to address challenges effectively, as I'm seen as both a leader and a colleague".*

Her experience highlights the importance of leadership that goes beyond technical expertise. It's not just about managing tasks but about cultivating relationships and trust—qualities that are often undervalued in technical professionals.

As one stakeholder noted; "*After MSF's management left, coordinating staff became difficult without someone overseeing daily operations. Having someone responsible for communication and coordination means issues can be resolved in real-time. Without that, there's a gap".*

The success of the MAT coordinator role underscores a key lesson; transitions are not just about handing over tasks, they are about ensuring the right people are in place, with the skills and relationships necessary to sustain the system. Without a capable coordinator, the transition could have faltered, demonstrating the

critical need for leadership positions that connect facilities, staff, and government stakeholders. This case reinforces the idea that handovers ultimately depend on people and relationships, and that investing in relationship-building and leadership development is essential for success.

Highlighting the clients' role

The final stakeholder lesson from Phase Two centers on the clients themselves. While the evaluation did not deeply explore the broader community perspective—an acknowledged limitation—it highlighted how clients, through organizations like HACK, could take on a larger role in the transition.

However, so far, HACK's potential has been seen mainly through an operational lens; "*HACK could be valuable in reaching out to patients, especially to help those who've dropped off return for services. Their outreach could be particularly effective in clinics where patient numbers are high but relatively stable".* This view reflects their practical contributions but falls short of recognizing HACK as a key actor in decision-making and accountability. This gap points to the need for a stronger rights-based approach.

HACK, the first PWUD-led organization in the county, was created with MSF's support to empower clients and give them a platform for advocacy, accountability, and community engagement. Yet, during the handover, its role was limited, as the organization's identity and capacity were still evolving. This was a missed opportunity. Adding to the challenge, MSF is now stepping away from supporting HACK, leaving its future unclear.

The interest in HACK's potential remains. County officers see its operational value; "*HACK could be valuable in reaching out to patients, especially to help those who've dropped off return for services. Their outreach could be particularly effective in clinics where patient numbers are high but relatively stable."*, and MSF staff acknowledges the risks of withdrawing support; "*Without support, HACK risks losing access to funding sources, putting operations at risk".*

The key lesson here is that HACK, and similar client-led organizations, need to be more than operational actors. They should also be decision-makers and accountability players. Handover processes provide a chance to establish this role—if they include clients early in the planning and commit to building their capacity. Later chapters in this evaluation will explore how to better incorporate a rights-based approach into future transitions.

Participation and inclusion: prioritizing the most vulnerable - starting with clients

To conclude, it is key to reaffirm that this key driver requires addressing power dynamics in stakeholder engagement. At its core, the compass guiding stakeholder involvement must always point toward the most vulnerable populations. Even in processes that may seem primarily "managerial", such as the handover of a health system, embedding the active participation of clients, especially the most vulnerable, is not just beneficial but essential. Their inclusion ensures that services remain relevant, equitable, and grounded in the realities of those they aim to serve.

KEY DRIVER 6: CULTURAL AND OPERATIONAL ALIGNMENT

Addressing the challenges of aligning MSF's culture and management/ operational style with those of the receiving organizations is crucial for a smooth transition.

Coherence of organizational culture and operational approaches between MSF and receiving organizations is critical for ensuring a smooth transition during project handovers. **MSF's management style**, characterized by independence, responsiveness and efficiency, may not seamlessly translate to new management structures. Even more so its deepest values and ethos. This can lead to significant challenges in transition. Examining this means to look at the deeper parts of the → *The Handover Iceberg*.

SUMMARIZED FINDINGS FROM PHASE ONE OF THE EVALUATION

Management style and skills

MSF's adaptive management approach allowed quick decision-making and flexible responses to challenges. The transition to more structured organizations raises concerns about maintaining this adaptability, especially without proper shadowing periods for new management teams.

Leadership

MSF cultivated leadership at all levels, enabling staff to take initiative beyond formal roles. This informal leadership style may face challenges in more bureaucratic structures where proactive action outside official channels is limited.

Existing network of connections

MSF served as a key connector between various stakeholders, building trust and understanding beyond formal coordination. The loss of MSF's connecting role may create challenges that formal agreements alone cannot address.

Explicit organizational values and paradigms

MSF's patient-centered care model and ethical standards for treating PWUDs face potential compromise during transition. There's risk of reverting to compartmentalized care approaches, threatening the integrated model MSF established.

Tacit cultural norms

The handover struggles to transfer unwritten rules and attitudes that shaped MSF's approach, particularly regarding treatment of PWUDs. Staff turnover and organizational culture differences threaten to erode these established norms.

Cultural and operational alignment: MSF challenges and achievements

Finding	Summary
Transitioning (adaptive) management	Lack of time for co-management and shadowing due to the late recruitment of new managers created staff anxiety about different management styles.
Grooming managers	The plan to promote clinic staff to management roles failed as medical professionals preferred clinical practice over management duties.
Under-investment in leadership capacity	With MSF's departure, less experienced units may struggle with management decisions, not having developed leadership skills and confidence.

MSF was pivotal - so, what now?	MSF's withdrawal risks reintroducing power struggles and inefficient overlaps in the established network, challenging coordination across administrative borders.
Handing over capacity to manage decentralization	The new MAT coordinator role risks being overstretched and lacks MSF's authority to handle broader coordination challenges.
Confronting bias against public services	Required proactive communication campaign to address patient concerns and rumors about standards of care post-handover.
Broadening partner engagement	There are variable levels of understanding among partners due to uneven interaction levels during the handover process.
Capitalizing on experiential buy-in	Direct observation of clinic operations proved crucial for stakeholder understanding and buy-in beyond formal meetings.
Can empathy survive employee detachment?	There is risk of reverting to a detached "MoH coat" approach when facing handover challenges.
Cultural shifts in communities	Community attitude changes toward PWUDs through sensitization created a lasting positive impact supporting handover.

PHASE TWO FINDINGS

A major achievement: continuity of staff

Ensuring staff continuity was a significant milestone in maintaining cultural and managerial consistency throughout the handover process. This achievement was rooted in early preparation during the Memorandum of Understanding (MoU) setup, yet it was not a given. It required extensive negotiations, and it was not formally confirmed until the very end, causing considerable anxiety among staff during initial visits. But today's MAT clinic remains largely staffed by the same personnel - a major success. Successfully integrating 48 staff members, including technical roles, was a standout accomplishment, particularly in light of initial budget constraints. A MoH officer highlighted the importance of the "multidisciplinary transition committee" put in place to ensure that "*MAT staff were integrated into general hospital roles and vice versa…".*

An important factor helping retention was the **employability of staff.** MSF's hiring strategy proved pivotal in facilitating a smooth transition. By prioritizing candidates with skills aligned to the county's HR system, MSF ensured staff were easily absorbed into government roles. As one interviewee noted; *"MSF's hiring strategy differed from other NGOs, which often bring in personnel with very specialized skills. Instead, MSF recruited staff with broader healthcare skills, allowing them to be absorbed easily into government roles. This approach made the transition smoother and ensured there wouldn't be a major gap in essential staffing after MSF's exit".* However, as with any highly employable workforce, there is a risk of staff moving within the system, potentially affecting long-term stability.

Another critical success was ensuring the presence of a **coordinating role to oversee the MAT clinics** post-transition. As one clinic manager remarked; "*MSF did well. The county MAT coordinator has been key, which helps with continuity. The uncertainties we worried about mostly turned out fine. Our hope is that the county will keep up this same spirit with the MAT clinic".*

Leadership is not a given!

The transition revealed the critical role of leadership and its dependence on both the operational environment and personal attitudes. While MSF recognized this early, the outcomes were mixed, highlighting the challenges of transferring leadership during a handover.

MSF's original plan to integrate county-appointed managers into operations through **shadowing and gradual supervisory transitions was not fully realized**. Bureaucracy and leadership turnover on the county's side delayed progress, leaving gaps when MSF exited. As one MSF staff noted; "*Had we phased in county staff earlier, they could have acclimated to the role, making the transition smoother. Ideally, they would have taken over supervisory duties gradually, rather than all at once".*

The **initial absence of central management and coordination** post-handover was acutely felt, as highlighted by county officers; "*Having a central leader is crucial. After the MSF management left, coordinating staff became difficult without someone overseeing daily operations".*

Then, the **MAT coordinator position, once in place, solidified gradually and steadily**; "*Her appointment has been a turning point for ensuring stability and ownership of MAT service*". The position initially lacked clarity—understandably so, as it had to make up for the comprehensive oversight MSF provided during its tenure. Over time, however, the role has sharpened, earning satisfaction from all stakeholders involved, building considerably also on her relations and commitment to leadership. The MAT coordinator felt that her **investment in building strong relationships** during the program's lifetime was key to this success; *"Staff were open to guidance and trusted my decisions because they knew me personally and respected my commitment to them".*

While MSF fostered a culture conducive to leadership, the MAT coordinator's personal commitment was pivotal. Her **self-funded leadership training** enabled her to develop critical relational and team-management skills that proved invaluable in her role; "*Having realized that technical skills alone weren't enough for effective leadership, I enrolled in part-time leadership courses on my own initiative and expense—one of my best decisions".* This was a unique case, especially given previous observations during the project visit; some medical staff, when offered management roles, preferred to stay within their technical expertise and comfort zones, understandably reluctant to shift into managerial positions. So, this raises a critical reflection; the MAT coordinator's leadership was not only a result of MSF's culture but also depended on her personal investment in leadership skills and having the right personality for the role. While MSF laid the groundwork and discreetly facilitated her selection—identifying her as a strong candidate, involving her in the handover discussion, and ultimately proposing her for the position—the actual development of leadership skills remained self-driven.

This **investment in leadership needs to be more intentional because across sites, the picture was not uniform**. While some clinics, benefited from strong leadership and clear structures, others faced significant challenges. In a decentralized clinic, for example *"coordination challenges emerged, as the in-charge was overburdened and unable to delegate effectively"*. This was partly due to the more complex setup of the clinic, which included an attached busy health center. Such a structure inherently required higher levels of coordination, and gaps were more likely to occur given that **task allocation had not been streamlined prior to the transition**.

The transition also shows the difficulties of adapting **MSF's leadership style—marked by agility and flat hierarchies**—to the government's more structured, hierarchical system. In some cases, these **hierarchies supported the work**, where clear lines of authority aligned well with the clinic's needs. However, elsewhere, the system's complexity proved harder to navigate. **Multiple management lines with differing levels of power created challenges**, requiring more nuanced coordination and adaptive leadership approaches.

A transformative shift for the county: from dependence to ownership

Handover transitions, no matter how well-prepared, are complex management and cultural shifts, particularly when aligning distinct organizational styles. As one county staff member acknowledged: *"We thought we were prepared, but when the responsibility was finally handed over to us, the reality hit.*

Suddenly, I had to make decisions alone, calling [xxx] for advice on things we used to handle together. It was challenging, but I see it as a learning lesson. Next time, I believe we'll transition a project much better. Talking about it and doing it are worlds apart".

This illustrates a key realization: effective handovers are not just about transferring operations. MSF's systems and processes were deeply embedded in its operational structure, shaping how decisions were made, issues were addressed, and roles were defined. Transferring these intangible elements is a far greater challenge than it may initially seem.

Despite differences in organizational cultures and setups, the handover benefited from a strong alignment of principles between MSF and the county, **hinging on a shared desire to achieve excellence in the service.** Another county officer observed; "*We're fortunate that MAT services have continued and that there's now a strong sense of county ownership".*

Clear alignment of principles can ease cultural gaps. The shared vision—centered on maintaining service quality and patient care—was instrumental in navigating organizational differences.

The shift from dependence to ownership was necessary and transformative, but difficult. It required county teams to adopt new decision-making responsibilities, often without the hands-on support they were accustomed to. As one staff member noted; "*Now that we know the transition is taking place, we're more serious and ready to run things ourselves".*

Looking ahead, a **new partner is expected to join the program**, adding another layer of complexity. While the evaluation could not fully anticipate this development, the **introduction of a new actor and project setup will undoubtedly influence the progress and setup achieved so far**. It will be interesting to observe how the management style and program requirements of the new partner interact with the systems and dynamics already in place, potentially reshaping the trajectory of the program and its ownership.

Management and operational challenges in handover

The handover revealed significant challenges in adapting to new management and operational responsibilities. These issues stemmed from differences in decision-making styles, supervision structures, and the complexity of public health systems. There are no unexpected challenges, nor major ones, and they are partially unavoidable. However, they underscore the importance of considering organizational cultures and systems to ensure smoother transitions and effectiveness.

- **Power:** Power is a key issue. Decisions that MSF could take independently are now harder for the current leadership, as they must navigate the hierarchy of the health system – and other government units. As a clinic manager mentioned; "*Integration remains tricky, especially when managing two distinct institutions. Unlike single-facility clinics, we manage two sites, making it difficult to unify operations. It is harder than at the time of MSF because the staff in place does not have the same power".*

- **Changes in supervisory roles / post-handover fragmented reporting structures:** Sometimes, the lack of departmental supervisors left staff without clear guidance. Roles like the Medical Activity Manager in Ruiru were not replaced. Leadership now rotates informally, and this **peer-led management** weakened authority and decision-making. Reduced mobility for supervisors also limited their ability to provide active oversight across facilities.

- **Slower Decision-Making**: The county's slower, more hierarchical processes frustrated staff accustomed to MSF's proactive approach. This impacted both morale and patient care, because delays in decisions might lead to disruptions; *"County processes take longer; it impacts how fast we can act. By the time we make a decision, certain things may have already impacted services".*

- **Structure of public services:** The MAT services require diverse institutions and units to interact. Without MSF's dedicated management roles, coordination became a challenge; "*When MSF left, coordination suffered. Without someone managing daily operations, we struggle to keep things running smoothly".* This is now improved with the successful appointment of a MAT coordinator. Coordination amongst different bodies might remain challenging, as seen when in resource-sharing difficulties between facilities under different jurisdictions, such as the clinic in Ruiru; "*Currently, supplies and oversight come from different counties, leading to significant resource challenges*. *This makes even something as basic as vaccine sharing between the two facilities complex***".**

Practical staff management challenges

The handover brought minor yet practical challenges that, while not unexpected, have begun to erode staff morale and operational efficiency in some cases, particularly regarding payment issues. The following refers mostly to the decentralized prison clinics, where managerial challenges are more complex.

- **Differing work hours and responsibilities:** Disparities in work schedules between prison staff (8 a.m. to 5 p.m.) and civilian staff at the MAT clinic (8 a.m. to 1 p.m.) complicate staffing across sites. Civilian staff resist extending their hours, leading to workload imbalances and gaps in service continuity when shifts are needed.

- **Salary and role disparities:** Differences in pay and job expectations between prison officers and civilian staff create tension, especially when roles overlap or responsibilities do not align neatly within the MAT clinic.

- **Procedural inconsistencies:** Procedural differences further complicate operations; "There's confusion about where prison staff should submit leave requests—whether to the county or directly to prison management". This ambiguity creates differences amongst staff and creates confusion.

- **Unpredictable payroll: "***MSF paid staff on time, while the county has delays. For example, they missed September payroll, affecting staff motivation"* a clinic manager reported. Salary delays became a major issue, resulting in strikes. To guarantee the services, it was agreed that county staff may stop work, but essential services, such as pharmacy operations, must continue, creating friction among colleagues when some workers remain active while others don't. County officers are aware of the issue; "*There's a budget gap that's emerged. One arm of the government blames the other, and neither the county nor the national level is stepping up to own the responsibility".*

At the core of organizational values: funding principles of care

A central focus for MSF was ensuring dignity and respect in the treatment of PWUDs, paired with raising staff motivation to prevent the adoption of what was referred as the "**MoH Coat**" - a dismissive attitude towards clients in public service roles. Of course it is important to avoid stereotyping, as many health professionals uphold strong values of care. However, there is a recognized risk that, in some cases, the stability of public sector employment may inadvertently reduce attentiveness and responsiveness to patient needs.

MSF's approach emphasized dignity and patient-centered care, with efforts to motivate staff to go beyond routine duties. As one MSF team member noted; "*There's been a bit of an issue with take-home doses since we left, as COP wants to re-evaluate that process. The team has held night meetings to address these issues, gathering documents. Their* ***patient-centered approach is genuinely impressive****".*

However, this commitment has been uneven since the handover. Staff transfers and organizational changes have led to noticeable lapses in motivation, with some patients reporting a decline in attentiveness; "*With the recent staff transfers, there's been a noticeable* ***laxity, and patients have noticed".*** This shift has

contributed to patient attrition, and it was observed that **attrition rose and patients were dropping out voluntarily**.

Strategies to counteract this were not yet in place. The **Participatory Assessment Tool had indeed reported a marked deterioration in client care**, particularly in the areas of trust, respect, and dignity of treatment, especially felt by the most vulnerable clients.

The nature of the service: integration - within or into?

The handover highlights a significant organizational and cultural challenge: ensuring that MAT services remain true to their specialized nature while adapting to a broader push for integration. Integration itself can carry dual meanings. On one hand, it can mean a service that **integrates within itself**—bringing together various elements (e.g., substance use support, methadone provision, and counselling) into a cohesive, standalone model. On the other, it can mean a service being **integrated into** a larger system, where it functions as part of a broader entity but may risk losing its distinctiveness.

MAT services were intentionally designed as a "**one-stop-shop**," where clients could access comprehensive substance use care in a single location. This approach aligned with the MoH long-term vision and was deeply valued by staff and patients alike. As a MoH staff explained; "*Instead of sending clients to multiple locations, we'd like a methadone patient to receive comprehensive addiction support in one place. This approach aligns with a broader integration vision for all services".*

However, there is a risk that, as the service becomes absorbed into the general health system, the original vision of integration—offering holistic care within one access point—may be diluted. Factors such as flexible HR-policies, which prioritize staff optimization over service specialization, could disrupt the continuity and identity of MAT services. As a county officer explained; *"A few postings came in, and it seems the old understanding that MAT would always be standalone has been challenged. Some staff thought they'd only work in MAT, but now they're finding they can be placed anywhere in the county system. We're calling on everyone to embrace integration into the broader health system. The CHMT and executive assess facility needs and reassign clinical officers as they see fit. The challenge is keeping MAT-specific expertise, which is why we focus on mentorship and consistent on-the-job training, ensuring staff mentor others before moving on"*.

Embedding MAT services into the broader system offers opportunities, such as spreading its ethos of care and improving alignment with overall health priorities. Yet, this integration must not come at the cost of diluting its role as a clear, standalone access point for PWUDs.

The challenge, therefore, is to strike a balance between integration **within** (maintaining the distinctiveness and capacity of MAT services as a cohesive whole) and integration **into** (embedding them into the health system without losing their focus and identity). True success lies in ensuring that integration enhances the service's strengths rather than dispersing or diminishing them.

KEY DRIVER 7: PERFORMANCE MONITORING FOR HANDOVER

Setting up clear targets and indicators specific to the handover process improves accountability and helps track progress.

Systems are needed to monitor whether services maintain quality post-handover or deteriorate. Performance monitoring for handover relies on clarity on what should be monitored and a shared understanding of what to do when reality does not match expectations—building mutual accountability. This is even more important when checking the performance of a model of care, which is not "business as usual" and needs to be checked against deeper indications of progress and achievement.

SUMMARIZED FINDINGS FROM PHASE ONE OF THE EVALUATION

Monitoring the handover process as it happens

Unlike the Kibera project, which had a monitoring dashboard, Kiambu lacked specific tools to track handover progress. The non-phased approach made progress monitoring difficult, highlighting the need for specific tools in future transitions.

Align monitoring systems early on

The project utilised two separate systems: MSF's detailed 60+ indicators and MoH requirements. Post-handover will only use the MoH system, suggesting a need to design monitoring initially around government systems while incorporating innovations.

Advocate for improvements in the national system

MSF contributed to MoH monitoring forms and supported the transition to e-monitoring - although not all proposed changes were adopted, necessitating continued effort tracking.

Excellence is not "one indicator", but compounds many

MAT services require comprehensive monitoring that includes intangible aspects (like stigma reduction), process metrics, and composite indicators demonstrating service integration. The current fragmentation across systems poses challenges to a holistic approach.

Linking M&E frameworks to handover agreements

Agreements need provisions for periodic in-depth monitoring beyond routine data. The project attempted deeper evaluation through anthropological studies but missed research opportunities.

Linking monitoring to action ensure use

Data must be accessible and actionable for decision-making. Sharing attempts (through dashboard) were unsuccessful due to access issues, instead relying on labour-intensive manual analysis.

Nourish evidence-based advocacy

Strong evidence is needed to support service continuation and protocol integration. Requires shift from activity-oriented to client-oriented monitoring to track comprehensive patient journeys.

Whose monitoring

Handover should incorporate diverse monitoring perspectives, including community organizations and academic institutions. MSF's post-handover monitoring role needs definition.

Performance monitoring for handover: MSF challenges and achievements

Finding	Summary
MSF investment in monitoring	Strong data management was established with trained clerks retained post-handover.
Influencing the MoH system	Successfully added mental health forms to MoH e-monitoring, though nutrition forms were not incorporated.
Project-centric monitoring	Designed around MSF needs first, then adapted for MoH, rather than vice versa.
Project-oriented monitoring	Lacks a patient-centered approach needed to understand client experiences and system effectiveness.
Activity-centric M&E	Monitoring remains siloed despite integrated management, risking the inability to track service integration.
Exploring experiences with PWUD	An anthropological study provided insights, showing potential for participatory monitoring.

PHASE TWO FINDINGS

Clarity of agreements: the basis for effective handover monitoring

Post-handover monitoring depends on having clear agreements about what standards the services are expected to meet. Without these, it's hard to know if the service is performing as it should. The MAT guidelines provide a solid baseline, but they don't include the extra focus areas where MSF worked to improve or innovate. This gap means monitoring mostly checks if the standard MAT setup is in place but doesn't capture whether the quality and specific ways of working introduced by MSF are being maintained. Lacking clear, specific agreements, a system in place can only check on basic functionality but misses the higher standards MSF aimed for. This highlights the need for tools to track national standards and MSF's added value.

Agreements and standards need to be popularized

The MAT service guidance, while technically robust, is not user-friendly for ongoing monitoring, as it is detailed and highly specific. This makes it difficult for anyone outside the system—clients, community members, or even some local stakeholders—to engage with or use effectively.

A key improvement could have been to simplify and share these expected service standards in a more accessible way. By popularizing and transparently communicating what the service is meant to deliver, these standards could become widely understood and embraced. This would lay a strong foundation for accountability, enabling clients and local stakeholders to hold the system to its commitments and maintain quality post-handover. For example, setting benchmarks for waiting times or service levels would provide tangible measures for communities to assess whether the county is meeting its obligations. Without such clear benchmarks, tracking performance and ensuring accountability becomes much harder.

Innovative Services at Risk Without Clear Agreements and Monitoring

The Empowerment Center, a key innovation of the project, exemplifies the risks faced by services not explicitly covered under the MAT standard guidelines. Built by MSF and now under county health system jurisdiction, the center plays a vital role in supporting PWUDs through social activities and community

engagement. However, its future is uncertain due to the lack of clear agreements defining its use and management.

Rumors about repurposing the space, including its potential conversion into a morgue, highlight the precariousness of the arrangement. While such efforts have so far been halted—thanks in part to county advocacy and community support—there remains no formal agreement ensuring the center's continuation. Even the ownership of furniture and equipment within the space is unclear, adding to the uncertainty Hack faces as it tries to maintain operations.

This ambiguity poses a significant challenge for monitoring. Without defined roles and responsibilities or clear expectations, it is nearly impossible to measure adherence to commitments or hold stakeholders accountable. Monitoring systems rely on precise agreements to track performance and flag risks. When such agreements are absent, innovative but non-standard services like the Empowerment Center lack the protection and oversight they need to sustain their impact.

The case of the Empowerment Center underscores the importance of embedding innovative components into formal agreements during handover planning. Without this foundation, post-handover monitoring loses its teeth, leaving critical achievements of the program vulnerable to being overlooked or abandoned.

What is monitoring for - reporting or accountability?

MSF's monitoring system tracked an extensive array of indicators, focusing on outputs and aligning closely with the organization's internal needs. While this data informed improvements during MSF's tenure, it was a project-centric system that ended with the handover. The significant investment in such a detailed system, knowing it would not be sustained by the center post-handover, raises questions about its long-term value. Why establish a complex monitoring framework if it does not align with what the clinic or future stakeholders will use?

Currently, basic data collection continues, but it appears bureaucratic, and there is little clarity on how it informs action or fosters accountability. A more impactful approach would have been to design a system embedded within the clinic and shared with other stakeholders—one that includes mechanisms like periodic meetings to review indicators or transparency boards to share progress. This kind of collaborative monitoring could ensure the system remains relevant and actionable post-handover, rather than being a resource-heavy tool that fades with the departure of the supporting organization.

Monitoring challenges beyond the clinic: risks for decentralized services

The project's commitment to decentralization significantly extended its reach, enabling services like take-home doses and localized outreach. These services were transformative, particularly for clients unable to visit the clinic regularly. However, the sustainability of these innovations now faces considerable challenges, both in their provision and their monitoring.

A lack of transport and resources has made maintaining these services increasingly difficult—an issue tied to the broader question of balancing ambitions with reality, discussed under Key Driver 2. Without the vehicles and logistical support previously provided by MSF, in-person visits have become rare. This not only restricts the ability to deliver decentralized services effectively but also limits the capacity to monitor their impact. As one staff member explained; "*Our monitoring is limited without in-person visits, so we don't always have complete visibility on their progress".*

This dual challenge is particularly significant. Reduced monitoring amplifies the risk of discontinuing these services because the data needed to demonstrate their effectiveness and adherence to standards is no longer

available. National authorities, who require evidence-based monitoring, may see this as a justification to deprioritize or phase out decentralized innovations like take-home doses.

The cascading effect is clear; without adequate resources for both service delivery and monitoring, the challenges multiply, potentially undermining the very innovations that made the project exceptional. Addressing these gaps requires a robust post-handover strategy that prioritizes resources for monitoring as much as for service provision. By bridging this gap, stakeholders can ensure the long-term viability of decentralized services, safeguarding their transformative impact.

Monitoring needs people - not just systems

Effective monitoring relies not only on systems but also on having dedicated people who can interpret and act on the data. County officers are aware of this. The appointment of a County MAT Coordinator was seen as a pivotal step; **"***Having a focal person is very key in terms of just ensuring there's no service disruption. You know that MAT issues are raised and discussed regularly"*. This role ensures that critical issues are consistently brought into decision-making processes at the county level. The county has also recognized the importance of involving clients in monitoring and linked advocacy efforts – a point that clearly emerged in discussions around the Empowerment Center's role. This is where monitoring efforts strongly link with accountability, as discussed in → *Key Driver 10*, accountability.

Whose perspective - client-centered, participatory monitoring

Clients are uniquely positioned to assess service performance and demand accountability, yet this perspective was largely absent from the project's monitoring approach. A client-centered, participatory system could have brought two key shifts:

- **From project-centered to client-centered monitoring:** Moving beyond measuring outputs and outcomes as defined by the project, to assessing services from the users' perspective, ensuring their experiences and priorities guide improvements.

- **Active participation:** Engaging clients not just as recipients but as contributors to monitoring systems, by being informed about outcomes or actively shaping and evaluating them.

While these approaches were not embedded in the project, local stakeholders—including county officers—recognized their value. For instance, county leadership expressed interest in involving PWUDs in shaping service delivery, acknowledging the potential for these clients to play a more active role.

Moving beyond recommendations: piloting participatory monitoring

The evaluation could have easily stopped at recommending the adoption of participatory monitoring systems, but such recommendations often risk remaining too abstract or vague. Given that monitoring and evaluation (M&E) fall squarely within our expertise, we decided to move beyond theory and pilot a practical approach. This decision was driven not only by the opportunity to demonstrate feasibility but also because piloting aligned with the evaluation's goals, offering concrete insights into the questions we sought to answer.

The system we piloted was designed as a "quick and dirty" tool, proving that even within a limited timeframe, a participatory service monitoring approach can be implemented effectively. The process included:

- **Defining core service aspects:** Through group discussions, key dimensions of clients-perceived service quality—such as communication, trust, and dignity—were identified alongside operational and clinical aspects.

- **Developing a scoring system:** A simple questionnaire was created, allowing participants to score these aspects on a scale from 1 to 5, making it accessible and easy to use.

- **Testing innovative analysis tools:** AI-supported analysis was piloted to process the collected data quickly and uncover trends, demonstrating its potential for use in ongoing monitoring efforts.

This system was not only a proof of concept but also a legacy for the clinic. Stakeholders already showed sufficient buy-in to suggest the system could continue even without MSF's involvement. It also serves as a tangible recommendation for MSF in future handovers, illustrating how a participatory monitoring framework can be established quickly and provide actionable insights.

By piloting the system, the evaluation ensured that this recommendation didn't remain theoretical but instead offered a practical model for enhancing accountability, fostering dialogue, and driving continuous improvement. This approach bridges the gap between evaluation recommendations and real-world application, providing a replicable blueprint for future transitions.

Missed opportunity in benchmarking

The 1-to-5 scoring system used in the Participatory Assessment Tool is a good starting point, offering a practical way to capture user perceptions of care. However, its value depends on what comes next; the conversations it sparks and the clarity it can bring to what perceived quality truly means. Without a formalized reference for what constitutes a "3" (acceptable) or a "5" (excellent), the tool risks being impressionistic. What does a "4" mean for a service? What are the agreed standards for "acceptable" or "ideal" care?

This lack of defined benchmarks becomes even more evident when assessing intangible aspects like "trust" and "respect". These elements are essential to a responsive and dignified service, but they require deeper conversations. What does respect mean in practice? Why might it feel lacking? How can trust be strengthened? Such discussions are not just about improving the tool or the service itself—they are foundational to building constructive, evidence-based dialogue.

By agreeing on what constitutes quality through these conversations, the monitoring process transcends its initial role. It becomes a platform for shared understanding and mutual accountability between clients and providers. This dynamic approach helps create actionable benchmarks and fosters collaboration, ensuring that monitoring not only tracks progress but also actively contributes to shaping a service that reflects the needs and expectations of its users.

Supporting monitoring capacities of local stakeholders

For monitoring to effectively align with accountability to beneficiaries, it is crucial to strengthen the capacities of supported community-based organizations (CBOs). Investment in Hack's monitoring capabilities, for example, could have had dual benefits; not only improving their ability to monitor the clinic but also enhancing their access to additional support and funding. Hack highlighted their challenges in meeting funders' demands for quantifiable metrics, explaining; "*Many funders require quantifiable metrics. That can disadvantage community-based programs where value isn't always measured in hard numbers. We need to advocate for alternative metrics to demonstrate value since securing funding without measurable outcomes*

is tough". This difficulty in assessing intangible aspects parallels the challenges of monitoring softer elements of service delivery —such as communication, trust, and accessibility—within the clinic. A more deliberate focus on these aspects during the project could have helped Hack both monitor these dimensions effectively and develop broader advocacy strategies, ultimately strengthening their ability to sustain their work post-handover.

KEY DRIVER 8: KNOWLEDGE MANAGEMENT AND LEARNING

Capturing and sharing key learnings from the project safeguard knowledge and can inform future MAT clinic operations and handovers.

Knowledge is a vital part of any handover, especially in a care model, yet it often takes a backseat to tangible resources like funding or supplies. While it's natural to ask; "Is there enough money to keep this running?" we should also ask; "Will the knowledge and insights we've gained survive—and make sense—in the future of this service?" A good handover doesn't just preserve knowledge; it ensures that it is seamlessly integrated into the operations of those taking over.

This isn't just about writing reports. It's about actively capturing the lessons that matter, turning them into practices and systems that future teams can use. Capitalization, as a key MSF process, is a chance to do just that: to reflect, codify, and prepare. But to work, knowledge management must be built into the handover itself, so that what's handed over isn't just the tools and resources, but also the expertise and insights to use them well. This ensures that the care model's legacy is not just preserved but continues to evolve and inform its future.

SUMMARIZED FINDINGS FROM PHASE ONE OF THE EVALUATION

Handing over a model of care is about handing over knowledge

A model of care handover should differ fundamentally from standard project handovers through its focus on knowledge transfer. It should aim to influence the entire medical system through three phases: *learning in* (acquiring expertise), *learning during* (adapting and innovating), and *learning after* (sharing lessons). Without transferring this knowledge, facilities may operate but fail to spread improvements through the system.

Relate knowledge to the operational environment.

Knowledge must be captured in relation to operational context and guidelines rather than project-specific, making it applicable for future practitioners and advocacy.

Preserving know-how and highlighting innovations

Projects accumulate both *explicit knowledge* (easily documented protocols) and *tacit knowledge* (subtle operational insights). Small adaptations to practices, often taken for granted, are crucial for care quality but challenging to capture. These insights could have emerged through three approaches: documenting seemingly minor but important operational details (like linking HepC testing to surveillance protocols), engaging stakeholders in discussions about daily practices, and facilitating exchanges between different MAT clinics to identify innovations.

Capture deep-level knowledge

Preserving project essence and culture is crucial for long-term sustainability beyond the surface-level transfer of procedures. [→ *The Handover Iceberg*]

Make experience vivid

Direct experience differs significantly from written reports. Good knowledge transfer effectively conveys expertise through – for example -multimedia tools.

AI can revolutionize knowledge management

AI offers potential for systematic knowledge documentation and sharing, though requiring critical and transparent application acknowledging limitations (not yet leveraged, we experimented in the evaluation).

Knowledge Management and Learning: MSF challenges and achievements

Finding	Summary
Building capacities	Strong investment in "learning in" through training, certification, and on-the-job mentoring.
Learning on the job	While effective, tacit knowledge risks being lost if staff leave; this needs mitigation through documentation.
MSF is sharing learning	The project shared innovations informally and through online events, but learning remains largely internal.
Investment in technical support	MSF chose technical support investment as an opportunity to leverage and share learning.
Anchor learning to MAT guidance	It is important to connect learning to standard protocols for broader resource sharing.
Capitalization as learning opportunity	Staff-led internal process created a strong knowledge-sharing space.
Investment in communication	Communication unit involvement helps capture program architecture and innovation.
Experiment with AI	Evaluation introduced AI documentation possibilities, creating new opportunities.

PHASE TWO FINDINGS

- **The handover itself was a valuable learning experience:** Despite challenges, the MSF handover has become a reference model for other transitions. Many stakeholders observed that they learned a lot in the process and that this experience could serve as a blueprint for future handovers involving the county. The professionalism displayed by MSF staff, their commitment to success, and the collaborative efforts among a diverse group of stakeholders in reaching and executing agreements were significant experiences for many participants to be remembered and applied in the future.

- **Knowledge remains largely tacit:** While the operational skills are retained due to the continuity of staff, much of the knowledge developed through MSF's project remains undocumented and tacit. National MAT guidelines provide a reference framework, but they do not capture the specific innovations and refinements introduced by MSF. To address this gap, the first evaluation report proposed creating a "commentary" on the guidelines—highlighting actionable "tips" and "learnings" to support both operational continuity and advocacy while anchoring these insights to national standards. The capitalisation process, though thorough and reflective, was primarily inward-facing, focusing on MSF's internal experiences rather than serving as a practical tool for the MAT clinic's ongoing needs. Efforts are underway to produce an external report that could address these gaps – not yet completed at the time of the visit.

- **The Risks of Tacit Knowledge and Documentation Gaps:** The prevalence of tacit and internal knowledge poses significant challenges during transitions, leaving the MAT clinic vulnerable to staff turnover and the gradual erosion of practices. Without a comprehensive corpus of expertise or guidance, critical insights risk being lost over time. This lack of documentation also mirrors broader challenges in monitoring and accountability, as both areas lack clear references for best practices. At the project's conclusion, essential elements of an improved model of care—such as qualitative and quantitative

indicators—remained undefined, leaving future practitioners without the necessary tools to sustain and expand on these advancements.

- **Learning is about the how, and the "why":** Effective learning involves not only documenting how changes are implemented but also articulating why they are necessary and impactful. MSF's improvements, such as providing porridge to vulnerable clients, are now viewed as "nice to have" rather than essential and are likely to be discontinued. The rationale behind such measures was neither documented nor adequately researched, leaving the new management with limited justification to sustain them. An observation such as, "*there are other vulnerable groups in the health systems, like pregnant women, who also need similar support. The county would struggle to sustain providing the porridge exclusively to MAT clients, as it is not equitable*", which is difficult to challenge. This reflects a broader issue; MSF's additional provisions, made possible by greater resources, were not leveraged into research or advocacy to check and document impact. As a result, the program risks losing key components that may have been vital to its success – and worth advocating for. Without a clear analysis of which enhancements had a determinative impact, future decision-makers lack the evidence needed to retain and prioritise them.

- **Knowledge will travel with people as they move:** The staffing issue poses a significant challenge as staff, now on permanent contracts within the health system, express interest in moving on—an understandable development. Management is currently able to retain staff but acknowledges the difficulty of finding replacements with the required expertise. As one manager noted: "*Now, with permanent contracts, there's interest in new experiences. Once the county can train more clinicians in MAT, it'll make transitions easier. But at the moment, I can't allow any staff to transfer out without a replacement".*
  These transitions are inevitable, particularly as the county seeks to maximize the use of its staff by deploying them across multiple departments. MAT services, with their relatively shorter patient contact times, are viewed as an area where staff can also contribute elsewhere, further fuelling the likelihood of mobility. All this points to the importance of reducing heavy reliance on the current MAT team. However, while basic training on standard operating procedures (SOPs) can be organized, the deep, specialized knowledge cultivated under MSF's leadership—knowledge that goes beyond SOPs to include the rationale behind practices and a cultural shift toward patient dignity, continuity of care, and holistic support—is far harder to capture or transfer.
  The absence of a standardized "training package" leaves the county ill-prepared to address these challenges. Post-handover strategies, such as targeted spot training, could prove invaluable in ensuring critical know-how is preserved within the clinic. However, this raises a crucial question; what defines the clinic's excellence, and what knowledge and practices truly matter for it to remain a "centre of excellence"? Without clear guidelines on what made the clinic exceptional and how these elements can be realistically retained, the sustainability of its high standards is at risk.

- **A demand for more training:** A strong demand for more extensive training efforts was reiterated during the transition, emphasizing the need to mitigate risks associated with turnover. Expertise concentrated solely within the MAT team presents vulnerabilities when key staff leave. As one stakeholder noted; "*For training, we should include county employees, not just program staff*". A wider pool of skilled personnel reinforces the sustainability of the program.

- **Learning thrives within learning organizations:** Learning is more than a process—it is a culture that must be deeply embedded in an organization's global modus operandi. In Kiambu, and based on interactions with other stakeholders, it appears that the approach taken reflects a broader trend within the MSF family. Across the organization, there is a tendency to prioritize internal reporting and documentation to meet MSF's operational needs, rather than focusing on creating resources that directly support the future knowledge needs of local clinics and stakeholders. This systemic focus on internal processes risks limiting opportunities for shared learning and collaboration that could ensure the sustainability and adaptability of initiatives like the MAT clinic.

- **Reaching external audiences:** The project did not establish accessible outlets where aggregated knowledge could be shared externally, reflecting an emphasis on internal knowledge sharing through platforms like SharePoint. For outsiders, the MAT experience is primarily visible through a handful of webpages and press releases (e.g., MSF Kenya's milestone announcement or Doctors Without Borders' holistic care overview). These focus more on external communication than fostering learning or practical replication.

- **Making learning a *collective* endeavour**: A significant strength of the Kiambu programme was its recognition of capitalization as a collective effort. By involving staff in the creation of the capitalization report, the programme was able to capture experiences and knowledge that might otherwise have been lost as staff transitioned out. However, could this process have been expanded to include more contributors beyond MSF? Engaging a broader group of stakeholders might have enriched the outcomes and ensured greater inclusivity. As one participant noted; "Engaging stakeholders in documentation allows real-time adjustments and shared ownership of strategies, improving transitions". This approach underscores the value of collaborative learning—not just as a means to document experiences, but as a way to build shared understanding and ownership that strengthens continuity and adaptation.

- **Making learning an *ongoing* and strategic endeavour**: The capitalization process could have been more effective if it had been approached not as a "final document" but as an ongoing process of harvesting and sharing knowledge. This approach might have included staff, the county, and even PWUDs themselves, fostering a more inclusive and dynamic learning environment. Continuous facilitation of learning would have supported the capture of tacit knowledge and its effective transitioning. For instance, clearer procedures documenting "soft" aspects—such as communication norms or approaches to patient support—could have been invaluable for planning a better transition.

- **Learning at the time of AI:** At the time of AI, the potential for collaboratively generating and sharing knowledge expands immensely, offering new opportunities for innovation and accessibility. The positive reception from staff when such tools were introduced suggests they are indeed worth experimenting with.

All the above calls for MSF as a whole to deeply reconsider its approach to learning. Knowledge should be recognized as a key resource—something to be collectively generated, documented, and shared—not as an ancillary product of operations. However, the processes to facilitate this remained inadequate and outdated. In this project, the country team simply responded to requests for conventional reporting, and most efforts to capture change remaining internal and output-oriented. Sharing did occur, such as through a very insightful series of online meetings. But these were limited to internal audiences and were difficult to access later.

This represents a significant missed opportunity. The project produced a wealth of valuable learning that could have influenced practices far beyond its immediate scope. For instance, operational insights could have been used to advocate for systemic improvements, inform other MAT centers, or shape future policies. However, the absence of a structured, outward-facing knowledge-sharing mechanism has made this learning challenging to transfer.

At the same time, the advent of AI opens new horizons for collaboratively generating and sharing knowledge. AI-powered tools can facilitate more systematic documentation, real-time analysis, and dissemination of insights, making knowledge accessible and actionable for diverse audiences. This potential reinforces the need for MSF to adopt innovative approaches to learning and sharing.

As raised earlier, is excellence in such initiatives defined by "having more resources" or "having more knowledge"? For a center of excellence, making learning and knowledge central is non-negotiable. MSF must

reflect on how to move beyond internal, static processes and adopt more dynamic, inclusive strategies that not only capture learning but also enable its application. By doing so, MSF could not only sustain the legacy of its projects but also amplify their impact.

KEY DRIVER 9: POST-HANDOVER INFLUENCE AND SUPPORT STRATEGIES

Defining MSF's ongoing role after the handover ensures continued support and maintenance of standards.

Can the handover of a center of excellence be simply “disengagement”? While the transition in Kiambu marked an operational shift, the project’s ambitions extended far beyond service delivery. It was designed to model care for people who use drugs and drive advances in MAT and harm reduction practices across Kenya.

A successful handover is then not just about maintaining services—it’s about ensuring that the broader lessons, innovations, and advocacy potential of the program are sustained. This means moving beyond Kiambu, using the experience to inform national replication and policy improvements.

This moment also offers an opportunity to rethink handovers themselves. For MSF, the challenge lies in finding the right balance; staying influential enough to ensure these ambitions are realized while stepping back to allow local actors to lead. Post-handover strategies can include technical assistance, consultative guidance, or advocacy partnerships—forms of support that extend influence without retaking operational control.

SUMMARIZED FINDINGS FROM PHASE ONE OF THE EVALUATION

Technical support

MSF committed to three months of light technical support post-handover for addressing immediate management transition issues and completing capitalization.

“Consulting” role

MSF could shift to advisory role sharing expertise through activities like "MAT clinic health checks," focusing on persuasion rather than control and building on local stakeholder relationships.

Hands-on support in mini projects.

Targeted "mini projects" could address specific clinic challenges post-handover, requiring strategic choices about where to remain involved versus step back.

Indirect support - supporting HACK and other allies:

Supporting PWUD initiatives like HACK offers avenue for continued influence, balancing assistance for national-level advocacy with respecting organizational independence.

Advocacy

The project aimed to promote PWUD-friendly models of care through policy influence at multiple levels. Since MSF developed a model rather than just providing services, advocacy work needs to continue post-handover through local monitoring of agreements, national engagement in MAT forums, and regional knowledge sharing.

Post-handover influence and support strategies: MSF challenges and achievements

Finding	Summary
Provision of technical support	Commitment made but the specifics are unclear; stakeholders request a defined support menu.
Explore post-handover support options	Need to consider non-traditional MSF support roles like consultation and mini-projects.
Long term support for the model	Handover focus too narrow given broader goal of influencing national care practices.
Risk materialization	Must monitor clinic performance to manage reputational risks and PWUD disappointment.

PHASE TWO FINDINGS

The first phase of the evaluation highlighted several possibilities for longer-term engagement, discussed with key stakeholders. Since the official handover, MSF has stepped in with targeted post-handover activities to address gaps. These included extra support to cover transition issues, like medicine supplies, three months of technical assistance, and continued backing for the PWUD CBO, which also kept the Empowerment Center running. These actions helped soften the abruptness of MSF's exit and were seen as making a real difference in maintaining the quality of the MAT services.

Technical support

The technical support provided by MSF post-handover was not just critical—it was indispensable due to key gaps in the transition timeline. Although the clinic's operations continued under the county's supervision after the handover in July, the incoming partner, LVCT, had not yet taken on an operational role. There was communication, however, the lack of operational overlap during the transition limited opportunities for hands-on collaboration and alignment between MSF and LVCT. An extended, possibly lighter, period of technical support from MSF might have better bridged this gap, ensuring that LVCT's leadership was more effectively aligned as it transitioned from being a partner in community outreach to a more active role in the overall management of the clinic.

MSF's technical support emerged as a highly respected and valued intervention. As one county officer acknowledged; "*We thought we were prepared, but when the handover happened, we realized how much we still needed MSF*". The respect and trust commanded by MSF staff made involvement a great asset during this uncertain period, frequently praised; "*[MSF's] technical support has been critical... [keeping] the team grounded during the transition*". Its steady presence allowed the team to navigate staffing changes, to deepen relationships amongst stakeholders and to maintain operational stability: "*[it] helped my team stay grounded while we adjusted to the changes*". Clinic managers also appreciated the support: "*The three months of technical support from MSF was essential. Supplies, especially medication with long shelf lives, were critical. We have not faced stockouts for core treatments. [xxx] was very supportive, even sharing reports and data with us*".

However, the temporary nature of the technical support left lingering uncertainty among staff about the future: "*We need clarity on what happens after these three months. Is there a longer plan for technical assistance?*". Several respondents suggested that extending the support period could have addressed the program's complexity more comprehensively; "*A six-month light transition period with technical assistance would allow more time for oversight and questions, especially on a complex program like this one*".

In hindsight, the technical support was clearly a vital bridge during a challenging phase. The respect and trust MSF staff commanded allowed them to provide meaningful continuity, even as structural gaps complicated the transition. This highlights the importance of deploying trusted and experienced personnel to smooth handovers, especially in contexts requiring sustained accompaniment.

Advocacy options

Advocacy remains crucial to protecting the gains made by the MAT program, especially in ensuring that people who use drugs (PWUD) are fully supported within Kenya's health system. MSF's vision has always aligned with **universal healthcare**, but this goal remains far from reality in Kenya. Vulnerable groups like PWUDs are not yet fully covered by the national health system, and the situation became even more challenging with the sudden shift from NHIF to SHIF during the handover.

The original plan was to transition PWUD patients into the **national health insurance** system to ensure their long-term care. However – precisely at the time of the handover – the national insurance system underwent a comprehensive overhaul in Kenya, disrupting the planned attempt at coverage and leaving many patients without the protection they needed. A clinic manager explained; "*This last-minute change has created a major shift. It will take time to address issues around key populations and inmates. They've mandated that all inmates be registered, but the system requirements make that nearly impossible. However, if they do follow through with the MAT supply plan, it would benefit us greatly. Plus, if we can sort out the registration for the key population, they could access specialised services".*

These challenges highlight why continued advocacy is necessary. Without it, there's a real risk that PWUDs will remain excluded from critical services provided free of charge when MSF was running the clinic, as part of its vision of a one-stop-shop, providing integrated care. Advocacy is needed to push for a system where vulnerable populations, like PWUDs, are fully included in national health strategies.

Advocacy must also address another key component of the project at risk of being lost, such as **take-home doses**. While they benefit patients, they have faced growing regulatory resistance that MSF could elude, having more recognition and also more means to overcome the logistical challenges of delivering and monitoring take-home doses; "*Right now we're having some issues with take-home doses…the Ministry of Health, through NASCOP, is now starting to raise concern…so I don't know, I think it just calls again for a lot of lobbying".* Without consistent advocacy, policies and practices that make care more accessible to patients may be rolled back, undermining progress.

Light support: the case for sustaining HACK

Transitions often benefit from small, focused areas of support—self-contained and standalone elements like occasional training, mentorship, or targeted mini-projects that address critical aspects of a program. These allow responsibility to shift while still providing reinforcement for areas requiring additional attention. However, in this case, with the program transitioning to a new partner, LVCT, such mini-projects may not be the most effective approach (even if there would be a demand for it, for example, of training for staff).

The exception is the support for HACK, the organization established by MSF to work with PWUDs and manage the Empowerment Center. HACK's role in promoting accountability, fostering community engagement, and supporting the PWUD network makes it a unique and valuable element of the program. Continued support for HACK aligns with the program's goals and could be structured in a way that complements LVCT's work rather than overlapping with or duplicating it.

Why does support for HACK makes sense? HACK's contributions extend well beyond the immediate scope of the program. It provides vital peer-led support to PWUDs, maintains the Empowerment Center as a safe and

stigma-free space, and fosters community engagement through activities like cleanup campaigns and sports events. As HACK representatives noted; "*We've kept the Empowerment Center open... it's become a safe space for patients. But our funding ends in December*".

HACK is a relatively new organization, and prematurely ending funding and support would place both the group and MSF's investment at risk. The team is understandably anxious about its future, knowing that organizational development takes time—often more than the transitional periods MSF allows. Supporting HACK isn't just about securing past investments; it's about recognizing the particular vulnerabilities of its members. With PWUDs, setbacks can hit harder, and the stakes are higher for maintaining the organization's stability.

Continued support for HACK also makes strategic sense. It ensures that the Empowerment Center—a core aspect of their work—remains operational, while helping the organization transition into a more stable, long-term setup. Even minor involvement, such as periodic mentorship or small grants, could make a meaningful difference. Supporting HACK makes strategic sense, but it will also require collaboration with LVCT to ensure complementary roles. MSF's light support could include appointing a Community Engagement Manager to provide ongoing guidance without significant costs. Just as critical, though, is ensuring that HACK has the ability to refer back to MSF when facing challenges or risks of being sidelined. *And always remembering that, as much as they are empowered and active, HACK are still clients of the MAT service, and being part of the organization is as much activism as it is therapy.*

KEY DRIVER 10: ACCOUNTABILITY (WITH PWUD AT THE CENTRE)

Establishing clear expectations and agreements helps guide the handover process and sets the foundation for future accountability, and systems that empower PWUDs to hold service providers accountable.

A handover cannot be an act of faith, relying solely on hope that agreements will be respected. Agreements must also adapt to new challenges— with the consent of all parties.

Transparent sharing of agreements is a vital first step to keeping the service on track. However, accountability goes beyond simply sharing agreements. It involves ensuring that agreements are respected and remain meaningful to those affected by them. Accountability rests on relationships and participation. It is about creating processes where diverse stakeholders, with varying power and roles, can take charge and respond to each other about their responsibilities. And of course, accountability might include – first and foremost - the clients of the service.

SUMMARIZED FINDINGS FROM PHASE ONE OF THE EVALUATION

Clear, documented commitments and agreements (possibly monitorable): Commitments are often unclear due to hesitancy, uncertainties, or poor capacity for formal agreements. MSF has worked to document discussions transparently but could strengthen this through innovative tools like structured records, meeting videos, or public summaries. These approaches ensure that agreements are understood and accessible, even when traditional minutes fall short. Linking commitments to measurable indicators and follow-up mechanisms is crucial to prevent them from becoming hollow promises.

Transparency, and communication of such agreements: For accountability to work, commitments need to be shared widely—not just among decision-makers but with all stakeholders. Transparency during the handover has been limited, as seen with staff uncertainties caused by unclear communication. MSF can set a positive example by using accessible formats like infographics, videos, or simplified local-language materials. Sharing agreements more openly, even in abridged forms, can build trust and enable community-based monitoring of commitments.

Spaces and protocols for negotiation: Accountability isn't static; it must adapt to changing circumstances. Agreements should allow room for renegotiation when needed. To enable this, MSF should focus on creating clear, inclusive coordination mechanisms that allow joint decisions to be made transparently. This avoids siloed operations and strengthens collaboration among all actors.

Spaces for redress - empowering accountability demands: When things go wrong, accountability relies on the power and legitimacy of those affected to demand redress. MSF has taken a key step by supporting the PWUD CBO, HACK, giving PWUDs a voice to hold systems accountable. However, HACK remains underutilized in this role. Strengthening its involvement and leveraging Kenya's growing rights-based approach can ensure a more participatory and responsive accountability system.

Accountability mechanisms (with PWUDs at the Centre): MSF challenges and achievements

Finding	Summary
Fuzzy agreements	Handover agreements contain grey areas, risking weakened accountability. Clear SOPs and capitalization efforts can help fill these gaps. Technical support may also address this issue.
Sharing agreements	MSF has an opportunity to model transparency by sharing agreements (abridged if necessary). A dedicated communication strategy is needed, as current practices (e.g., undisclosed MoUs) fall short. Community-based monitoring, especially through HACK, could ensure accountability.
Capitalization as an opportunity	The capitalization process could improve transparency by creating and sharing documentation in accessible formats. Currently, significant project reports are not publicly available.
Challenges of accountability in handover	MSF's withdrawal limits its direct role in ensuring accountability. However, advocacy, consultation, and civil society support could maintain influence. A shift from a managerial to a "commons pool" culture may be needed.
Supporting PWUD organization	HACK's creation was a promising step for accountability, but it remained marginal during the handover, limiting its legitimacy and impact. Strengthening its role is crucial for future responsive.

PHASE TWO FINDINGS

Previous findings highlighted the need for **clear, monitorable agreements shared transparently** with all stakeholders, including clients. In this handover, **documentation was weak**—even for those who participated in the process. Without a clear record, accountability was already compromised.

This gap was even more pronounced for those excluded from discussions, the PWUDs or their representative organization, HACK. Without transparent decision-sharing, **PWUDs were left completely out of the loop**. This not only sidelined their role but also **weakened their ability to demand accountability** and ensure services met their needs.

Clear documentation and broad sharing aren't just nice-to-haves—they are critical for accountability. They ensure decisions can be tracked, questioned, and improved by **all stakeholders**, not just those with more power.

Recognizing the importance of documentation and accountability for long-term sustainability—and the opportunities **AI** now offers to simplify these processes—the **evaluation ran practical experiments** to demonstrate what this could look like. The goal was to show how documentation and transparency can be embedded into programs in a way that is actionable and impactful.

These areas—transparency in decision-making and accountability—are often **seen as "soft" or secondary concerns**. This perception leads to them being **sidelined within the program and, later, in the handover**. They are viewed as vague concepts, not as technical disciplines with concrete tools and approaches.

This needs to change. For MSF, **embracing transparency and accountability as technical specializations** could transform how these aspects are integrated into future projects and handovers. By treating them as core areas of expertise, backed by modern tools like AI, MSF can make them practical, impactful, and central to sustainable outcomes.

Shortcomings in documentation

One consistent issue during the Kiambu handover was insufficient documentation, which made tracking the process and sharing decisions difficult. Agreements often remained informal discussions in the room and would lead to understandings that were not formally documented or transparently shared beyond internal minutes.

This informality is a challenge, especially when working with government institutions that might find it hard to commit fully. The previous evaluation highlighted how a grey area often exists between what is discussed and what is formalized. Without clear records, it becomes harder to track progress, enforce agreements, and maintain accountability.

A culture of accountability, supported by practical tools for tracking and following up on decisions, could help bridge this gap. Comprehensive, shared records are essential for sustaining operations and ensuring that clients can hold the system accountable. Addressing these documentation gaps is critical to fostering transparency and achieving effective, sustainable transitions. It can help to:

- **Track decisions throughout the process**: Shifting negotiations during the Kiambu handover created confusion. A shared, evolving document could have kept plans consistent and stakeholders aligned.

- **Provide a clear access point for documentation**: Documentation was scattered, with no central agreement platform. Fragmented records in internal minutes were hard to access and use, complicating efforts to locate and follow key decisions.

- **Create a reliable reference for incoming partners**: Lack of a consolidated handover document might challenge the transition to the new incoming partner, creating discontinuity and gaps on critical issues.

- **Ensure decisions are maintained through leadership changes**: Frequent leadership turnover made formal records even more crucial. For example, a NASCOP leader proposed funding HACK, but without documentation, the idea was lost when leadership changed. Informal agreements proved too fragile to withstand such transitions.

- **Strengthening accountability with clients:** Transparent sharing of information about services is the cornerstone of client accountability. It is a key component of rights-based services and will be explored further in the next section.

Experiment 1: AI for clear handover documentation

The lack of clear records was a major challenge for the new MAT coordinator. Luckily her experience in the programme and her deep involvement in the handover process, along with her role in capturing meeting minutes, gave her a strong understanding of the discussions and their context. This context made a significant difference—reading minutes without it can be frustrating and often useless.

However, she quickly realized the existing minutes were not practical for day-to-day use. She neither had the authority nor the time to turn them into something actionable and comprehensive. This is where AI came into play, transforming the process entirely.

Using AI, we were able to produce reference documents that were clear, actionable, and easy to work with—achieved in a fraction of the time it would normally take. Her contextual knowledge was essential in validating the AI-generated results, ensuring accuracy and relevance.

- **Minutes are not enough:** Minutes alone don't meet the needs of a handover process. They must be transformed into documents that are sharable, actionable, and authoritative. AI offers an efficient way to achieve this transformation.

- **Validation is Key:** AI can act as a smart scribe, producing clear drafts in seconds, but it's only a tool. The critical step is the validation process, where documents are reviewed, confirmed, and agreed upon by stakeholders. This ensures they are reliable references for accountability.

- **AI as a game-changer:** AI makes creating structured, usable documentation seamless. It's a tool that should be seriously considered for future transitions, offering efficiency and clarity without compromising accuracy.

This experiment highlights how AI can simplify the complex and often overlooked process of creating effective handover documentation. With proper validation, it can play a transformative role in ensuring accountability and transparency.

Mechanism for client-driven quality and satisfaction checks and accountability: accountability as empowerment

MSF, with the county's support, excelled in creating a network of key stakeholders. As one government officer noted; "*One area where MSF particularly excelled was in communication. They ensured that when they decided to extend their support, everyone was fully informed, which is not something all NGOs do*".

However, decision-making around the handover fell short in some areas, notably by excluding certain actors—most crucially, PWUDs themselves. This was a missed opportunity, especially considering MSF's significant investment in empowering PWUDs through initiatives like the Empowerment Center and the creation of a representative organization for clients. Unfortunately, their involvement remained operational, focusing on aspects like running the Empowerment Center and connecting clients to livelihoods or community initiatives. The potential to leverage HACK - the CBO MSF itself had created - for accountability was largely unexplored.

Future handovers must engage clients much more closely—not only by including them in handover negotiations, where they could provide valuable input, but also by ensuring transparent communication about agreements. Clients should also be supported in monitoring these agreements and given platforms to discuss service satisfaction directly with providers and duty bearers.

If services aim to be rights-based, these mechanisms are not optional—they are essential.

The Participatory Assessment Tool

To avoid vague recommendations or hazy expectations, the evaluation took a practical approach by prototyping a client-driven accountability system. The goal was to demonstrate the feasibility of implementing such systems—currently absent in the program—to ensure better transparency, trust, and ownership of the service. Effective service checks require deliberate processes and tools to enable meaningful accountability. Four key components are essential:

1. **Clarity of service standards:** The foundation of any accountability system is a clear agreement on what defines a good standard of service. Of course, MAT guidelines are in place, but they are too complex to be monitorable by users —or even by the service in every aspect. Many MAT guideline standards, such as ensuring patients are "treated with dignity," remain abstract and challenging to translate into specific, observable practices. This creates a gap between the guidelines' intentions and their practical assessment.
   To build the Participatory Assessment Tool, we quickly explored what aspects of the service mattered to clients in a focus group with HACK. However, this process was unilateral—i.e., only involved HACK, not other stakeholders—and was not refined in further discussions, leaving room for evolution.
   Satisfaction aspects should evolve over time to better reflect service realities. For instance, "*communication with PWUDs*" needs clearer parameters: what does it include, and how can it be assessed? Similarly, for childcare, what specific elements must be present for it to meet acceptable standards? Participatory processes can help address these gaps by fostering a dual understanding: for

clients, they offer clarity about what standards entail and what they can expect; for providers, they push for a clearer articulation of abstract ideas, such as what "dignity" means in practice. These discussions not only refine the tool but also build understanding and accountability through shared ownership, ensuring that the tool evolves alongside service realities.

2. **Mechanisms for evidence collection:** Evidence collection must be structured and practical. In this case, a questionnaire was used as a starting point due to its simplicity and ease of administration. However, other options, such as periodic discussions on specific service aspects, structured feedback mechanisms at delivery points, or focus groups to explore survey findings in depth, should be considered. A combination of tools ensures a more robust and comprehensive picture of quality.

3. **Analyzing and sharing results:** The power of evidence lies in how it is analyzed and shared. Clear and compelling presentations strengthen conversations and drive improvements. Simple visuals and metrics—such as quality scores, satisfaction ratings, and trends—help stakeholders quickly grasp findings. Disaggregating data ensures that the specific concerns of the most vulnerable clients are highlighted. The evaluation revealed that this was a challenge for HACK. Before conducting the assessment, we reviewed their previous work consulting other stakeholders. MSF had already built HACK's capacity to run focus groups, which they used effectively to inform their community work with new evidence and insights, but documentation of analysis – from note to reporting or presentations – had remained a bottleneck. So, when it came to analyzing a sizable questionnaire, the time and expertise required would clear exceed the capacity and resources of a small organization like HACK. To address this, quick experiments with AI were conducted during the development of the questionnaire and more extensive ones within the companion report. Having prototyped different options, the next step would be to choose the best formats to share analysis and findings with local stakeholders.

4. **Platforms for discussion:** Quality checks are meaningless without mechanisms to share and discuss findings among stakeholders. Identifying the most effective platforms for these exchanges is crucial. For HACK, potential options include: periodic meetings with the MAT coordinator, communication with county focal points, participation in the hospital administration discussions on service quality, and presentations to patients and staff at the MAT center. The evaluation did not test such platforms, but creative options—such as inviting HACK representatives to a Zoom discussion about the tool—could be a first step. The real difference, however, will come from establishing stable, local platforms for dialogue. These platforms ensure findings are actionable and drive sustained accountability. Documenting the outcomes of these discussions would also add another layer to building a robust accountability system.

Experiment 2: AI for supporting service checks processes

Health service checks have long been a tool for ensuring accountability to service clients and have been used in Kenya as well. These checks rely on mechanisms for scoring services—such as questionnaires or focus group discussions—where service quality is collectively assessed, and findings are shared with providers to inform improvement. While this process may seem straightforward, conducting effective participatory assessments requires significant time and capacity to gather, analyze, share, and document findings and agreements. This is where AI can become a game changer.

- **Evidence collection:** In collaboration with HACK, a questionnaire was developed using an online platform that doesn't yet rely on AI but is likely to incorporate AI features soon. For example, the platform already allows participants to record comments, but HACK lacks the time to manually

transcribe these. Voice-to-text technology, which is expected to be built into such platforms, would significantly enhance the collection of qualitative insights. Additionally, when focus groups are used to discuss and deepen findings, AI can provide concise summaries of discussions. This offers a far more effective alternative to conventional note-taking, saving time and ensuring that insights are systematically captured and ready for review.

- **Evidence analysis and sharing:** This is where AI shows its greatest potential. While basic insights can be generated directly from the questionnaire platform, creating detailed visualizations, interpreting data, and communicating findings effectively require advanced analytical skills and considerable time—resources that small, busy CBOs like HACK simply don't have. The pilot highlighted AI's ability to overcome these bottlenecks. AI tools can quickly organize data into requested templates using pre-set prompts (provided in the quality document). Beyond that, AI offers more dynamic and organic exploration of the data. For instance, it can handle specific queries such as: "*Which population finds this aspect of the service most challenging?".* This level of tailored analysis is revolutionary for participatory assessments, making processes faster and more insightful. The pilot report demonstrated how such capabilities could significantly enhance data interpretation and communication.

- **Platforms for discussion and documentation:** Once results are ready for discussion, AI can streamline the preparation of minutes and documentation. For example, a final speaker could summarize key points using a voice-to-text app, generating a draft document that participants can quickly validate and sign. While we couldn't test this step directly, HACK did experiment with using AI tools like *Otter* to summarize their internal discussions. These early trials showed the potential for AI to reduce the burden of documentation while maintaining accuracy and accessibility.

By incorporating AI into the evidence collection, analysis, and documentation stages, quality check processes can become faster, more efficient, and more accessible for small organizations. These innovations address long-standing bottlenecks that could otherwise hinder progress, making accountability more actionable and impactful. The pilot report offered a glimpse of what is possible, paving the way for further integration of AI into service participatory assessments.

What would be needed to put a such s system in place?

Implementing a robust client-driven accountability system is feasible but requires more than technical solutions. The real challenges lie in capacities, platforms, mindsets, and power dynamics**:**

- **Capacity of the clients to own and run the system:** HACK has gained significant capacity to consult peers, largely through MSF's support. Training on focus group facilitation, for instance, has strengthened their ability to gather insights and become more representative—a key element of accountability. The pilot demonstrated that HACK already possesses the foundational skills to run a system like this.

- **Platforms for dialogue:** The absence of platforms where findings can be discussed and PWUDs recognized as a legitimate counterpart has been a missed opportunity. During the handover, HACK was neither consulted nor presented with findings, sidelining their role. Building such platforms must be integral to ongoing monitoring and transition planning. Currently, monitoring efforts are limited to basic performance metrics, and MSF ceased data collection at the point of handover. A better approach would involve establishing platforms during the program's lifetime, enabling seamless integration into the handover. For example, these could include periodic meetings with MAT coordinators, discussions with county focal points, or regular reviews with hospital administrators. Such platforms could have set the stage for HACK to engage meaningfully with other stakeholders.

- **A Shift in mindset:** For an accountability system to succeed, stakeholders must view it as part of daily operations rather than an external add-on. This requires a virtuous cycle of commitment. **Service providers** must be willing to dedicate time to listen and act on findings. **Clients** must remain motivated to lead analyses and have the resources to do so.
  The evaluation highlighted that MSF's commitment to accountability cantered on clients was limited. For example, MSF lacked mechanisms for service satisfaction checks within its own programme informed and accessible by the client, a significant gap for an organization that had demonstrated such a strong commitment to empowerment and dignity. These mechanisms could have strengthened client empowerment and paved the way to make accountability a more central part of the program's legacy. Building such mechanisms gradually during the program would have normalized their use, making post-handover implementation far easier.

- **Power and recognition:** Accountability ultimately rests on power dynamics. While HACK has shown great potential to advocate for service quality, their capacity to influence relies on external validation and backing. A small but telling example—witnessed during the evaluation—illustrates this challenge; during an open day, community visitors were denied entry to the centre by security, despite their attendance didn't violate any rules. The issue was only resolved because MSF staff were present to intervene. This incident raises concerns about whether HACK has the authority to address such issues independently. Without mechanisms to back their role and ensure agreements are respected, HACK's ability to enforce accountability remains limited. Moreover, while stakeholders recognize HACK's importance, their role overlaps with that of LVCT, the clinic's new partner. This overlap raises questions about whether HACK will be fully recognized or sidelined. As one member of HACK explained, "*In Mombasa, we saw MAT clinics with multiple CSOs supporting them. Here in Karuri, LVCT has been the main one. But maybe HACK could step up and fill gaps. We have local knowledge, and people trust us because we're peers. If we could partner with LVCT, or take on some of their work, we could reach more clients, especially those who are vulnerable".* The handover could have been a moment to define and share responsibilities for service accountability. However, leadership gaps left this opportunity unrealized.

- **Incentives for participation:** Even if HACK monitor clients' satisfaction and organizes events, attracting participation remains a challenge. Local dynamics often require small incentives to secure engagement, especially from leaders or Ministry of Health staff. As one HACK member observed; "*Just getting local leaders and Ministry of Health staff to attend events can be tough if there's nothing in it for them. People expect at least a small token. Without that, we lose respect and turnout".* Established, routine platforms could have mitigated this challenge by normalizing participation over time.

Clients of the MAT program care deeply about the service and are invested in preserving its quality. They represent MSF's strongest allies in maintaining the program's legacy. As HACK expressed during the evaluation; "*We don't want this to be a one-way evaluation. We want to show that we're capable of running our own assessments, and your support would give it more weight. That's what we're aiming for—showing that HACK is taking the lead here".* By empowering HACK and ensuring their integration into a broader accountability framework, MSF can reinforce the program's sustainability and amplify the voices of those who rely on its success.

AN AI ASSESSMENT OF ACHIEVEMENTS ON KEY DRIVERS

As a way to summarize findings, I asked AI to score achievements against the Key Drivers identified in the evaluation. This was also a bit of an experiment—to check whether the chapters communicated the essence of the findings effectively and to see if an external lens could highlight any blind spots or areas needing clarification.

At first glance, the scores might feel a bit severe. After all, the service is running, the transition avoided catastrophic disruption, and there is evident commitment from stakeholders. That's no small feat, particularly in such a resource-constrained environment. But the scores aren't meant to diminish these successes—they're a tool to identify pressure points. They highlight specific areas that, while not critical to basic functionality, are essential if we're aiming for the full potential of what this service could be.

For instance, accountability to clients—the people this service is ultimately for—was an area flagged as needing much more clarity and structure. Similarly, while operational continuity was achieved, some cultural and systemic elements that underpin quality care risk being lost without further integration. These aren't failures—they're opportunities to push beyond "just running" toward a service that thrives sustainably and delivers excellence.

Pinpointing what matters The project identified and preserved key elements of excellence, such as operational sustainability and the clinic's culture. However, these were not fully formalized or clearly conveyed during the handover, limiting the ability of new stakeholders to integrate these effectively. Capitalization efforts were valuable but too late to influence the process meaningfully.	**Medium**
Reality check There was a clear understanding of resource disparities and sustainability challenges, but insufficient attention was paid to addressing compromises or prioritization. This left some gaps in ensuring the program could adapt to post-MSF realities.	**Medium**
Strategic foresight and phasing While retaining staff and ensuring operational continuity were strong achievements, the late start in planning and rushed timeline hindered readiness. A phased approach and stronger integration from the start could have improved outcomes.	**Low to Medium**
Adaptiveness MSF demonstrated flexibility in operational adjustments but did not embed sufficient mechanisms for adaptation into the handover process. The absence of contingency planning and co-management strategies reduced the ability to respond effectively to evolving challenges.	**Medium**
Stakeholder engagement and ownership transition County-level ownership was strong, with clear pride and responsibility for the project. However, engagement with community members and PWUD representatives was minimal, which weakened inclusivity and reduced shared accountability.	**Medium to High**
Cultural and operational alignment The transition highlighted the tension between MSF's high standards and the receiving organizations' capacity to sustain them. While operational alignment was partially achieved, sustaining MSF's cultural and quality aspirations proved more difficult.	**Medium**
Performance monitoring for handover Monitoring systems were not integrated into the handover process, and the lack of consistent performance tracking hindered adaptive management. This limited accountability and oversight during the transition.	**Low**
Knowledge management and learning The project generated valuable insights but did not fully leverage them to inform the handover. Lessons learned were not structured to ensure they could be applied effectively by stakeholders to sustain or adapt the clinic's success post-handover.	**Low to Medium**
Post-handover influence and support strategies Short-term technical support ensured continuity and addressed immediate challenges. However, there is uncertainty about whether MSF's long-term influence will persist, particularly in terms of advocacy and strategic guidance on systemic issues.	**Medium**
Clarity of commitments and accountability mechanisms Accountability mechanisms were generally weak, with no clear structures ensuring clients could hold stakeholders responsible. Accountability to clients—the primary beneficiaries—was notably absent, reflecting a significant gap in governance during the handover.	**Low**

What worked? What could have been done better?

The findings from the previous visit identified strong and weak points in the handover process, which were largely confirmed by the second phase of the evaluation. As they align closely, they are not extensively readdressed here. However, a few areas noted as challenges in the earlier report showed signs of improvement and are briefly highlighted below.

What went well?	What could have been done better?
• Learning from past experiences. • A tangible legacy: dignified buildings. • Ensuring stakeholder buy-in. • Investment in staff capacities and attitudes. • Creation of excellence and a sense of pride. • Building ownership and confidence. • Successful advocacy. • Investment in the community side and PWUDs. • A context-aware project. • Data protection and legal involvement. • Provision of technical support.	• **Early transition planning**: While delays persisted, starting 1.5 years before closure marked a step forward compared to past projects. • **Gradual transfer of control**: MSF's provision of technical support post-handover helped ease the transition, though control transfer remained abrupt. • **Joint recruitment and salary alignment**: Recruiting medical staff directly under MoH worked well, ensuring smoother integration. This part works well because the salary has been the same and remained the same. Also recruitment of all positions currently working in the MAT was done jointly with MOH. • **Managing staff anxiety**: Despite late retention confirmations, staff remained committed, reflecting strong relationships and pride in their work. • **Transitioning management, leadership support**: Even with leadership shifts, most staff were retained, ensuring service continuity with MAT oversight. • **Secure at-risk practices**: Efforts to flag vulnerable practices were proactive, though contingency plans could have been stronger. • **Accountability, communication, and feedback loops**: While there was close engagement with core stakeholders, broader documentation and transparency measures were weak. • **Partnership challenges**: While struggles persisted with LVCT Health, MSF's capacity-building efforts and ongoing dialogue for post-handover kept the partnership functional. • **Involvement of PWUDs as active actors**: Sensitization efforts reflected growing recognition of their role, but active participation remained limited.

The previous report listed the most evident loose ends of the handover process. These are not necessarily negative aspects or signs of failures, but rather a compilation of minor and major issues that require close attention – and were emphasized by the stakeholder, raising alarm bells. The following section explains what has happened since:

Loose End	What was the concern anticipated?	How things turned out
Decentralization efforts	Decentralization improved accessibility but was challenging to maintain. Concerns included supervision post-handover, logistical challenges like methadone delivery, and lack of spaces for social activities in decentralized clinics.	Decentralized clinics faced logistical challenges, including methadone delivery and home support, which were harder to coordinate due to resource constraints. However, the appointment of a MAT coordinator holds potential to address these issues by ensuring supervision and more effective resource reallocation.
One-stop shop	Risk of fragmentation in services, with comprehensive care potentially becoming siloed. Integration with	Services showed signs of fragmentation. Psychiatric care availability declined, and technical staff's stronger alignment with MoH supervisors introduced silos. The

	existing health services was a concern, particularly with line management shifts and less frequent psychiatrist involvement.	"one-stop shop" approach was weakened by the shift in operational priorities, making the integrated model harder to sustain.
Logistics (transport-heavy services)	Services like home support, referrals, and deliveries depended heavily on vehicles. Concerns included whether vehicles would be handed over and whether this would ensure continuation of transport-heavy services.	Transport-heavy services faced significant challenges. Vehicles were not fully replaced or integrated into the county's logistics, leading to a reduction in home visits and delayed referrals. Follow-ups relied more on phone calls, which were less effective.
Retention and payment of staff	Confidence in retaining MoH medical staff was high, but the retention and payment of non-medical staff (e.g., security) remained uncertain and contentious.	MoH medical staff were retained. Strikes occurred during the transition due to dissatisfaction with pay and job security. This highlighted gaps in workforce stability and created challenges in maintaining service continuity.
Global and preventive care	Extensive support services (e.g., referrals, routine tests) for PWUDs were at risk of being scaled back. Advocacy for free services was critical but required multi-level negotiation.	Preventive care and broader health services declined, particularly referrals and tests that were previously free. Advocacy for free services struggled without MSF's direct involvement. The transition to the Social Health Insurance Fund (SHIF) added complexity, reducing accessibility for vulnerable populations like inmates and low-income PWUDs.
Hygiene	MSF provided facilities for showering and cleaning, filling a gap typically handled by community organizations. Concerns included whether this would continue post-handover.	Hygiene provisions were discontinued, disproportionately affecting PWUDs and reducing the sense of dignity provided by the service. This absence was keenly felt by clients, as hygiene was seen as a core component of their experience.
Agile, adaptive management capacity	MSF's flexibility in managing challenges and piloting strategies was at risk of being lost. The project's ability to maintain coordination and promote excellence was a concern.	The transition introduced more rigid bureaucratic structures, slowing response times and reducing the ability to innovate or adapt to emerging challenges. This created gaps in maintaining the service's excellence and agility.
Investment in learning	Concerns included reduced investment in internal and external learning, risking the clinic's status as a benchmark. Maintaining and sharing SOPs and protocols was critical.	While MSF had emphasized training, adherence to high standards, and documentation of protocols, the transition risks diminishing these efforts. There is limited evidence of how such institutional knowledge and external learning opportunities will be maintained, potentially weakening the clinic's position as a benchmark for excellence.
High standards	Maintaining the high standards established by the Kiambu project was crucial. Monitoring mechanisms were needed to ensure non-negotiable elements of the model remained in place.	Standards remained acceptable in core functions but declined - especially in resource-intensive areas like referrals and take-home doses. Monitoring mechanisms were weak, making it difficult to assess or address quality.
Livelihoods and rehabilitation activities	Livelihood initiatives were promising but underdeveloped, with sustainability challenges. There was	Empowerment Centre faced uncertainties post-MSF funding. Volunteers can not fully sustain activities without minimal financial support, threatening the continuity of rehabilitation efforts.

	goodwill to continue, but firm plans were lacking.	
Limping partnership	Weaknesses in LVCT Health's community efforts were a concern as it took on both community and MAT components. Sustainability depended on addressing these gaps.	LVCT continues to face challenges in adapting to changing PWUD use patterns and had not yet formally assumed clinic management at the time of the evaluation. However, discussions with MSF were ongoing during the transition to address operational gaps and ensure a smoother handover.
Advocacy	Advocacy efforts needed to continue post-handover to address systemic issues, such as ensuring PWUDs are recognized as a vulnerable category deserving free healthcare.	The future advocacy strategy remains unclear. With MSF exiting the project, it is uncertain how its advocacy efforts in national platforms and forums will continue and remain rooted in the specific needs and experiences of the clinic. While stakeholders have expressed clear advocacy priorities—such as harm reduction policy and ensuring access to care for PWUDs—it is not yet evident how these will be addressed within the new setup.
Accompaniment for PWUDs and their CBO	Support for HACK and the Empowerment Centre was limited to a six months post-handover, raising concerns about sustainability.	Support for HACK is still ongoing but likely to end soon. Its future sustainability remains uncertain, with limited formal agreements or funding in place to ensure continuity. This could reduce its ability to serve as a critical engagement space for PWUDs post-transition.
Cultural and behavioral changes	MSF introduced a patient-centric culture that prioritized dignity and rights, but there was a risk of reverting to bureaucratic practices post-handover.	The patient-centric culture introduced by MSF seems to be eroding under the pressures of limited resources and bureaucratic constraints. This shift is reflected in the Participatory Assessment Tool results, which highlighted the most significant challenges in aspects such as trust, communication, dignity.

What can be learnt for future handovers?

Drawing definitive conclusions is challenging as the handover is still unfolding. MSF's support was only recently withdrawn, and the new partner has yet to begin its work. The transition will likely take on new dimensions as the incoming partner introduces its objectives, structures, and approaches, reshaping relationships and support systems.

Another significant uncertainty is the future of the PWUD organization and the Empowerment Center it operates in Kiambu. The center has been highlighted as a valuable and needed facility by its users, rated as the most satisfactory service in the MAT clinic by its users in the Participatory Assessment. Any reduction in this service—without viable alternatives—could have consequences.

Overall, this report reinforces findings from the previous evaluation. It celebrates the success of MSF in making the handover happen within the planned timeframe, bringing along all the stakeholders. It confirms that some loose ends are still there, but overall, anxiety and worse-case scenarios have been resolved. The service is still running, and stakeholders benefit from its core activity. This report can also confirm that the handover process has been a rich learning experience for its committed stakeholders, demonstrating that transitioning a program is far more than a mechanical transfer of operations. An effective handover must address intangibles, such as cultural dynamics, systemic alignment, and the surrounding ecosystem.

This evaluation and the previous one, therefore, generated frameworks and tools that systematized such high-level learning: **what key considerations need to drive a handover?** They can serve as valuable resources for MSF's reflection and future planning. Within these frameworks, practical insights have been distilled to capture the essence of the Kiambu handover; what happened in practice, what worked, what didn't, and what remains unresolved.

As this report is written, the service continues to function at slightly reduced but still acceptable standards. The county's commitment remains strong, and users acknowledge the importance of the service. However, **the full impact of the handover—both its challenges and successes—will require more time to emerge**. **When and how can MSF then learn about its impact?**

Post-handover strategies, such as continued advocacy on MAT services or some targeted engagement, can leverage the expertise and trust built by the project. Maintaining an ongoing connection to the project offers a critical learning opportunity from its long-term outcomes. A particularly effective way forward would be to remain in contact with the PWUD community that MSF helped to organise and empower. These individuals are best positioned to monitor and to advocate for the continuation and improvement of services, ensuring that the program not only endures but thrives under new leadership. MSF can continue to be their powerful ally and supporter.

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