STOCKHOLM EVALUATION UNIT

EVALUATION OF

MSF MATERNAL AND CHILD HEALTH PROJECT IN KENEMA, SIERRA LEONE

Informing the targeted approaches to transition the project into the public health system

FEBRUARY 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 must adhere to the SEU Ethical Guidelines for Evaluations.

It was prepared independently by Constancia Mavodza and Chido Dziva Chikwari.

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ACRONYMS

ANC	Antenatal Care
ARI	Acute respiratory infection
BEmOnc	Basic Emergency Obstetric and Newborn Care
BCG	Bacillus Calmette-Guerin
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CG	Consultation Group
CHC	Community Health Centre
CHW	Community Health Workers
ED	Emergency Department
EmOnc	Emergency Obstetric and Newborn Care
FGD	Focus Group Discussion
FHCI	Free Health Care Initiative
FP	Family Planning
HP	Health Promotion
HR	Human Resources
HTC	HIV Testing and Counselling
ICCM	Integrated Community Case Management
IMCI	Integrated Management of Childhood Illnesses
IMS	International Medical Staff
IPC	Infection, Prevention and Control
IPD	In-patient Department
ITFC	Inpatient Therapeutic Feeding Centre
KGH	Kenema Government Hospital
L&D	Learning and Development
MCV	Monovalent C meningococcal vaccine
MH	Mental Health
MMR	Maternal Mortality Rate
MCH	Maternal and Child Health
MoH	Ministry of Health and Sanitation
MSF	Médecins Sans Frontières
NICU	Neonatal Intensive Care Unit
PHC	Primary Health Care
PHU	Peripheral Health Unit

PLW	Pregnant and Lactating Women
PMR	Project Medical Referent
PNC	Post-Natal Care
QoC	Quality of Care
OTP/ ATFC	Outpatient therapeutic programme/ Ambulatory Therapeutic Feeding Centre
RA	Research Assistants
RDT	Rapid Diagnostic Tests
SGBV	Sexual and Gender Based Violence
SLDHS2019	Sierra Leone Demographic and Health Survey 2019
SRH	Sexual and Reproductive Health
SOP	Standard Operating Procedures
TBA	Traditional Birth Attendants
ToR	Terms of Reference

EXECUTIVE SUMMARY

BACKGROUND

Sierra Leone has one of the highest maternal and under-five mortality rates in the world. There are structural and social factors that have impeded curative and preventative interventions for Maternal and child health (MCH) in Sierra Leone. Kenema district's health system includes Kenema Government Hospital (KGH) that is both a district and a regional hospital mainly used for referrals and Peripheral Health Units (PHU) which are government run primary health care (PHC) facilities that provide community level PHC. Embedded in the Kenema district health system is the Médecins Sans Frontières (MSF)'s Maternal and Child Hospital (MSF-MCH) that is also a referral hospital and provides Comprehensive Emergency Obstetric and Newborn Care (CEmONC) and paediatric healthcare services.

MSF's Kenema project became operational in 2017/2018 focusing on strengthening community and district health systems through two primary specific objectives:

1. To reduce maternal and under-five mortality and morbidity in Kenema,
2. To enhance the human resource capacity to deliver quality maternal and child health care.

The Kenema project activities are summarised in Figure 1.

EVALUATION AIMS

This evaluation sought to assess the implementation, effectiveness and plausible impact, and context of the Kenema project as a mechanism for developing evidence-based recommendations to support the transition of the project from MSF to the government and/or other stakeholders at the end of its timeline. In this assessment, the project's relevance, appropriateness, effectiveness, efficiency and impact within its implementation context since inception, were explored. The evaluation customised a framework adopted from the Medical Research Council's Guidance for the Process Evaluation of complex public health interventions; where complexity of the Kenema project is reflected in its multi-year, multi-component structure.

EVALUATION METHODS

A detailed desk review of the Kenema project documents, strategies and frameworks, as well as existing guidelines, SOPs or manual of operations was conducted. Beyond the desk reviews, a rapid literature review was also conducted to further understand the MCH landscape primarily in Sierra Leone but also in other similar contexts. Two data sources were used for a secondary data analysis. Specifically:

1. Project reports for 2021 – 2023 including project indicators
2. Raw data for key variables (determined by the evaluators after analysis of indicator data and visit to Kenema) provided by the Kenema Project Data Manager for 2021 – August 2024

Additionally, this evaluation employed an exploratory qualitative research design to better understand participants' experiences, perceptions and thoughts about the Kenema project. The

qualitative research was conducted using a combination of semi-structured individual, paired and group discussions. The evaluation team visited the Kenema project between 29 July and 10 August, to collect qualitative data; and to understand data flow and interpretations of the quantitative data. A total of 208 participants, excluding the consultation group (CG) members, were part of this evaluation. Of these, 57.7% (n=120) were female. The CG made up of key personnel in the Kenema project was also part of this evaluation. Members of the CG were interviewed, and the evaluation team and CG had scheduled sessions to share the findings and provide a space for validation, reflection, interpretation and sensemaking. Overall, this evaluation utilised a convergent non-sequential mixed-method design. With this backdrop, the evaluation findings in this report are primarily presented separately.

MAIN FINDINGS

QUANTITATIVE

Overall hospital bed occupancy has increased from 71% in 2021 to 78% in 2022 and 98% in 2023 (Annex Table 1a). Although the hospital target (80-90%) was not met in 2021 and 2022, it was surpassed in 2023, possibly due to the closure of the maternity ward 2 in 2023 without a change in the bed occupancy target/denominator. Average monthly available bed days increased from 2,387 in 2021 to 3,689 in 2022 (Table 2). A significant increase in available beds was affected in May 2022 but decreased in December 2022 (Annex Figure 1). Overall, there has been a gradual increase in monthly utilised bed days each year from 1,073 in 2021 to 2,735 in 2023 and 2,945 for January – August 2024.

Overall, the hospital has seen an increase in Emergency Department (ED) paediatric consultations since 2021 with 5697 consultations in the same year, followed by 6,818 consultations in 2022 and 6,963 consultations in 2023 (Table 1a); which would likely contribute to the increases in bed occupancy as already established. In each year consultations have surpassed the hospital target and could be a result of hospital outreach improvements over time. Overall, the majority of consultations lead to admissions (65% in 2021, 67% in 2022 and 67% in 2023).

There also appears to be a seasonal trend for admissions with the highest number of admissions observed in May in both 2022 and 2023 and lower numbers in the last quarter of the year; however, this trend has not been observed in 2024 where monthly consultations have remained between 500-600 each month and admissions between 400-500 each month.

The average monthly hospital deaths in 2021 were 21 and increased to 47 in 2022 then dropped to 44 in 2023. There have been 46 deaths between January – August 2024. When comparing by departments (Table 4), the highest mortality is reported consistently in ICU across the 3-year period under review. This is followed by mortality in ITFC and IPD and the lowest mortality is reported in ED. The average monthly deaths in ED were largely consistent between 2021 – 2023 (6, 5 and 5 respectively) but have risen to 9 for January – August 2024 (Table 4). The average monthly deaths in IPD, ICU and ITFC have also followed the same trend with increased monthly deaths reported in 2024. The average length of hospital stay in ITFC has dropped from 10 days in 2021 to 8 days in 2022 and 7 days in 2023. Overall hospital mortality among admitted patients (6%) in the project remains higher than the target of 5% across all three years of the secondary analysis.

The median number of pregnant women admitted monthly rose from 45 in 2022 to 110 in 2023 and 125 in 2024 (June – August) (Table 5). The median number of c-sections each month also increased

from 20 in 2022 to 38 in 2023 and 45 in 2024 (January – August) (Table 5). The caesarean section rate decreased from 50% in 2022 to 28% in 2023 (Figure 7). CEmONC obstetric mortality was 1% for 2022 and 2023 (Target < 1%). CEmONC neonatal mortality was 10% in 2022 and increased to 14% in 2023 (Target <15%). According to the project indicators only 38% of newborns were vaccinated in maternity in 2023 (Table1) this was inconsistent with raw data provided by the project which showed much lower numbers of newborns fully vaccinated.

The majority of quality control indicators surpass the project targets for 2023 and have shown positive increases between 2021 – 2023. There was an increase in the proportion of iCCM communities, consulting at least 90 Under 5 (U5) children per quarter among MSF targeted communities, from 58% in 2021 to 79% in 2023. All PHUs supported by MSF have had secure cold chain from 2022 and all PHUs supported by MSF in 2023 had a verified water source. Under 5 children screened for malnutrition by CHWs decreased from 98% in 2021 to 82% in 2023 (target 100%). Similarly, U5s screened for malnutrition in PHUs dropped from 81% in 2021 to 47% in 2023.

QUALITATIVE

The qualitative findings are organised by the macro-themes from the DAC criteria as requested in the Terms of Reference (ToR): Relevance, Appropriateness, Effectiveness, Efficiency, Impact, Continuity, Coherence and Sustainability**.**

Relevance

- Project activities are primarily addressing the maternal and child health needs of Kenema communities through PHC approaches of outreach activities and secondary care approaches of service provision at the MSF hospital.
- The use of semi-temporary infrastructure (Gaptek) to build the hospital is at odds with the longevity or sustainability of the project beyond MSF's tenure running the project.

Appropriateness

- The resources availed and strategic set up of the project responded to addressing known maternal and child health challenges in Kenema.
- The combination of secondary care and primary health care activities adopts both top and down approaches to maternal and child health care needs, addressing both supply and demand side barriers and opportunities to improving MCH in Kenema.
- Negative perceptions on the appropriateness of some project activities have been shaped by inadequate communication and community engagement.

Effectiveness

- The quantitative effect of the Kenema Project's contributions to reducing maternal and child mortality in Kenema was not established in this evaluation due to limitations of the quantitative data used, but qualitatively community members and health providers identified observing reductions in maternal and child deaths due to the project interventions.
- The outreach activities, specifically the PHU support and ambulance referral systems, have been effective in reducing the delays in access to care and improving the quality and availability of MCH services at PHC levels.

- The effectiveness of the outreach support at PHUs is conditioned by MSF's presence at the PHU. On the days that outreach is not present, some of the supported PHUs still expect patients to pay for services, among other challenges.
- An unintended effect has been the dependency on Kenema project activities by both community members and government stakeholders. This can compromise the transferability and sustainability of these activities by a different implementor/steward, as well as create expectations that cannot be met among project beneficiaries.

Efficiency

- Significant human, financial and infrastructure resources have been invested to operationalise the Kenema project since its inception.
- Human resources have not always been efficiently deployed in the project with potential overstaffing of hospital wards, and underutilisation of both IMS and locally hired staff.
- A multi-sectoral approach to addressing MCH is missing in the project. Such an approach would enhance efficiency through shared costs, resources, learning and insights as well as knowledge and service delivery.

Impact

- This evaluation could not quantitatively establish the significant impact of the Kenema Project on reducing maternal and child mortality and morbidity in Kenema due to the limitations of the data used. Qualitatively, all stakeholders in this evaluation find the project activities to be contributing to improving MCH outcomes.
- Some unintended consequences include:
  - For the effective ambulance system, there is a disruption in the public health ambulance system, creating unnecessary competition for clients.
  - For accessing the quality MCH care and ancillary services at the MSF hospital, clients (pregnant women and mothers) now make themselves or their children ill to enable them to access the hospital services - most of which are to access ancillary services (primarily food, laundry and baby care packages).

Coherence, continuity and sustainability

- Internal coherence between the outreach pillar and the MSF hospital can be strengthened to better understand the effect and interconnectedness of the two and potentially improve reporting on indicators; and MCH outcomes themselves.
- External coherence between the project and other MCH stakeholders as well as with MoH could be stronger and should be prioritised as part of the handover activities and exit strategies.
- Continuing the QoC established by the Kenema project is likely not feasible and the project may need to consider a threshold of minimal standards of care as part of exiting the project.

RECOMMENDATIONS

1. Establish robust data collection and management systems

In the remaining four years, the project has an opportunity to adequately show its contribution to reducing maternal and child mortality and morbidity, while also strengthening the health system by bolstering information systems. The process of standardising and improving the quality of indicators and their definitions has already begun; and should include hospital targets and their rationales. This should also be supported by training data teams, including on querying and interpreting data.

2. Strengthen documentation and knowledge management systems

To minimise internal incoherences and possibly inefficiencies as well, it will be important to have a documentation and knowledge management system that shows key activities, decisions made, rationales for those decisions as well as the envisioned next steps.

3. Strengthen the outreach service activities

At the time of the evaluation, the outreach activities strategy was being reassessed. The revised version should prioritise addressing the current challenges identified (making patients pay when MSF leaves, poor malnutrition screening in the community and PHUs, inconsistent essential drug supply to PHUs in need); and the Kenema project must place great importance on strengthening the internal coherence between the outreach and hospital pillars.

4. Continued capacity building/strengthening efforts for health providers

While medical QoC was high in the project, there were instances of inappropriate medical prescriptions; as well as reduced malnutrition screening that could be mitigated for or addressed with adequate or reinforced training for the CHOs and staff responsible for making these prescriptions.

5. Prioritise investing in the capabilities and capacities, needed for successful handover

Training, upskilling and/or reskilling government employees in health and operational skills for running a project such as this. These are skills that can be used to improve KGH, but also to take on similar projects with other development partners.

6. Focus on depth of existing activities and minimise breadth (introducing new activities)

To ensure an effective handover, the project may need to scale down activities in the upcoming years, focusing on improving or strengthening the ones likely to be taken over; and limiting the introduction of new activities that may not be able to penetrate during a transitionary period. Alternatively, the project could ***consider a different handover timeline****.*

7. Establish internal and external coherence

For MSF to exit this project well and transfer it to another stakeholder (MoH) in the upcoming four years, strong coherence will be needed. The project team needs to dedicate resources (time, human, financial) to establishing this coherence.

8. Shift decision-making abilities to local project management leadership

The limited contextual responsiveness of this project is significantly due to decision-making that is not informed by the contextual realities and understanding. Having local, qualified and equipped staff, who are active contributors to decision-making of what will or will not be strategic and operational objectives in Kenema is paramount, to ensure longevity and continuity of projects like this one.

INTRODUCTION

Sierra Leone has one of the highest maternal and under-five mortality rates in the world. In 2019, the maternal mortality rate (MMR) was 717 per 100,000 live births, which was an improvement from the rate of 1,165/100,000 live births recorded in 2013 (1). The leading causes of maternal deaths among women aged 15-49 are obstetric haemorrhage (46%), hypertension (22%), obstructed labour (21%) and sepsis (11%) (2). In 2020 neonatal mortality was 31 deaths per 1,000 live births and infant mortality was 75 per 1,000 live births (5). In 2021, the under-five mortality rate was 105 deaths per 1,000 live births (1, 2) which was also an improvement from 110 deaths /100,000 live births that had been reported in 2015 (6). The leading causes of under-five mortality in Sierra Leone have been newborn conditions, malaria, acute respiratory infection (ARI), and diarrhoeal diseases (7); and the leading causes of neonatal deaths have persistently been prematurity, birth asphyxia and sepsis (6).

There are structural and social factors that have hindered curative and preventative interventions for MCH in Sierra Leone. They include a lack of 1) access to free quality care - such as trained healthcare staff; 2) quality medication; 3) infrastructure to reach health facilities; 4) knowledge and understanding about health and wellbeing; and 5) professional accountability (7). Women in rural areas are 1.5 times more likely to give birth without a skilled birth attendant in hospital, compared to those in urban areas; and are also more likely to not give birth at a health facility (6). Delays in accessing care while already at the health facility have been shown to be mainly associated with neonatal deaths experiences (8) indicating that in some cases women are able to reach health facilities but experience care delays once they arrive.

In 2010, the government introduced the Free Healthcare Initiative (FHCI) to provide free healthcare to pregnant and lactating women, as well as under-five children (9, 10). The aim of the FHCI is to contribute to improving maternal and under-five outcomes. However, the initiative is hindered by health system challenges including weak management, gaps in the supply chain for medication as well as limited availability of health providers (9). Additionally, health providers continue to require clients to pay for services as well as commodities to both sustain these services, but also as side income for the providers (10-13). Layering onto all these existing challenges, the Ebola outbreak of 2014 – 2015, exacerbated maternal and child health challenges in the country including reducing the number of health care workers in the system (14).

While the maternal and under-five mortality rates remain high, they do show improvements. These improvements have been due to several factors anchored by the government prioritisation of essential obstetric and new-born care, which attracted large donor investments to increase the availability and quality of emergency obstetric and newborn care (EmOnc) services (15). Training and employment of health providers to replace those lost in the Ebola outbreak (16), and in 2019, the national ambulance service had also received improvements to enhance the referral system to ensure that women and children did not face delays in seeking and accessing care- especially for complicated cases that often resulted in mortality and morbidity (15). However, even with these improvements, the quality of MCH care remains poor as a lack of medication and supplies, and the voluntary nature of health provider employment persists (13, 14).

MATERNAL AND CHILD HEALTH IN KENEMA

Kenema district's health system is organised into different components. There is the Kenema Government Hospital (KGH) that is both a district and a regional hospital mainly used for referrals. Peripheral Health Units (PHU) are government run health facilities that provide PHC at community level. At household level, Community Health Workers (CHWs) are trained community volunteers conducting home visits to provide health education, screen for malnutrition, diagnose and treat simple malaria, diarrhoea, and pneumonia as well as conduct defaulter tracing and community surveillance (11). Additionally, there are also traditional birth attendants (TBAs) who support expecting women throughout their pregnancies, while traditional and spiritual healers treat illnesses through plant/animal products and by spiritual means (17, 18). Lastly, pharmacies (often called drug shops in SL) sell medications and can also give injections (15). Embedded in the Kenema district health system is the Médecins Sans Frontières (MSF)'s Maternal and Child Hospital (MSF-MCH) that is also a referral hospital and provides Comprehensive Emergency Obstetric and Newborn Care (CEmONC), as well as paediatric services.

Sierra Leone has the fifth highest under-five mortality rate among off-track countries and Kenema's high rate (154.2) is second only to Pujehun district (159.5) in the country (19). One 2020 study, conducted with communities in Kenema that have interacted with MSF activities (Gorama Mende and Wandor chiefdoms) sought to understand health seeking behaviours in the context of FHCI (15). Community members noted that their first point of contact to seek care is the PHU, provided there are no barriers. For them, these barriers include residing in hard-to-reach areas which has an impact on transportation ease and cost; unanticipated payment for services, or associated commodities of care; as well as fear of health staff at the PHU (15). Addressing these barriers would likely contribute to improving MCH outcomes in Kenema.

MSF'S KENEMA PROJECT

MSF has been present in Sierra Leone for over thirty years and played a significant role during the 2014/2015 Ebola outbreak. Kenema has been an endemic area of Lassa fever since the 1970s; and when layered with the Ebola outbreak, the district is a hotbed for haemorrhagic fevers. Additionally, in Sierra Leone, and more specifically Kenema, maternal and under-five mortality and morbidity has remained persistently high (11). This combination of challenges resulted in MSF's design and development of the Kenema Project with two primary strategic objectives:

1. To reduce maternal and under-five mortality and morbidity in Kenema,
2. To strengthen the human resource capacity to deliver quality maternal and child health care in Kenema.

The Kenema Project became operational in 2017/2018 focusing on community health systems strengthening. The maternity and child hospital were built and became operational in 2019, initially offering paediatric and nutrition services. The capacity strengthening efforts through the MSF Academy began in 2017 and gained traction in 2019. This included the introduction of integrated Community Case Management (iCCM), supporting 6 different PHUs. In 2022, the maternity

department offering Comprehensive Emergency Obstetric and New-born Care (CEmONC) services became operational (Figure 1).

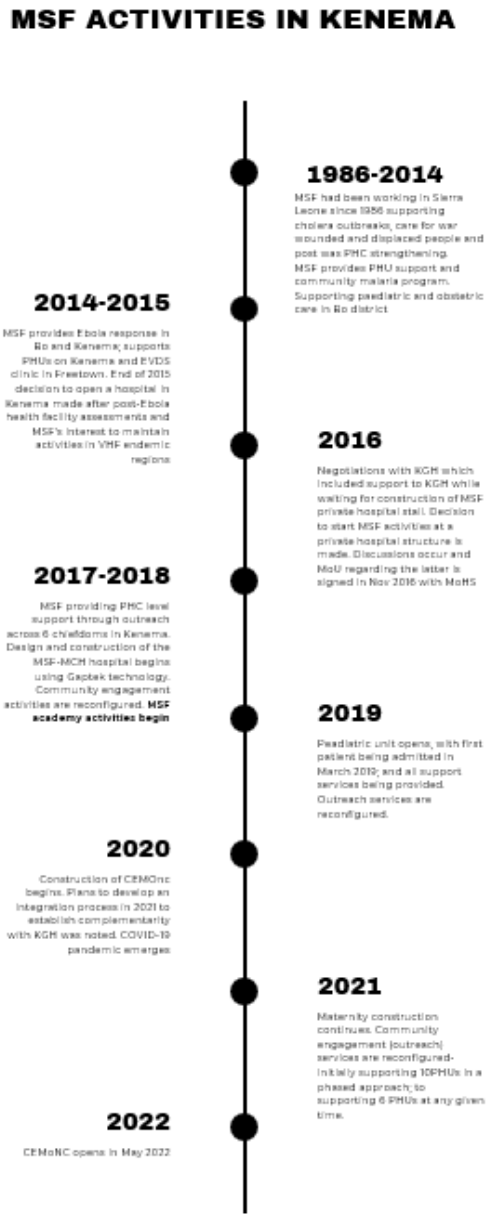


Figure 1: MSF Activities in Kenema

OUTREACH SERVICES

MSF's outreach activities have been implemented since the inception of the project. These activities primarily focus on strengthening the provision and access to quality maternal and child health services, including SRH, at community and household level. The outreach activities assist the MoH by supporting PHUs through:

1. Provision of essential drugs and commodities.
2. Capacity building and mentorship of PHU staff.
3. Health Promotion, and rehabilitation of PHU facilities.
4. Facilitating referrals from primary to secondary healthcare through an ambulance system.

5. Financial incentivisation for the health providers working at these facilities.
6. Implementing integrated community case management (iCCM) of malaria, and diarrhoea, through CHWs.

These six community-based anchor activities are now referred to as **the outreach services of the Kenema Project** in the present-day; and the level of effort for each activity at a PHU is determined by a needs assessment of the PHU. The six PHUs being supported at the time of the evaluation where Boajibu, Dama, Hangha, Kpandebu, Gbanguima and Blama. MSF support to the latter PHU had just stopped at the time of the evaluators' project site visit. New needs assessments were being conducted to determine additional PHUs to support. MSF's intention is to proceed and support all 134 PHUs in Kenema, by the time MSF exits the project, using a phased approach that was still being designed.

MATERNAL AND CHILD HEALTH SERVICES

In 2017/2018, the outreach support being provided to the PHUs was reduced as the construction and opening of the MSF-MCH hospital was implemented which will be referred to as the "MSF hospital" in this document. Paediatric services were the first to be built. The MSF hospital was opened in 2019, admitting its first paediatric patient in June of the same year. While the under-five services began operating, the construction activities continued. In 2022, the MSF-maternity component was opened, and the MSF hospital became fully operational. The maternity department has the In-patient department (IPD) which is the point of entry, as well as the maternity ward, and the operating theatre. The paediatrics department has an IPD, the neonatal intensive care unit (NICU), and the Intensive Therapy Feeding Centre (ITFC). A dedicated Lassa fever isolation unit is also a part of the hospital. Additionally, the hospital also has auxiliary services that include the Laboratory and blood bank, the antimicrobial resistance stewardship group for infection, prevention and control (IPC), the kitchen and laundry, and the MSF Academy among other activities (Figure 1).

THE MSF ACADEMY

The MSF Academy began its involvement within the Kenema project in 2017 with the set-up of 50 2-year scholarships for local citizens to be sent to Ghana and return as both Registered Nurses (n=25) and Registered Midwives (n=25) and join MSF-MCH as staff. This first scholarship was followed by a second one for 12 registered nurses (6 MSF and 6 MoH) to study an 18-months Nurse Anaesthesia Diploma Course in Ghana. The Diploma course was extended to a BSc in Anaesthesia for 8 of them (6 MSF and 2 MoH). The 6 MSF Nurse-Anaesthetists joined the MSF MCH's OT upon their return. A three-month on-boarding course was also put in place by the MSF Academy prior to the launch of the MSF-MCH.

The MSF Academy also develops and delivers curricula to train different health care providers (Nursing, Midwifery, OT nurses, CHOs) that work with and within MSF projects more broadly. For the Kenema project, the MSF Academy has a team in Kenema, operating from a training centre built within the hospital campus, and providing competency support and training to employees of the MSF-MCH hospital. Additionally, health providers from the PHUs that are supported by the Kenema project, benefit from capacity building through the MSF Academy OPD (Outreach) program.

Most of the CPD programs rolled-out by the MSF Academy have been recognised via counter-signed competency certificates by the Nursing & Midwifery Board. According to the Academy team, the CHO Board is on course to also recognise the CHO Competency certificate. 184 staff have graduated with an MSF Academy competency certificate and a total of 364 will have graduated by Q2 2025. The MSF Academy also contributed financially to the expansion of the Training centre.

At the time of this evaluation, the Academy is in a transition phase. It will be phased out in 2025 as all the MSF Academy programs being rolled out will have been finalised. The BCNC (Nursing) clinical mentors, who are under project budget, will move from the MSF Academy organogram to the MedOps organogram, supported by an anticipated forthcoming new position of Quality-of-Care Manager who will be reporting to the PMR.

AIMS AND OBJECTIVES

This evaluation sought to assess the implementation, effectiveness and plausible impact, and context of the Kenema project to develop evidence-based recommendations for transitioning the project to the government and/or other stakeholders at the end of its timeline. In this assessment, the project's relevance, appropriateness, effectiveness, and efficiency within the context it is being implemented were explored.

This juncture of the MSF-Kenema project presents an opportunity to understand how the project has contributed to better health (systems) outcomes in Kenema and Sierra Leone more broadly; and then to utilise this understanding to shape the continuation of the project during MSF's remaining time running the project, and beyond.

THE CONSULTATIVE PHASE

The Kenema Project evaluation Consultation Group (CG) reflects project stakeholders within MSF and was created by the Head of Mission to be a steering group for the project evaluation. It consists of staff from both MSF Sierra Leone and MSF Belgium who are involved with the Kenema project decision making and implementation. The members include Head of Mission, Paediatric Advisor, Project Coordinator, Project Coordinator Support, SRH & Sexual Violence Advisor, the Project Medical Referent (PMR), MSF Academy Project Manager, the Medical Coordinator and Support, and the Human Resources (HR) Referent. Additional informants who were consulted during this phase included the Epidemiologist -data, PMR support, MSF Deputy Operational Coordinator, Laboratory & Pharma Support, and the Clinical psychologist.

All the CG members and additional consulted persons were invited to participate in an interview to get a detailed and individual encounter of their experiences, perceptions and knowledge of the MSF-Kenema Project, and their understanding and expectations of the evaluation assignment.

Discussions with this group began in parallel to the desk and literature review process. This approach was used because it was paramount for the evaluation team to have some overarching understanding of the CG members' expectations and needs in the lead up to visiting Kenema. Most of the consultation group members' expectations of the evaluation fit under the four domains raised in the Terms of Reference (Appropriateness, Effectiveness, Efficiency, Impact, Coherence, Connectedness and Sustainability). However, the focus in each of these domains differed by consultation group member and somewhat complimented or reflected the technical expertise of the members. Consultation group members raised and wanted the evaluation to respond to:

- **The definition of data indicators for routine collection and actual performance of the project.** The Kenema project has routine data collection that is meant to provide insight into the performance of the project; however, the majority consensus from members was that data was not easily accessible. CG participants noted that there is no clear indication of what data is available, and if available how to interpret the data, primarily due to the lack of clear definitions

of the indicators used. Many indicators have been redefined over the period of the project. Participants requested that the evaluation assist in not only identifying the gaps in data collection tools but also in framing the importance of data for decision-making. CG members would like the evaluation to make recommendations on how to improve the data management system so it can better be utilised in assessing the overall effectiveness of the activities being implemented. Linked to the poor data management system, CG members noted that there is no clear working document that can be used to assess whether the project has been efficient and impactful on MCH in Kenema.

To address questions around efficiency and impact of the project, the evaluation will use the document review, interviews with project staff, and observation during site visits and focus group discussions (FGDs) to assess the efficiency and impact of the project.

- **Outreach and Community Engagement in the Kenema Project.** Some of the CG members articulated that there has been limited focus and support for outreach activities, despite outreach playing an essential role of demand generation for the MSF hospital. Several consultation group members mentioned that there is a need to explore the appropriateness and effectiveness of the current outreach activities, particularly in getting a wider reach in Kenema. The evaluation will address this through focus group discussions with community members and interviews with MSF outreach staff.

- **Top-down approaches within decision making and implementation.** Participants in the consultative phase highlighted that decision-making processes for what, how and when a change should occur, as well as the implementation of project altering decisions, often have a top-down approach in the project. Members discussed how decisions are primarily made by international mobile staff (IMS) who have high turnover. This was seen to have negative effects on activity implementation which is often seen to be done by locally hired staff. This reflects some of the intersectional and power relations aspects of the evaluation, which will seek to understand how this plays out and affects project outcomes. The document review, observations and interviews with MSF project staff will assist in exploring this.

- **Collaboration and Advocacy.** Some CG members flagged that MSF's ways of working in Kenema have been siloed and limited to some PHUs across the district. For these CG members, MSF has not adequately engaged the MoH and other organisations that work on addressing MCH issues. Members of the consultation group acknowledged that there was a need for MSF to strategise the way it builds relationships and collaborates with other stakeholders, particularly in the case of long-term projects such as a hospital that will need continuity and sustainability. For this, some of the participants want the evaluation to explore and inform how MSF-Sierra Leone can better collaborate with MoH and other stakeholders on advocacy and project handover.

- **Sustainability of the Kenema Project.** With on-going discussions of possible integration of the maternity component of the project with MoH, there was a heavy emphasis during the consultative phase to have the evaluation address this issue. The consultation group wants the evaluation to provide recommendations on which route the project must take (integration/ handover/slow exit). The sustainability component of the project will be significantly explored in

this evaluation. It will include collecting and analysing data to better understand the historical and present context of the Kenema project, and how this understanding may be utilised to shape and map the remainder of the project. Focal persons in the integration efforts will be engaged to understand the status of the project's integration strategy and its implementation.

- **MSF's expertise is not development.** There was a consensus that long-term development work is not MSF's area of technical expertise. Medical preparedness and rapid response in crises are MSF's expertise. There was acknowledgement that the pitfalls in setting up and running the Kenema hospital entails that MSF has a lot of learning to do. There was also a school of thought that maybe the Kenema MCH project was too ambitious. Additionally, some members felt that one of MSF's weaknesses was a lack of proactive engagement in rectifying errors or addressing challenges. For them, MSF waits for outsiders to come and inform them of challenges instead of actively seeking out implementing staff, beneficiaries and relevant stakeholders to learn and engage with about the maternal and child health in Kenema (connectedness). Through interviews with MSF implementing staff, the evaluation will explore this area of coherence and connectedness.

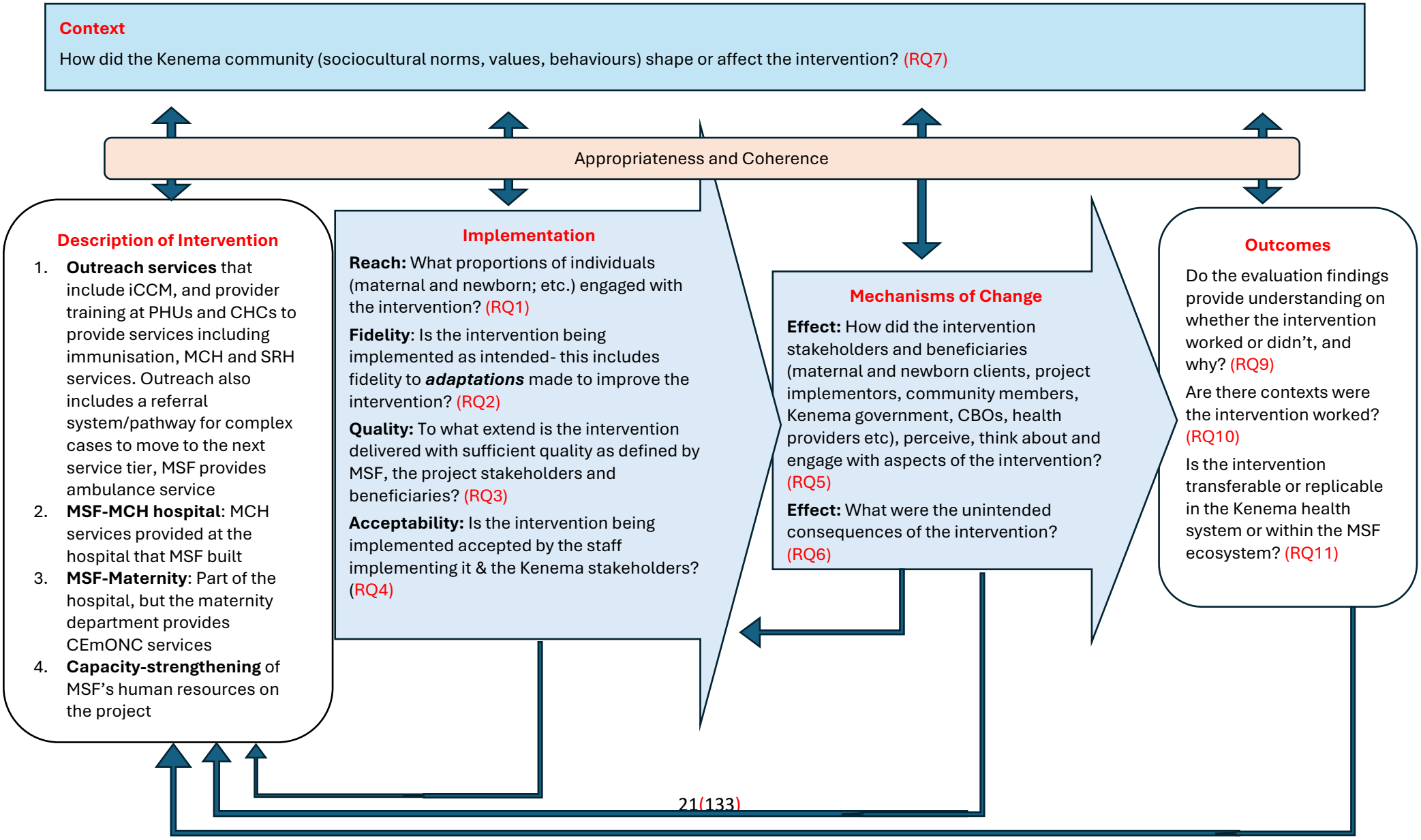
It is in the context of this consultative process, together with the ToR, desk and literature reviews that a basis for the evaluation of the Kenema MCH project has been established.

METHODOLOGY

EVALUATION FRAMEWORK

This evaluation customised a framework adopted from the Medical Research Council's Guidance for the Process evaluation of complex public health interventions (20); where complexity of the Kenema project is reflected in its multi-year, multi-component structure *(21-24)*. In this framework, Implementation (what was implemented, why, how and when), Mechanisms of Change (what was the experience of beneficiaries and stakeholders) and Context (what are external macro, meso and individual factors that interact with and affect the project) enabled this evaluation to explore, understand and assess the Relevance, Appropriateness, Effectiveness, Efficiency, Impact and coherence of Kenema Project Activities. This has been established and presented in the Inception Report *(25)* (Figure 2).

Figure 2. Evaluation Framework



LITERATURE AND DESK REVIEW

A detailed desk review of the Kenema Project documents, strategies and frameworks, as well as existing guidelines, SOPs or manual of operations (over 300 documents, each with page counts ranging from one to over a hundred) was conducted. The desk review also included national laws, policies and guidelines related to MCH in Sierra Leone that may play a part in determining the kinds of medical and non-medical activities that the project can implement, and provide contextual knowledge of the project setting.

Beyond the desk reviews, a rapid literature review was also conducted to further understand the MCH landscape primarily in Sierra Leone but also in other similar contexts. A detailed methodological strategy guided the extraction of the critical literature[1]; and resulted in a sample of 95 articles that were reviewed. The literature review enabled understanding and interpretation of findings, based on existing evidence, as well as triangulation with the other data sources in the evaluation.

Findings from the desk and literature reviews were used to shape some of the topic guide questions, in addition to complementing experiential findings from the interviews and FGDs, as well as the quantitative analysis, in order to design and develop recommendations that are an output of this evaluation.

QUANTITATIVE DATA COLLECTION

Two data sources were used for the secondary data analysis reported in this evaluation. Specifically:

1. Project reports for 2021 – 2023 including project indicators.
2. Raw data for key variables (determined by the evaluators after analysis of indicator data and a visit to Kenema) provided by the Kenema Project Data Manager for 2021 – August 2024.

In addition to the secondary data analysis, the evaluators met with the Data Team during the field visit to review primary data collection tools and the data flow of the project. Particular attention was paid to the data collection tools, where and how data are entered into registers and subsequently entered into the database, as well as data capturing procedures for the MSF Hospital and PHUs. This was aimed at understanding the flow of data for the project as well as ways through which this can be improved.

Although access to DHIS2 was provided to evaluators it was not used for this evaluation due to key limitations including challenges with navigating and aligning which DHIS2 variables the project uses to calculate indicators, and inconsistencies which were observed when this was attempted.

[1] ((maternal and child health) AND (Sierra Leone)) OR ((maternal and child health) AND (Kenema))

QUANTITATIVE DATA ANALYSIS

Three phases of data analysis were conducted. The preliminary analysis of project indicators was conducted in Phase 1 of the evaluation (June 2024) and was used to inform presentations to the consultation group, discussions with the project epidemiologist, some elements of qualitative data collection and extraction of raw data from the project databases. The findings from the preliminary data analysis in Phase 1 were shared with the qualitative research assistants and evaluator prior to the commencement of FGDs and semi-structured interviews to elicit cross-cutting learning, provide context for the hospital data, and allow the use of qualitative methods to compliment and provide context to some of the quantitative findings. The main data analysis of secondary data provided was conducted in August 2024 and the findings were presented to key project staff during a validation meeting in September 2024, and followed by Phase 3 of data analysis also in September 2024. Additional data on the MSF Academy indicators was sought for analysis in October 2024, after preliminary review of the first draft of the evaluation report.

The data was extracted from Excel and all analysis were carried out using STATA v15-0 software (StataCorp, TX, USA). Descriptive summaries of the data were conducted. The data was stratified by month and year and population into tables and presented as figures. Continuous variables were summarized as medians, and categorical variables as counts (percentages).

The evaluators also met at the end of the data collection phase and shared findings from the final analysis to synthesise the quantitative and qualitative findings of the evaluation.

QUALITATIVE DATA COLLECTION

This evaluation employed an exploratory qualitative research design (26, 27) to better understand participants' experiences, perceptions and thoughts about the Kenema project. The qualitative research was conducted using a combination of semi-structured individual, paired and group discussions. A team of four qualitative researchers that included local research assistants (n=2) collected the data both in-person and virtually between July- September 2024.

KENEMA FIELD VISIT

The evaluation team visited the Kenema project between 29 July and 10 August, to collect qualitative data and to understand data flow and interpretations of the quantitative data as described in Section 3.3. During this visit, FGD and interviews and observations were conducted (see sections below). The evaluators also had informal conversations with staff working in the Kenema project as well as at KGH to not only understand the project but to also ask clarifying questions about some of the data that was being collected in real time. The field notes used to capture these conversations are also considered as data sources in this evaluation.

A total of 208 participants, excluding the consultation group members were part of this evaluation. Of these, 57.7% (n=120) were female. The evaluators included men from the community to better explore any gendered differences in the experiences, perceptions and thoughts about the Kenema

Project. Data was collected through 23 FGDs, 1 group discussion (GD), 14 interviews, 2 paired interviews (PI) and 4 key informant interviews (KII). Participants' ages ranged from 18 to 67 years and participants represented staff from MSF, PHUs and KGH as well as focus group discussions from the community (Figure 3).

FOCUS GROUP DISCUSSIONS

Focus group discussions were conducted to explore and understand beneficiaries' experiences, perceptions, and thoughts on engaging with the MSF-Kenema project activities. A group discussion (n=3) was held at one PHU because all three midwives wanted to be spoken to together, and the evaluators did not name qualified this as a focus group discussion. The twenty-three FGDs were primarily split by sex: 13 female-only, 6 male-only and 4 mixed groups. The mixed groups were those with community gatekeepers like chiefs, teachers, TBAs, and CHWs. These FGDs also comprised of participants who had directly benefited from the PHUs supported by MSF (patients) and community members staying in communities that engage with the Kenema project but who are not necessarily patients. In this evaluation the communities included Kpandebu, Hangha, Kenema Town, Gbangaima, Boajibu, and Blama. Community members also represented participants who had engaged with outreach services in the community as well as those who hadn't. At the evaluation's inception, the plan was to include participants who know of MSF but have not been beneficiaries directly or indirectly. However, at recruitment and during the field visit, it became evident that the members of the communities included in this evaluation have all engaged with or benefitted in some way from the Kenema project.

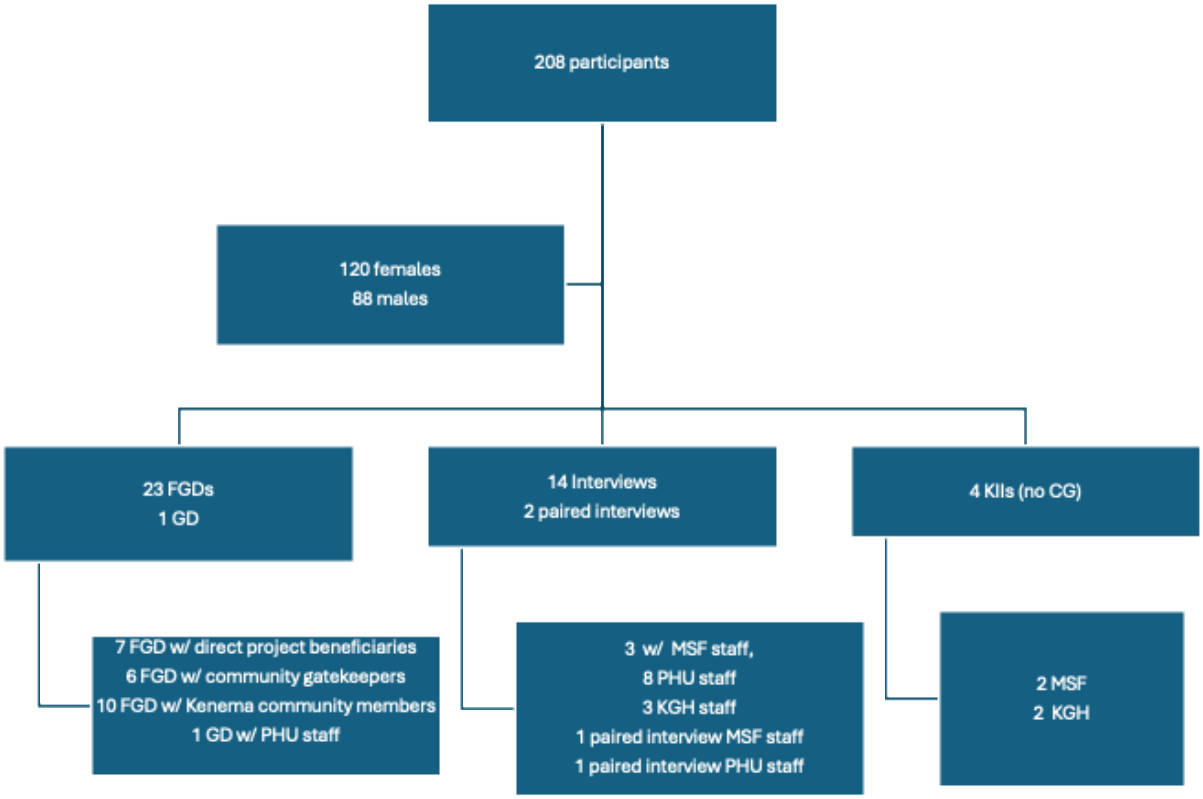


Figure 3: Sample of Qualitative Data Collected

SEMI-STRUCTURED INTERVIEWS

In addition to the interviews that were conducted with the consultation group, an additional 14 interviews and 2 paired interviews were part of this evaluation. 1 paired interview (2 people) consisted of colleagues in the same department at MSF in Kenema, and another one consisted of colleagues at one of the PHUs. The individual interviews included MSF, KGH and PHU staff members across primarily maternity and paediatrics departments as well as from the MSF Academy, and advocacy departments. These interviews explored practical and lived experiences of bottle necks, challenges, enablers and facilitators for the project and sought to understand how these stakeholders envision an MCH programme in Kenema, using their experience working with, and/or for the MSF Kenema project.

As a type of semi-structured interview, key informant interviews (KII) were also conducted with leadership at KGH and MSF to provide an overarching understanding of national, district and programmatic priorities and factors that influence MCH in Kenema and in Sierra Leone, and to explore the leadership that might be relevant and needed to transition this project from MSF into the public health system. Additionally, discussions with CG members throughout the evaluation timeline continued to be seen as key information.

NON-STRUCTURED OBSERVATIONS

During the field visit to Kenema, the evaluation team conducted non-structured observations (28, 29) as part of the data collection. The evaluators attended a staff meeting and also visited the MSF hospital departments (maternity, paediatrics, Lassa fever unit, human resources). During these departmental visits, the evaluators engaged in discussions with department heads, as well as their staff, and the latter were observed as they conducted their duties. These visits allowed the team to have an in-depth and experience-based understanding of the complexity and magnitude of the Kenema project. The team also visited and observed select PHUs that are supported by MSF. At the PHUs, observations included receiving a tour of the facility and being shown MSF's structural contributions to enabling safe and adequate maternity and under-five care at community level. The qualitative evaluators took daily notes (in the form of field notes) to document these observations, remain reflexive about the field visit experience and to begin to triangulate what was being observed with the other data sources.

QUALITATIVE DATA ANALYSIS

Qualitative data was analysed using thematic and constant comparison approaches (30-32). Analysis was iterative so that emerging themes could be explored during subsequent data collection. For example, during the field visit the qualitative team met daily at the end of the day to discuss key emerging findings and decide how or if these findings should be explored in upcoming data collection. The analysis was also responsive to the findings as well as additional contributions from the consultation group sessions and feedback, and sensemaking discussions during these same CG sessions. The main aim of the qualitative analysis was to reach thematic saturation (33), which was achieved.

Consultation Group Sessions

A Consultation Group (CG) made up of key personnel in the Kenema project was a part of this evaluation (*Section Introduction*). The evaluation team and CG had scheduled sessions to share the findings and provide a space for validation, reflection, interpretation and sensemaking. In this manner, the CG sessions were part of data analysis as the discussions from the sessions added meaning and context to the findings that may have been absent or may have been missed during the other data analysis processes.

ETHICAL CONSIDERATIONS

MSF's ethical guidelines anchored all the evaluation processes. All participants were 18 years or older and provided verbal consent to participate in this evaluation. Data was anonymised and the identification of participants protected. The team did not experience any direct sensitivities around contraceptive use and/or traumatic birth experiences during data collection. However, measures had been put in place that included having MSF counselling support be readily available in the case of a triggered experience or response.

Data was collected in the language that communities were comfortable with. Most of the community members were comfortable with speaking to the research assistants in Krio. However, Mende is the dominant language in Kenema, and health promoters who are government employees, but also receive intermittent MSF support, were on standby to support with interpretation if it had been needed.

STRENGTHS, LIMITATIONS AND MITIGATION OF EVALUATION APPROACH

One of the limitations of this evaluation is that the recruitment efforts for qualitative data were conducted by the Kenema project team, which could result in favourability-bias if the team only recruited participants who would find MSF favourable, especially the community participants. To mitigate for this, the evaluators triangulated data across different sources seeking convergence or divergence to balance this potential risk. The recruitment strategy could not necessarily be changed in the context of this evaluation and overall, the evaluation team did not feel that this was a dominant factor, although relevant.

The Kenema project is a multi-component intervention, and this evaluation was commissioned for the whole project. As such, the evaluation cannot go in-depth for all the components/activities in the project. With this context, the evaluation covered the breadth of all the project activities. To establish depth, the evaluation focused on the historical context of the project, the maternity and the paediatrics activities as these were critical for the main purpose of this evaluation: to support the Kenema project team in evidence-informed recommendation for the implementation and transferability of the project during its remaining four years.

Key strengths of the quantitative approach for this evaluation were that data analysis was conducted in three phases with each phase informing and strengthening the next. Data was analysed for 2021 – 2024 which allowed some assessment of the project's evolution over time. The extraction of raw data from the project allowed for more detailed analysis of project data over time and within each year, facilitating an assessment of annual patterns and fluctuation of data points within each calendar year. It also facilitated the calculation of median data points for some data points.

Key limitations of the quantitative approach for this evaluation were that there was no access to project data prior to 2021. This was attributed to a loss of data on the project stored in DHIS2 prior to 2021. Although several attempts were made to access some of the data from elsewhere, several limitations were encountered specifically:

1. Data available for some project components but not all.
2. Data inconsistency between data provided and data reported with added difficulty of linking datasets.

Additional limitations of this analysis include its breadth with over 50 indicators which are not ordered by priority. This makes it challenging to have a full grasp of all the project components. In addition, it was not made clear how project targets for the indicators were derived. Some of the project indicators report only proportions and have changed over time, making it difficult to assess trends in some instances. Within datasets provided there were instances of missing data and inconsistencies between what was reported in the project reports and what was provided as raw data by the project team during the same period. Furthermore, no DHIS2 data was used for this evaluation which limited the ability to perform district level analysis of key indicators and make inferences on project impact at a district or national level.

CONTEXT OF THE EVALUATION

MIXED METHODS

Overall, this evaluation utilised a convergent non-sequential mixed-method design (34, 35). In this design, both qualitative and quantitative methods are deployed simultaneously with research questions already framed from the beginning, as opposed to sequential designs where qualitative methods or results must influence the quantitative ones, or vice versa (34).

The quantitative data in this evaluation were the routine MCH services and other project activities uptake data that was being collected as part of Kenema project activities. The qualitative data were iteratively analysed, distinctly and before the major quantitative data analysis (Phase 3) that occurred as the evaluators had been provided with a comprehensive quantitative dataset. The purpose of using mixed-methods approaches is to 1)Triangulate the two methods as an avenue for validation (36); 2) Gain a fuller understanding of the findings and potentially clarify, refine, and explain the findings across both methods; and 3) where feasible, have the results of one method inform the other (37). In the case of this evaluation, the feasibility of having the results of one method inform the other was limited due to the non-sequential way in which the data was collected.

Therefore, the evaluators selected the level of interaction[2] between the qualitative strand[3] and the quantitative strand to be an independent level of interaction (38). This level occurs when the two strands are dominantly implemented distinct from each other; and the analysis is conducted separately. In an independent level of interaction, the two strands are brought together during the overall interpretations of a study, when the main conclusions are being drawn (35, 39).

With this backdrop, the evaluation findings are for the most part presented separately in this report. Linkages and references to validate and triangulate between the qualitative and quantitative findings will be embedded in the sections. A conclusions section brings the two strands together to gain a fuller understanding of the findings and clarify, refine and further explain results across both methods.

EVALUATION TIMELINE

The evaluation began in June 2024 with a first draft of the final report being produced in October 2024, after analysis, sharing emerging findings. It is important to note that during this time, decisions and activities within the Kenema Project continued to occur, some of which align with the recommendations in this evaluation. Where relevant, these complementarities are acknowledged throughout the report.

[2] The extent to which the two strands are kept independent or interact with each other.

[3] A strand is a component of a study that encompasses the basic process of conducting quantitative or qualitative research: posing a question, collecting data, analysing data, and interpreting results based on that data.

MAIN EVALUATION FINDINGS

The evaluation findings are reported in two components beginning with the quantitative findings from the evaluation and followed by the qualitative findings. Intersecting the two sections will primarily occur in the conclusions section.

QUANTITATIVE FINDINGS

The quantitative findings are organised according to the project indicators with nested discussions and recommendations of the findings for each subgroup of indicators. All the referenced tables and figures are found in the Annexes. A composite of these sub-recommendations feeds into in the overall recommendations of this report.

HOSPITAL BED OCCUPANCY

Overall hospital bed occupancy has increased from 71% in 2021 to 78% in 2022 and 98% in 2023 (Table 1a). Although the hospital target (80-90%) was not met in 2021 and 2022, it was surpassed in 2023.

Average monthly available bed days increased from 2,387 in 2021 to 3,689 in 2022 (Table 2). After a significant increase in available beds in May 2022, the number decreased in December 2022 (Figure 1). This increase was due to changes in bed numbers in ITFC and Maternity in 2022 because of prior utilisation but were later reduced in 2023. Available bed days have remained consistent at approximately 3,000 since January 2023.

Total number of utilised bed days was lowest in December 2021, likely due to effects of COVID-19 in the region at the time and consistently lower consultations and admissions at the hospital in December.

It was noted that since January 2023 the hospital has been responsive to influxes (increases in patient numbers) and allowing for the opening of new spaces, for example in maternity and ITFC, but bed capacity within the project database has been maintained at 19 and 33 respectively for these wards.

Overall, there has been a gradual increase in monthly utilised bed days in each year from 1,073 in 2021 to 2,735 in 2023 and 2,945 for January – August 2024.

Discussion of results

- Overall bed occupancy for the hospital has been increasing since 2021. The hospital has been able to respond to demand by increasing available beds in specific departments when necessary. It is advantageous that the hospital has flexibility to be responsive to needs, which attests to project relevance and appropriateness. However, as presented, this indicator does not give a true picture of the hospital's capacity which has not been fully utilised.

  ⇒ **Recommendation**: This indicator can be adapted to reflect overall utilisation of the hospital's capacity in terms of beds (i.e. if the hospital has scope to increase bed numbers, what is the maximum possible available bed days and how is the hospital performing relative to this threshold). This has not been captured by the hospital nor the available indicators. These variations within and across departments should also be captured.

- There have been some challenges with the calculation of utilised bed days on the project. The nature of these challenges has changed over time but generally persisted since 2021. Available and utilised bed days are calculated from ITFC+IPD+MAT+NEON. However, only ITFC data are available for 2021 in DHIS2. At present the data team is having challenges tracking the utilised bed days on the project as the utilised database is doubling utilised bed days, and this is adjusted manually by the data team.

  ⇒ **Recommendation**: The calculation of reporting of overall bed occupancy and availability on the project needs to be revised to reflect true capacity of the hospital.

  ⇒ **Recommendation:** Challenges with data extraction for reporting of this indicator require resolution within the affected databases.

EMERGENCY DEPARTMENT (ED) CONSULTATIONS AND ADMISSIONS

Overall, the hospital has seen an increase in ED paediatric consultations since 2021 with 5,697 consultations in the same year, followed by 6,818 consultations in 2022 and 6,963 consultations in 2023 (Table 1a); which would likely contribute to the increases in bed occupancy as already established. In each year consultations have surpassed the hospital target. Paediatric admissions were 3,729 in 2021 and increased to 4,775 in 2022 but saw a slight decrease in 2023 to 4,657.

When assessing the average monthly admissions, it clearly shows that between January – August 2024 the average monthly paediatric admissions has been higher than the preceding years (417 in 2024 compared to less than 400 for 2021 – 2023). Across all three years admissions surpassed the targets. Overall, the majority of consultations lead to admissions (65% in 2021, 67% in 2022 and 67% in 2023).

There also appears to be a seasonal trend for admissions with the highest number of admissions observed in May in both 2022 and 2023 and lower numbers in the last quarter of the year; however, this trend has not been observed in 2024 where monthly consultations have remained between 500-600 each month and admissions between 400-500 each month.

The hospital is within its targets for both red and yellow paediatric cases triaged and sent to ED for consultation for 2021 – 2023. Among children under 5 admitted at the hospital only 82% were screened for malnutrition in 2023; this is lower than what was reported in 2021 and 2022 (96% and 93% respectively) and below the hospital target (100%).

Discussion of results

- In many instances it was not clear how some of the hospital targets were derived. There are possibilities that they were derived at project inception based on the need of the communities at the time. However, adjustment and meaningfulness have not been central to the adaptations of these over time in ways that are meaningful to the project.

  ⇒ **Recommendation**: During revision of the project indicators, it is paramount that the project targets be revised and their meaning for operations be derived.

- There is an overall increase in the load of consultations at the hospital. This trend is likely to increase and may be due to increasing need for services in the communities serviced by the hospital, a strengthened referral system, increased awareness of the project beyond Kenema or a combination of these factors, as will be shown in the qualitative findings.

  ⇒ **Recommendation**: Hospital planning should factor the increase in consultations in planning for subsequent years including the demand this will place on resources for the hospital.

- Granular analysis of the consultation and admissions data show a seasonal trend in admissions in 2022 and 2023; however, this was not observed in 2024. Seasonal trends are likely due to the changing weather (e.g. lack of clean water in some months resulting in increased cases of diarrhoea, seasonal spikes in malaria incidence).

  ⇒ **Recommendation:** Hospital management should factor the seasonal variation in consultations and admissions within planning for subsequent years including the demand this will place on resources for the hospital. There has been some indication of this in changes to the hospital bed capacity (increasing bed numbers when load is higher).

HOSPITAL EXITS AND DEATHS

The average monthly hospital exits have gradually increased from 2021 to 2023 with a median of 755 monthly hospital exists in 2021, followed by 1,104 in 2022 and 1,269 in 2023 (Table 4) (Figure 3a). The average monthly hospital deaths in 2021 were 21 and increased to 47 in 2022 then dropped to 44 in 2023. There has been an average of 46 deaths per month between January – August 2024. The overall hospital mortality rate has been consistently 6% and higher than the target (<5%) across all three years under evaluation. The hospital mortality rate excluding ED has also been 6% and higher than the project target for all three years. Separately the ED mortality has remained consisted at 1% for all three years (target 1%).

When comparing by departments (Table 4), the highest mortality is reported consistently in ICU across the 3-year period under review. this is followed by mortality in ITFC and IPD and the lowest mortality is reported in ED. Similar to admissions there is seasonality in hospital mortality with higher numbers of deaths reported in busier seasons (April – July) and the lowest deaths reported in December/January. We note that in 2021 overall hospital deaths reported were not a composite of the deaths in individual department and likely an error in reporting. This was discussed with the data manager during data validation, and it was noted that some 2021 data was recorded on desktops and not available in DHIS2 and thus what was shared with the evaluation team is likely a reflection of data management challenges within MSF at the time.

Average monthly deaths in ED were largely consistent between 2021 – 2023 (6, 5 and 5 respectively) but have risen to 9 for January – August 2024 (Table 4). Average monthly deaths in IPD, ICU and ITFC have also followed the same trend with increased monthly deaths reported in 2024. ICU has the highest number of average monthly deaths with 17 in 2021, 21 in 2022, 22 in 2023 and 33 in 2024.

The average length of hospital say in ITFC has dropped from 10 days in 2021 to 8 days in 2022 and 7 days in 2023.

Malaria case fatality among IPD admissions was highest in 2023 (4%) when compared to 2021 and 2022 (3%) (Target 5%). Malaria case fatality rate among ITFC admissions was higher than IPD across all three years and highest in 2022 (8%) and lowest in 2023 (0.2%).

Discussion of results

- Overall hospital mortality among admitted patients in the project remains higher than the target of 5% across all three years of the secondary analysis. Maternal mortality in Sierra Leone is one of the highest in the world and the mortality rates of neonates, infants and children under five are also significantly high, globally. Investments and activities implemented by MSF such as the active ambulance service and community outreach activities have not resulted in a drop in hospital mortality. The sustained higher than optimal hospital mortality even within a highly equipped facility may be driven by continuous late presentation of complicated cases. When compared to paediatric deaths in the MSF run hospital in Liberia in 2009 where paediatric mortality was also 6% (40), minimal improvements have been seen in Kenema despite the huge running/overhead costs of the Kenema Hospital.

  ⇒ **Recommendation**: A detailed assessment of the causes of hospital deaths at Kenema is warranted to establish why the hospital mortality, by department, has not decreased over time and remains comparable to that of similar settings in Sierra Leone or in the region- especially because one of the main aims of this project is to reduce maternal and child mortality.

- Monthly hospital deaths were lower in 2023 when compared to 2022. This could be a result of improved patient care, or people coming to the hospital early before complications (likely due to activities of the ambulance service or community outreach activities) or the hospital may have seen less complicated cases, or it could be a chance finding.

  ⇒ **Recommendation**: Ongoing monitoring of hospital deaths comparing months and years is necessary to understand trends. It is important that this monitoring goes beyond values reported in indicators (month on month raw data review), including reflection and discussion amongst hospital departments. Internal coherence with outreach activities is also necessary, with the aim of assessing how more deaths can be averted. Such an approach will also assist the hospital in early response.

- Recording of Hospital deaths is an ongoing challenge with changes in how this is reported across various departments and challenges with the ascertainment of true historical data.

  ⇒ **Recommendations:** Review and clarification of hospital deaths by department and consolidation of databases used across the project.

- There is an alarming increase of deaths across all departments in the hospital in 2024 (Table 4). The increases are high and consistent across departments.

⇒ **Recommendations:** Urgent assessment of causes of deaths across all departments.

COMPREHENSIVE EMERGENCY OBSTETRIC AND NEWBORN CARE

As the maternity ward only opened in May 2022, the majority of CEmONC indicators were not available for 2021 and had missing data for 2022. The median number of pregnant women admitted monthly rose from 45 in 2022 to 110 in 2023 and 125 in 2024 (June – August) (Table 5). The median number of c-sections each month also increased from 20 in 2022 to 38 in 2023 and 45 in 2024 (January – August) (Table 5). The caesarean section rate decreased from 50% in 2022 to 28% in 2023 (Figure 7).

The proportion of facility deliveries out of expected deliveries in Kenema was 46% in 2021 and 44% in 2022 and 2023 (Target 70%). Less than half of the expected deliveries are facility deliveries. It is unclear how estimates of expected deliveries are derived, nor which facilities are included in ascertaining this value.

CEmONC obstetric mortality was 1% for 2022 and 2023 (Target < 1%). CEmONC neonatal mortality was 10% in 2022 and increased to 14% in 2023 (Target <15%). 73% of neonates were breastfed within the first hour of life in 2023 (target 100%).

The number of stillbirths decreased from 149 per 1,000 births in 2022 to 120 per 1,000 births in 2023 (Figure 6), which may be reflective of improved elements of QoC like staff capacity to manage complicated deliveries or community awareness to seek care early, as well as experience in the project as maternity services began being provided in 2022. The project target for still births is <25.7 per 1,000 births, meaning that despite showing an improvement, the number remains quite high relative to the target. No indicator data was available for Partogram chart audits.

Vaccinations

According to the project indicators only 38% of newborns were vaccinated in maternity in 2023 (Table1) this was inconsistent with raw data provided by the project which showed much lower numbers of newborns fully vaccinated. In Sierra Leone the vaccination schedule for children includes BCG at birth, penta-1 at 6 weeks, penta-2 at 10 weeks, penta-3 at 14 weeks, and MCV-1 at 9 months (41). When assessing raw data provided by the project there was only 1 vaccination recorded (December 2022) prior to September 2023. The proportion of vaccinations has increased in 2024 where the highest number of newborns fully vaccinated per month were recorded in June 2024 (18); however, there has been no consistency across the months.

There was no data available for pregnant women vaccination with tetanus-diphtheria.

Discussion of results

- The majority of the indicators for CEmONC are only available for 2023.

⇒ **Recommendations:** there is need for long term monitoring of fluctuations of these indicators. This will include consistent capture of the critical data points and comparison with different time points internally (MSF hospital) as well as similar facilities (e.g. KGH).

- CEmONC neonatal mortality increased by 4% between 2022 and 2023. This increase may be due to admissions of more complicated cases. However, this is not reflected in obstetric mortality which has remained consistent between 2022 and 2023.

  ⇒ **Recommendation:** Assessment of neonatal care within the hospital to ensure the highest level of care is maintained for this subgroup. This assessment should include a review of the causes of neonatal deaths in 2022 and 2023 for the implementation of preventative measures.

- There have been some positive shifts in CEmONC indicators including the decrease in stillbirths between 2022 and 2023 and the decrease in caesarean sections during that same period. The national stillbirth rate for Sierra Leone was 23.14 per 1,000 births in 2021. When compared to national data, the MSF hospital stillbirth rate is significantly higher (120 per 1,000 births). As the MSF hospital is tailored for more challenging cases this comparison may not be ideal; however, the stillbirth rate recorded by the project is also exceptionally higher than the project target and assessments of why this remains high when the necessary care is available is warranted. A review of the project targets may also be needed to ensure alignment with the context of the project and cases presented where there may potentially be much higher risk pregnancies and births.

  ⇒ **Recommendation:** Assessment of neonatal care within the hospital to ensure the highest level of care is maintained.

- There are very low number of vaccinations in the maternity ward. This may be due in part to the MSF hospital's dependency on the MoH for these vaccinations, where the MoH only comes to vaccinate on specific days, increasing the likelihood of no vaccinations for patients who do not stay or are not available on those set days.

  ⇒ **Recommendation:** There is an urgent need to review and revise pathways to care for newborn vaccinations. Although this is something MSF has been collaborating with the MoH, the proportion of newborns vaccinated remains low and existing pathways may need strengthening. One way to do this may be to increase MoH vaccination days as part of the integration activities, which would improve vaccine uptake now, but also serve as streamlining MSF activities into MoH.

- There are some CEmONC indicators where targets are not reached but implementation is largely dependent on hospital staff activities. These include FP counselling.

  ⇒ **Recommendation:** Staff checklists and reminders for key activities will assist in the completion of some activities that are preforming below the expected hospital targets.

QUALITY CONTROL

The majority of quality control indicators surpass the project targets for 2023 and have shown positive increases between 2021 – 2023. These include charts and alert forms showing adherence to MSF guidelines.

Medicine did not appear to be prescribed appropriately across all departments in 2023. Although there is no data for these indicators in 2021 and 2022, indicator data from 2023 shows less than 50% of medication prescription instances were appropriate in all departments.

Discussion of results

- The majority of quality control indicators are performing well; however, considerations should be made to ensure these align with MoH guidelines as the hospital begins transition. This is critical as the MSF hospital functions on a premise of high quality of care and there is an anticipation for this QoC to be maintained during and beyond the transition phase of the hospital to MoH.

  ⇒ **Recommendation:** Ensure quality control measures and indicators are aligned to those of MoH to ensure alignment during and beyond the hospital transition phase.

- The majority of medication prescription was not appropriate for all departments. This issue may stem from how this indicator is calculated. However, such low performance is a critical red flag. It is not clear what benchmark is used and how this data is collected.

  ⇒ **Recommendation:** There is an urgent need to review medication prescribing across all departments to ensure this aligns with how medication should be prescribed within the hospital.

INFECTION PREVENTION CONTROL

Hand hygiene compliance among hospital and CHC staff has decreased since 2021 (Table 1b) (Figure 9). Cleaning compliance using a reflective surface marker has improved from 66% in 2021 to 81% in 2023 and surpassed the project target of >75%. IV bundle compliance improved from 59% in 2021 to 91% in 2022 and 88% in 2023 although this is below the target of 100%. SIPA assessment has improved from 31% in 2021 to 92% in 2023 (target 70%).

There is no data for IPC plans initiated and completed across all three years.

Discussion of results

- Although the collection of IPC data is critical for maintenance of hospital standards, these are not clinical activities and to allow focus on the improvement of clinical indicators it may be prudent for these to be dropped from the list of hospital indicators which is currently quite long.

  ⇒ **Recommendation:** Remove IPC from project indicators. These data can be collected and reported internally to staff to ensure compliance and maintenance at high levels but in the absence of major incidence should not be included as project indicators.

- Hand hygiene at the hospital and CHC is poor.

  ⇒ **Recommendation:** Ongoing reminders are warranted to ensure staff complete all necessary hand hygiene procedures. This may require brief refresher trainings, printed material in facility to remind staff and consistent internal checks by senior members of staff.

REFERRALS

The majority of patient referrals to KGH from MSF hospital had feedback recorded (98% in 2022 and 100% in 2023). The occurrence and recording of coordination meetings with KGH appear inconsistent (75% reported in 2021 and 7% reported in 2022, no data reported in 2023). It is not clear what the total number of meetings should be and why there are such large shifts in this indicator between the two years where it is reported. Additionally, in qualitative discussions, KGH staff noted that such meetings to discuss patient diagnosis and treatment plans were not happening anymore which made it difficult for the KGH staff to manage patients from MSF.

Under-5 consultations at primary health units, correctly referred to a secondary health care out of all under-5 primary health consultations that needed referral to secondary health services at CHCs supported by MSF have increased gradually from 58% in 2021 to 72% in 2022 and 99% in 2023 (target >70%) (Table 1d). HP community referrals that arrive to PHUs supported by MSF out of all HP community referrals made represented 76% in 2021 and increased to 97% in 2022; however, they dropped to 78% in 2023 (target >70%) (Table 1e).

The referral out rate at the staff clinic has decreased from 2.2 in 2022 to 1.9 in 2023.

Discussion of results

- It is positive to note that completed referrals to KGH are captured. Given MSF plans to hand over the hospital to MoH, capturing the bidirectional relationship between KGH and MSF is important.

  ⇒ **Recommendation:** Ongoing capture of referrals to and from KGH during the transition phase of the hospital. Where feasible more granular data on the types of referrals should be captured.

- There is a need to review and capture coordination meetings between MSF Hospital and KGH, particularly during the transition phase.

  ⇒ **Recommendation:** Where meetings are held between MSF and KGH these should be captured and recorded. This may not be an indicator for the project but will provide useful information on the ongoing relationship with KGH.

- There are some fluctuations in successful community HP referrals to PHUs supported by MSF. The drop in successful referrals for 2023 is of concern.

  ⇒ **Recommendation:** A review of reasons for incomplete community referrals to PHUs. There may be need to more support to strengthen community referrals to PHUs. Possible reasons for incomplete referrals may be transportation challenges or distances needed to travel to PHUs or low severity of referred cases.

PHARMACY

The hospital's pharmacy indicators do not appear to be captured consistently or correctly. A review of pharmacy indicators and how this data is collected and reported is warranted.

The proportion of MSF supported PHUs with all essential IMCI/iCCM and Outpatient therapeutic programme (OTP) drugs and supplies gap-filled by MSF increased from 25% in 2021 to 96% in 2022 and dropped to 92% in 2023 (target 75%). Rupture (stock-outs) of essential drugs for outreach activities decreased from 75% in 2021 to 4% in 2022 but then increased to 10% in 2023. The target for rapture is <5%. Staff involved in outreach activities spoke strongly about the challenge of rupture of drugs which made it challenging to meet support expectations for the PHUs anticipating these drugs.

⇒ **Recommendation:** Review and revision of hospital pharmacy indicators with view that these may be better placed as routine monitoring and evaluation data rather than a project indicator.

⇒ **Recommendation:** There is a need to assess the reasons for rapture in outreach activities as this increased in 2023.

LABORATORY

Almost all patients receive blood within 4 hours of need at the hospital and only 2 blood transfusion reactions were reported in 2023. The contamination rate of blood culture has been higher than the target (<3%) for both 2022 and 2023 where it was 4.5 and 5.6 respectively. Blood culture and antibiograms reported within 48 hours dropped from 97 in 2022 to 73 in 2023.

⇒ **Recommendation:** With increasing hospital load, the demand on the laboratory is likely to increase. This may have negatively affected some of the key indicators such as reporting and contamination. The project should ensure that any adjustments made external to the laboratory should also factor in ripple effects within the laboratory.

MENTAL HEALTH

All ITFC beneficiaries arrived for mental health (MH) counselling after referral across 2021 – 2023. This was similar for HIV testing and counselling (HTC) beneficiaries in 2021 and 2022. However, a drop was observed in 2023 where only 71% of HTC beneficiaries arrived for MH counselling out of all those referred. Only 27% of caretakers received a psychoeducation session prior to discharge in 2022 and 47% in 2023 which was below the project target of 80%. A similar drop is observed for patients sent for HIV testing who receive full pre/post-test counselling as 99% received this in 2021 and only 71% in 2023. Drops in the proportion of patients admitted to ITFC who receive developmental milestone screening were also recorded with 96% reported in 2021 and only 41% reported in 2022. There was no data provided for this in 2023.

Discussion of results

- Overall, there appears to be a de-prioritisation of mental health/counselling activities across the hospital since 2021. Almost all indicators appear to have a negative decline with less patients receiving counselling or education sessions or developmental screening. Reasons for this de-prioritisation are not clear and may be linked with staff training, or availability of trained staff to conduct activities. The workload on staff who are required to do many other clinical activities in addition to those reported here may also pose a hindrance.

⇒ **Recommendation:** Project evaluation of all MH activities which may be impacted by low staff training, high staff load or general de-prioritisation of mental health activities at the hospital.

OUTREACH

The average number of consultations per under-5 (U5) child in supported iCCM villages in the catchment area of PHUs supported by MSF was 0.5 for both 2021 and 2023 (target 0.5). The denominator for this indicator is unclearly defined. There was an increase in the proportion of iCCM communities, consulting at least 90 U5 children per quarter among MSF targeted communities from 58% in 2021 to 79% in 2023.

All PHUs supported by MSF have had secure cold chain from 2022. The majority of CHWs (96%) in 2021 demonstrated knowledge of identification of danger signs for referral to care.

In 2023 all U5 cases of diarrhoea and phenomena were treated in iCCM communities targeted by MSF. This reflects the likely effectiveness of iCCM activities in addressing under-5 mortality and morbidity factors at PHC level and possibly eliminating the need to refer such cases to a facility.

The proportion of TBAs that demonstrate knowledge of identification of danger signs out of all TBAs in iCCM communities targeted by MSF has increased steadily from 33% in 2021 to 74% in 2022 and 99% in 2023. The proportion of Pregnant and Lactating Women (PLWs) and women of reproductive age referred by CHWs/TBAs for SRH services and are received at PHUs supported by MSF increased from 61% in 2021 to 89% in 2023 and has surpassed the target of 80%. Postpartum women and their newborn receiving PNC1st visit within 7 days out of all post-partum women who gave birth at a facility supported by MSF was 75% in 2021, 39% in 2022 and 97% in 2023.

Under-5 children screened for malnutrition by CHWs decreased from 98% in 2021 to 82% in 2023 (target 100%). Similarly, U5s screened for malnutrition in PHUs dropped from 81% in 2021 to 47% in 2023.

There was 100% appropriate prescribing practice for positive rapid diagnostic tests (RDTs) in 2023. Correct antibiotic prescribing according to IMCI guidelines has also improved from 83% in 2021 to 97% and 96% in 2022 and 2023 respectively.

There were 100% referrals to primary health care for children U5 registered by a CHW with at least one danger sign from iCCM communities in 2023. There has been consistent improvement in U5 primary health consultations correctly referred to secondary health care from 58% In 2021 to 99% in 2023, suggesting that the training provided to the CHWs on identification and referrals is being effective.

The average length of treatment per child cured U5 in Outpatient therapeutic programme/ Ambulatory Therapeutic Feeding Centre (OTP/ATFC) programme has increased from 7 weeks in 2021 to 11 weeks in 2023 and is currently higher than the project target of 8 weeks.

All PHUs supported by MSF in 2023 had a verified water source. However, in 2023 there was a small proportion of villages that did not have access to a safe water source and no villages had vector control preventative approaches.

Discussion of results

- The majority of MSF activities in iCCM communities are performing well; however, there are few which appear to have not improved specifically screening for malnutrition in PHUs and CHWs. These were both below the 100% target in 2023 and lower than performance in previous years. The average length of treatment for cured U5s in OTP/ATFC programs has also increased from 7 weeks in 2021 to 11 weeks in 2023. This increase may be due to late detection of children with malnutrition and a result of the reduced screening for malnutrition.

  ⇒ **Recommendation:** Outreach staff should ensure that staff in PHUs and CHWs maintain high levels of screening for malnutrition among children U5.

HEALTH PROMOTION

The majority of caretakers have scored >70% on message comprehension out of all caretakers tested at the MSF Hospital and communities from 2021 – 2023 (88%, 86% and 94% respectively, target >70%). Caretakers receiving admission orientation increased from 51% to 87% between 2022 and 2023.

Seventeen community engagement sessions were done at MSF-supported PHUs in 2023 (4 per PHU). The health promotion (HP) community referrals that arrive to PHUs supported by MSF decreased from 97% in 2022 to 78% in 2023. Health promotion is critical for disseminating knowledge, as well as sensitising communities about risk factors and how they can respond in emergencies. This decrease in HP-based referrals may be contributing to the persistent delayed presentation for MCH care at the MSF-hospital and the subsequent increase in hospital mortalities over time.

66% of children from catchment area discharged from ITFC and residing in catchment areas of PHUs supported by MSF and Kenema city were enrolled into an available OTP/ATFC programme in 2023. This is lower than the target of 90% but higher than recorded in 2021 (14%). This also suggests that those children who do not reside in MSF supported communities but accessed ITFC at the MSF-hospital did not receive further support after being discharged. Again, this strengthens the criticality of aligning outreach and hospital services to function complementarily and collaboratively for needed follow-up support.

Across all 3 years under review, the majority of caregivers whose child received a blood transfusion received a blood donation session. Among caregivers assessed at MSF hospital 59%, 51% and 91%

could correctly describe how to give treatment of the prescribed medication to their children from 2021 to 2023.

⇒ **Recommendation:** Strengthen HP community referrals to HPs.

STAFF CLINIC

Between 2022 and 2023 MSF staff clinic consultations reduced from 25 per day to 14 per day. During the same period, the malaria positivity rate increased from 47% to 58%. All staff were contact traced after correct contract tracing Standard Operating Procedure (SOP) in 2023.

⇒ **Recommendations:** The staff clinic is one of MSFs activities in Kenema, but it is not a project activity and may not be well placed among the project indicators. Instead, it can be tracked as part of MSF resource utilisation assessments.

QUALITATIVE FINDINGS

The qualitative findings are organised by the macro-themes from the DAC criteria as requested in the Terms of Reference (ToR): Relevance, Appropriateness, Effectiveness, Efficiency, Continuity, Coherence and Sustainability**.** Each macro-theme has subsequent sub-themes to provide more nuance as part of the data interpretation.

RELEVANCE OF THE KENEMA PROJECT

In this evaluation, relevance refers to the extent to which the project activities and objectives respond to stakeholders' needs, priorities, and policies and can continue to do so if circumstances change. The guiding questions (see ToR) for this include:

a. To what extent is the project responding to the needs of the targeted populations?
b. Has the project been in accordance with the priorities of MSF-OCB?
c. How does the project align with the priorities of the relevant local authorities?

These questions are further reinforced by exploring the reach, fidelity, quality and acceptability of the project activities that were implemented, as well as the effect of the project activities on its intended beneficiaries and stakeholders; the unintended consequences of the project; as well as understanding the role of the context in which project activities where implemented (Annex I: Evaluation Matrix).

Key Findings on Relevance

- **Project activities are primarily addressing the maternal and child health needs of Kenema communities**, through PHC approaches of outreach activities, and secondary care approaches of service provision at the MSF hospital.
- **The use of semi-temporary infrastructure (Gaptek) to build the hospital is at odds with longevity or sustainability** of the project beyond MSF's tenure running the project.

Relevance: providing medical, quality care

MSF is a "medical, humanitarian organisation". The 'medical' and 'humanitarian' aspects of MSF are positively magnified in the Kenema project. Quality clinical care was exemplified in observations of staff at the hospital, as well as from community members who have accessed the services. Clients were reported to come from as far as Freetown and Guinea because they have been told one is guaranteed 'quality care' at the MSF hospital. Some of the participants noted that the deficiency of the project comes in the other aspects of health care, that are important/necessary to improving health outcomes but are not medical or humanitarian. For example, one on the key challenges in the Sierra Leone health system is the lack of incentivisation for health providers and the ripple effects that exists because most of the health providers are not paid. MSF has an opportunity to utilise its learnings and insights from the Kenema project. It has not been visibly using the evidence about how HRH incentivisation can work, to advocate or make a case for adequate financing of health providers' salaries in the country, which would potentially reduce the drug/commodity thefts as well as the persistence in making patients pay.

Relevance of the MSF hospital

According to participants and document sources in this evaluation, MSF was resourced to use the lessons learned from the Ebola pandemic to support the prevention, treatment and care for Lassa Fever in Kenema. However, according to participants, this strategic objective did not receive adequate buy-in from the MoH, which prompted MSF to shift its strategic placement to other health system challenges like MCH in the district. Such that at inception, this project did not have complete government buy-in. However, over time the relevance of the hospital in addressing MCH needs was realised.

Participants from the MoH particularly articulated the relevance of the MSF's maternity efforts. According to them, KGH is a referral hospital serving three districts and beyond including cases from Liberia as well as Pujehun, which is the district in Sierra Leone that has the most maternal and child deaths. Therefore, KGH is overwhelmed, and their capacity cannot meet the needs of the population it serves. In the case of caesarean sections, staff at KGH noted that when they are overwhelmed, they refer to the MSF hospital, or they request materials and logistics support. This kind of referral occurred primarily during a time when KGH's surgeons were not available or in cases where KGH is running out of stock for essential drugs.

"There was a time when all of Kenema district did not have magnesium sulphate to manage (pre) eclamptic cases; and MSF supported with 200 vials"

(Interview 2, female, KGH staff)

In addition, community members lauded the hospital services' relevance, but they raised some concerns about the process of providing these services. For them MSF supports under-five children, but they could not reconcile why or how the project will treat and support an under-five child brought to the hospital but will not treat the parent/guardian who has brought them, even if that parent/guardian may also be ailing. This raises an important consideration about holistic care and support, including whether MSF is equipped or willing to provide such care and support.

Relevance of the outreach services

In terms of medical services, the outreach services manage the paediatric and under-5 cases using iCCM and train the PHUs to be able to conduct safe deliveries at the PHU and quickly identify the complicated cases that need to be referred. Outreach is also where SRH is primarily offered, including family planning.

The outreach support provided to the PHUs is highly valued and considered relevant by its beneficiaries. PHU staff appreciate and find relevant the financial incentives, additional training and essential drug commodity support they are receiving through the Kenema Project. The project's goal is to complement government efforts through gap-filling. Even in MSF-supported PHUs, it is unrealistic to expect a sustainable supply of essential drugs, as the main drug supply is coming from MSF.

"Most of the PHUs easily stock out of medication, because they are being supplied with drugs on quarterly bases, and if a PHU is covering let's say about 10 thousand people and have small amount of drugs, let me say with two weeks they could have stocked out of drugs, but for the PHUs that MSF support, they do monitor that their drugs are being well supplied and how they're being given out, so you see that they don't stock out of drugs"

(Interview 8, PHU1 staff)

Community members need the services at the MSF-supported PHUs. Many of them leave the PHU closest to them to access the PHUs that are supported by MSF. There is a perceived guaranteed quality care and support from a PHU that is supported by MSF.

Outreach activities are also addressing sexual and reproductive health (SRH services) needs through supporting and training the PHUs and communities to have safe deliveries and adequate ANC. Additionally, the SRH component in outreach has also launched SGBV activities to ensure that survivors and victims have access to care and support. Women appreciated the provision and support for contraceptive care through MSF and noted that they now plan for their families how they want to.

"MSF even come and meet us in our village and sensitise us on how to take care of our children, the type of food we should give to them, so we feel very proud of them when they go to visit us, sometimes even take the injection to us for our children, even you have given birth to a lot of children, they would advise you to stop and they would give you medicine for that for free or if you want them to stop you not to give birth anymore"

(FGD10, females, MSF hospital)

While it is clear that SRH services are addressing needs, some MSF participants articulated that introducing the SGBV component right now may compromise quality of care within the project since the SRH department is understaffed and SGBV requires adequate resources, human and otherwise, to provide quality care. It was noted that there is a Rainbow Initiative that addresses SGBV in Kenema, and perhaps a collaborative referral programme between the initiative and the project would support adequate SGBV service provision.

Additionally, community gatekeepers also appreciated the respect and involvement that the project facilitates, with many of them articulating that MSF reaches out and includes them when they are planning activities.

Contextual relevance and resilience

The contextual resilience, and in some cases contextual relevance of the Kenema project as it is, is compromised. For example, the hospital is primarily Gaptek, which is an infrastructure that has an expiration date, and the company that provided the Gaptek no longer exists. Based on this, at some point in the next 5-10 years, this infrastructure's quality will deteriorate. Additionally, the hospital is off grid in terms of water and solar, with sophisticated systems operated from Europe. This has implications for how feasible the transferability and subsequent sustainability of project activities are. Before considering the medical components of MCH service delivery, the current ask/position to have the government take over such an operation presents a significant hurdle. The Kenema health system is not equipped for such an operation and will unlikely become adequately equipped in a 4-year period. In the handover strategy and its operationalisation, it will be prudent for the project to acknowledge this limitation. As part of handover activities, MSF may need to consider changing some temporal structures to permanent structures or less complex ones that can be easily maintained after the handover process.

Improving socio-economic wellbeing

One of MSF's mandates as an NGO in Kenema through the agreement signed with governments, was to contribute to the socioeconomic wellbeing of Kenema communities. While this finding was not primarily articulated by the community, participants from both the district government and the community applauded MSF for creating jobs and employing both their children and unsalaried health providers. The government appreciated that MSF has been able to take health providers who are not pin coded (unsalaried) and employ them with a salary in the Kenema Project.

"Most of our brothers and sisters were jobless, but when MSF came, they were able to help the majority to work in the medical field to deliver services for communities, so we don't even want anything to happen to MSF."

(FGD10, females, MSF hospital)

Additionally, MSF support has gone beyond MCH services and has included rehabilitating water sources to make them safer to drink, which the communities noted was important and beneficial to them and their wellbeing.

APPROPRIATENESS OF THE KENEMA PROJECT

In this evaluation, appropriateness refers to the extent to which the project objectives and operationalisation are aligned with the identified needs and gaps. The guiding questions (see ToR) for this include:

a. Were the organisational, strategic set up (re. human resources, functional/hierarchical matrix, project components) and the deployed resources flexible enough to respond to changes in the project?
b. To what extent were limitations and barriers of access to health services known and appropriately considered in the design and/or at a later stage of the project?
c. Which opportunities can increase the project's appropriateness?

These questions are further reinforced by exploring the fidelity, and quality of the project activities that were implemented, as well as understanding the role of the context in which project activities where implemented (Annex I: Evaluation Matrix).

Key Findings on Appropriateness

- **The resources availed and strategic set up of the project responded** to addressing known maternal and child health challenges in Kenema.
- **The combination of secondary care and primary health care activities appropriates** both top and down approaches to maternal and child health care needs, addressing both supply and demand side barriers and opportunities to improving MCH in Kenema.
- **Negative perceptions on the appropriateness of some project activities have been shaped by inadequate communication and community engagement.**

MSF Response to access to health service challenges in Kenema

The factors that hinder access to MCH services in Kenema have been documented and include distance to facilities, appealing treatment at public health facilities, inability to pay for services, use of traditional medicines and prioritisation of economic activities (delayed access), among other factors. Primarily, the Kenema project has addressed these challenges through its activities. Participants reiterated the project's importance in training TBAs and providing them with stipends as a mechanism for discouraging home deliveries. One of the MCH challenges that has been reported in the literature about Sierra Leone is the significant use of traditional medicines and herbs, which then result in complications and a need for secondary or tertiary care. Community members reflected on their use of herbs before the project's presence in their communities or before their awareness of the comprehensive care package that is offered by MSF.

"My child was sick, I was giving her herbs, and a sister told me to take the child to MSF. As soon as we arrived, the doctor took the child from me pamper the baby, encourage me, I felt good"

(FGD5, females, KPandebu)

Community members consistently compared the MSF hospital to government services. For them, the quality of care at the MSF hospital was highly acceptable and regarded compared to government hospitals. At the MSF hospital everything is free, the providers are friendly, and MSF staff respond immediately and offer care, improving the likelihood of positive outcomes for pregnant women and children, as reflected in the increase in hospital discharges over time *(see section Main evaluation findings, Quantitative findings, Hospital exits and deaths).*

"Government hospital is a government death, because if you go there without money, you will lose your patience, because they would just write prescription for you and tell you these drugs are not available you can go and buy them… The differences between MSF and PHU here are that at the PHU you have to pay for everything down to gloves"

(FGD18, females, Boajibu)

Female beneficiaries noted that they would want MSF to teach their government nurses how to treat them well and kindly**.** One of MSF-OCB's strengths is the utilisation of person-centred care, which is part of the MSF Academy's curriculum, when providing health services. There is potential for this part of the curriculum to be cascaded as training for government staff who will take over, as an approach and part of the handover activities.

There was an awareness from the males in communities, who are not direct recipients of MCH care, that MSF's role is important and appropriate. They spoke about how they also come to MSF PHUs on ANC days with their wives and have experienced the quality and friendly care. There is evidence (42-44) that shows the value and importance of including men in MCH care but this Kenema project has not conducted activities to directly intervene with men for improved maternal and child health in the Kenema communities.

Sensitisation and socialisation of MSF-hospital criteria.

Broadly, the MSF hospital criteria for paediatric care are U5 children who have the top 3 morbidities, which are malaria, pneumonia and/or diarrhoea plus malnutrition. The quantitative results showed that malnutrition screening is not happening consistently at the hospital, as well as in the community for clients who engage with project activities. This may imply that the eligibility criteria are not being fully adhered to (U5 children being admitted without recorded knowledge of their malnutrition status).

The eligibility criteria for maternal care are a longer checklist that is found and used at the emergency room, which is the entry point for care. Participants highlighted that the Kenema project does not adequately inform them of the maternity eligibility criteria, such that some of them show up to the hospital anticipating access to care but do not receive it. Community members wanted better sensitisation on the services available at the MSF hospital and who is eligible to access those services, noting that the outreach team could be responsible for this health education/ promotion activity. This was reinforced by some government participants who stressed that they are aware that MSF is providing quality services and quality treatment to pregnant women and children, but only when they meet the criteria. For these government staff MSF needs to inform the public of their criteria, as there is some perception that if you are pregnant, you can access MSF services.

These findings suggest a continuous need to socialise and inform all stakeholders on the hospital criteria and how to establish determining eligibility.

EFFECTIVENESS OF THE KENEMA PROJECT

In this evaluation, effectiveness is defined as the effect (qualitatively) of the project on its intended beneficiaries, its implementors as well as other stakeholders who have been involved in the project. Additionally, effectiveness also refers to how well the project has achieved its intended objectives and set targets over time. The guiding questions (see ToR) for this include:

a. What are the set objectives and expected results in the historical evolution of the project?
b. What are enablers and barriers (expected or unexpected) that were influencing the achievement of the set objectives?
c. What opportunities can be identified to make the project more effective?

These questions are further reinforced by exploring the reach, fidelity, acceptability and quality of the project activities that were implemented; the unintended consequences of the project; as well as understanding the role of the context in which project activities where implemented (Annex I: Evaluation Matrix). The intended objectives of the project have been described in the Introduction, (MSF's Kenema project) and the quantitative sections have noted that for the most part it is unclear how hospital targets (the rationale) were set. This section presents the findings connected to effectiveness.

Key Findings on Effectiveness.

- **The quantitative effect of the Kenema Project's contributions to reducing maternal and child mortality in Kenema was not established in this evaluation, but qualitatively community members and health providers identified observing reductions in maternal and child deaths due to the project interventions.**
- The outreach activities, specifically the **PHU support and ambulance referral systems, have been effective in reducing the delays in access to care and improving the quality and availability of MCH services** at PHC levels.
- **The effectiveness of the outreach support at PHUs is conditioned by MSF's presence at the PHU.** On the days that outreach is not present, some of the supported PHUs still expect patients to pay for services, among other challenges.
- **An unintended effect has been the dependency on Kenema project activities by both community members and government stakeholders**. This can compromise the transferability of these activities by a different implementor/steward, as well as create expectations that cannot be met among project beneficiaries.

The effect of PHU support

Males in Kenema articulated the support and contributions from these activities and how they positively impacted the communities. Men spoke about the structural changes that MSF did at CHCs (fixing labour rooms, roofs of the health centres, solar, toilet water and electricity rehabilitations, etc.). They articulated that MSF's presence in the communities has reduced the need to refer malnourished children to KGH meaning that the care is brought to the community, closer to the children and their families.

"MSF selected five (5) of those communities to be supporting them with drugs through the community health workers (CHW), which has helped reduce unnecessary death rate, they bring in the drugs themselves and give it directly to CHWs, as they train them also, and at the end of the month, they report to them how it was used and the change or improvement it has made"

(FGD4, males, KPandebu)

The support provided to PHUs is not consistent nor adequate. This is underpinned by inconsistencies in the routine quantitative data from the PHUs and exemplified by the poor results on malnutrition screening within the community *(see section Main evaluation findings> Quantitative findings> Outreach).* One PHU noted that the Kenema project failed to provide them with essential drugs (for maternity), even after they had been consistently asking, and the CHWs supporting this PHU also noted that they are not being provided with commodities to support their work. For this PHU, the government of Kenema had also stopped supplying essential drugs to the PHU because they consider the PHU an "MSF PHU" with expectations for them to maintain a standard of excellence. However, the other PHUs noted that they receive all the essential drugs they need from MSF, who is supplementing (gap filling) government supply to ensure they do not run out.

The eligibility criteria for PHU support includes having a large population catchment area, high morbidity, logistical challenges and/or inability to provide quality services, which likely makes all 134 PHUs in Kenema eligible for the 1-year level of support. At the time of this evaluation's data collection, MSF was moving out of one PHU and conducting needs assessments to then move to support other PHUs. The community members supported by this PHU noted that they still required support 1 year after the Kenema project had been intervening. They reflected how the PHU would go back to inefficient and ineffective ways of working after MSF departed, reflecting concerns about what happens when MSF leaves.

"When we come to the clinic, they will tell us the key is not around, they will ask us to go and buy the drugs. When MSF is around, they treat us free but as soon as they leave the [health provider] will leave the clinic."

(FGD4, males, Pandebu)

"At the clinic, when MSF was not around, the staff shouted at me, the toilet was filthy, there was no water. On the card it is written not for sale but when we come the nurses ask for money. The days MSF are not around the nurses at the clinic ask for money"

(FGD5, females, Pandebu)

The Kenema Project's effectiveness is also conditioned by its presence at the PHUs. At one MSF-supported PHU, data was collected from both the health providers and community members who access the PHU. The health providers noted that the outreach support was relevant, appropriate, and effective, and they felt incentivised and motivated to conduct their work. However, community members, notably pregnant expecting and new mothers, noted that the MSF system only works when the outreach team is present at the facility. When the team leaves, the community members continue to be asked to pay for commodities, drugs, and fear the negative attitudes of health providers. This finding was reinforced by MSF staff as well: their awareness that when they leave drugs/stock at PHUs,

the staff there will sell them to the patients after they leave. To mitigate this, the community members said they now wait and come to the clinic for services only when they know that the MSF team or one of its members is there, because on other days it is *'business as usual'.* In this case, access to readily available quality services becomes undermined.

The integrated community case management (iCCM) approach was generally noted to be effective. According to some participants, iCCM has been effective as both a preventative (of complications) and treatment measure ensuring that there is a reduced need for under-five consultations at the PHUs. iCCM is used as part of the outreach services for under-five support and conducted by CHWs. As part of iCCM, CHWs provide drugs for malaria and diarrhoea, and they should also be conducting screening for malnutrition which was shown to be poorly reported on *(see section Main evaluation findings> Quantitative findings> Outreach).*

One significant finding illustrating the effectiveness of the project's work for women in the communities was around family planning health education. In a focus group with males from an MSF supported community, they spoke candidly about the importance of the project work around family planning. They noted that MSF was already providing health education about contraceptive use, before they could offer the commodities in the community. According to them, the Kenema project was able to get buy in and support from even religious leaders, other community stakeholders and parents of girls who are using contraception, and this has normalised contraceptive care in their communities.

Overall, there are thoughts that outreach activity is seen or treated as secondary to the main hospital activities among some staff at MSF *"the project always takes outreach as the last priority"*. This notion was reinforced in other discussions that stated the challenges related to the outreach activity, which include:

1. The outreach team does not have full control to manage its staff and activities, which prolongs decision-making.
2. The outreach services never have enough essential drugs and stock available relative to the catchment area they are supporting.

This finding may explain why some PHUs noted that they are not provided with essential drugs when they request them from MSF but also magnifies how the potential effectiveness and plausible impact of the outreach activities may not be realised. This finding also complements the high rupturing of drugs for outreach activities that is quantitatively reported on *(see section Main evaluation findings> Quantitative findings> Pharmacy*

Lastly, at the time of the evaluation, the exit strategy planned to reduce the PHU support from 1 year to 6 months to enable MSF to cover all 134 PHUs in the time left on the project. Supporting all the PHUs in Kenema has the potential to be effective in reducing delays in accessing care, building the capacity of health providers at the PHUs, and demonstrating the value of strengthening primary health care. However, the reduced time has consequences for the breadth and depth of support that can be

provided, including the likelihood that the quality of care and support to these PHUs will be compromised because of the reduced time.

The effectiveness of the referral system

The effectiveness of inter-referral systems between the PHUs and the MSF hospital, and then between the KGH and MSF-MCH, is relevant and appropriate but may not be completely effective. While the PHUs found the MSF ambulance services to be important, relevant and responsive (compared to the national ambulance service), one observation from the evaluation was that the post-surgical ward (a proxy for complicated cases, potentially needing CEmONC services) at KGH was full, even though KGH does not have a maternity OT and is using the regular surgical ward to support pregnant women. In such a set up KGH should/would be referring these clients to the MSF hospital as they indicated they tend to occasionally do. In this case, the KGH ward was full, and the MSF hospital has had to shut down one maternity ward due to not reaching full bed capacity. Efforts are needed to interconnect the interactions between KGH and MSF, to reduce duplication across hospitals and nurture collaboration in ways that streamline integration (external coherence).

There are diverging perceptions about the referral systems and capabilities and the MSF hospital. For the community, the referral system (ambulance taking them to MSF hospital or KGH or PHU depending on need and eligibility) works as MSF *"will never leave you alone" and* ensures that one is referred to either Kenema or Freetown. For KGH stakeholders, they felt that they never have enough information on patients who are first served at MSF hospital but then end up receiving follow up or additional care at KGH. For another partner who is a significant contributor to MCH in Sierra Leone, they perceive that MSF refers high risk complicated cases (these often end up with this partner) because the MSF hospital aims to record as few deaths as possible. This latter point diverges from routine quantitative findings which show that the MSF hospital is recording increases in hospital deaths over time, with the first half of 2024 recording the most deaths occurred compared to previous years *(see section Main evaluation findings> Quantitative findings> Hospital exits and deaths)*. This perception fosters the discrediting of MSF, including misleading notions of data manipulation. Additionally, KGH staff also had a differing understanding of the referral system. One informant noted that KGH does not/cannot refer to the MSF hospital because KGH is a regional and tertiary hospital, while another staff member noted that part of the collaborative relationship is that MSF refers to KGH and KGH also refers to MSF.

For the Kenema project, when a patient is discharged from the MSF hospital, depending on the condition at discharge the patient is directed to their PHU for follow up care and/or the outreach team follows up on the patient. However, it was noted that even when outreach does follow-up, there are patients identified as cases whose care and decisions about that care have not been well-managed. In this case, the outreach's management of follow-up cases finds weaknesses or poor quality of the care provided in the hospital. The extreme divergences in perception may be indicative of communication or dissemination limitations in the project. It is possible that MCH stakeholders are not aware or have not been made aware of the depth and breadth of care that the MSF hospital can offer, including where the limitations are. This gap leaves room for misinformation and hesitancies to spread, illustrated as divergences in the understanding of the MSF project's referral system as well as eligibility

criteria. These divergences may also be magnifications of the organisational siloed way that the hospital and outreach services have been operating (internal incoherence),

There were some unintended consequences of an otherwise effective ambulance referral system. In one instance, participants spoke about being asked to pay something to have the PHU call the MSF ambulance to come and pick them up. This reflects how, even with a quality initiative like the Kenema project, it is an intervention that is affected by the context in which it is embedded (the public health system) and affects that same context.

Compromised systems and processes

Systems and processes to track adaptations, decisions and rationales for these decisions/adaptations are poor. MSF has a high staff turnover, both international and local. Staff, especially technical experts, enter the project and make decisions or map the way forward based on 1) often little comprehensive available information from their predecessors and 2) often already limited contextual understanding if they are international mobile staff (IMS). If the staff turnover policies in the MSF structure cannot be changed, then there needs to be systematised knowledge management, and reporting mechanisms that would equip any incoming staff with enough information to enable them to build on or consider what is already existing and make adequately informed decisions about ways forward.

The effectiveness of the integration process

The integration process is ongoing. There was a recognition that the time to execute integration activities needs to be adequately budgeted for, perhaps reinforcing the need to dedicate the remaining years of the project to the effective integration and not to adding new activities or strategies unless they are supporting integration.

Some of the MSF staff involved in this integration project noted that participating in the integration process has become a capacity-enhancing project, with them becoming trained in government relations, negotiations and lobbying. Some mentioned that this is their first time being involved in such a process and they view these as beneficial learning moments. This capacity strengthening is a skillset that can be transferred beyond the Kenema project with these staff, especially if a similar circumstance (handing over projects to governments) happens in other contexts.

EFFICIENCY OF THE KENEMA PROJECT

In this evaluation, efficiency refers to how well resources were used: the extent to which Kenema project activities delivered or were likely to deliver results in an economic and timely way. The guiding questions (see ToR) for this include:

a. What kind of resources have been invested to achieve the results assessed?
b. Were resources used timely and efficiently in the context of changes in the project?
c. How could resources have been used more economically and more timely to achieve results?

These questions are further reinforced by exploring the fidelity, acceptability, quality of the project activities that were implemented, as well as understanding the outcomes of the project activities and this evaluation (Annex I: Evaluation Matrix).

Key Findings on Efficiency

- **Significant human, financial and infrastructural resources have been invested** to operationalise the Kenema project since its inception.
- **Human resources have not always been efficiently deployed** in the project, with potentially overstaffing of hospital wards, and an underutilisation of both IMS and locally hired staff
- **A multi-sectoral approach to addressing MCH is** missing in the project. Such an approach would enhance efficiency through shared costs, resources, learning and insights as well as knowledge and service delivery.

The Kenema Project is a complex, multicomponent intervention implemented by a diverse range of human resources beyond health. Human and infrastructure resources, as well as 6.6 million euros (in 2023) have been committed and invested to operationalise this project. As already established in section Main evaluation findings> Qualitative findings> Contextual relevance and resilience, the limited longevity of the Gaptek infrastructure (which is the primary construction of the hospital) diminishes the long-term value of the hospital infrastructure and compromises how far into the future this hospital can continue to function, beyond MSF stewardship.

One of the efficient investments has been the ambulance system, that avails enough vehicles to be able to have an effective referral system as has been articulated in the findings here. The government hospital system often does not have a vehicle available, or the driver or fuel to go and collect patients in the community, but the MSF ambulance system is able to intervene when and how it is needed, which has amplified its acceptability in the community as well as the quality of care overall within the Kenema Project.

There were concerns raised around the efficient use of resources, which underpinned the government's call to have no resources. One example provided was the Lassa fever isolation ward/area that currently exists. It is almost always empty and yet has about 20 staff employed and solely dedicated to it, resulting in staff going to work and spending the day doing nothing.

Another human resource concern was linked to the number of staff that has historically been working on the project, and more specifically the numbers of IMS that historically have been posted to the Kenema Project. These figures have dropped over the last 1-2 years, to establish a more efficient work environment. There are still a significant number of staff observed on the ward floors, and there continues to be HR concerns about staff levels of effort and time off work taken, because there are many of them.

Missing a multistakeholder Approach

Participants reflected that if this project wants to achieve its set objectives of reducing maternal and under-five mortality then one key ingredient was needed and currently missing: a multi-stakeholder approach to increase the efficiency in addressing MCH challenges.

"Mothers will take their malnutrition children to get PlumpyNut from another organisation and come back to MSF with that same child just to get more plumpyNut, so it's happening"
(KII2, male, KGH)

Additionally, there was a recognition that the root causes resulting in elevated maternal and child deaths need to be addressed to improve the outcomes. Some project staff reflected on how they observed linkages between poverty and food insecurity, and poor MCH outcomes. However, MSF does not address these directly from a preventative lens, and some staff reckoned that even if MSF cannot/does not address these issues, partnering with the stakeholders who do, would have enabled this project to have greater impact.

"We need to have a different action plan from different NGOs working in different system from economy agriculture, to finance, microcredit health etc. this will improve the intervention of the humanitarian operation process in the country that has such a huge crisis and many difficulties"
(Interview14, male, MSF staff)

For many of the women who came to the MSF hospitals, whilst the free care they received was noted as important, what was even more significant for them were the non-medical components of 1) kind health providers with positive attitudes, 2) free food, and 3) free and readily available commodities for their pre, during and post-natal periods (diapers, laundry soap etc).

Overall, a detailed cost-effectiveness or cost-efficiency analysis or evaluation would need to be conducted to effectively quantify the efficiency of the project.

IMPACT OF THE KENEMA PROJECT

In this evaluation, impact refers to the extent to which project activities generated or are expected to generate significant positive, negative, intended or unintended higher-level effects. The guiding questions (see ToR) for this include:

a. What do target beneficiaries and stakeholders perceive as wider contributions of the project?
b. Which unintended consequences (positive or negative) can be identified?
c. These questions are further reinforced by exploring to understand the role of the context in which project activities where implemented (Annex I: Evaluation Matrix).

Key Findings on Impact

- **This evaluation could not quantitatively establish the significant impact** of the Kenema Project on reducing maternal and child mortality and morbidity in Kenema. Qualitatively, all **stakeholders in this evaluation find the project activities to be contributing to improving MCH outcomes**.
- Some unintended consequences include:
    - For the effective ambulance system**, there is a disruption of the public health ambulance system,** creating unnecessary competition for clients.
    - For accessing the quality MCH care and ancillary services at the MSF hospital, **clients (pregnant women or mothers) may be manipulating the system, to enable them to access the hospital services**, most of which are to access ancillary services.

Reducing maternal and child mortality and morbidity

While the quantitative data analysis is unable to show direct significant associations between the reductions in MMR and under-five deaths and MSF activities, the people in the community consistently spoke about observing these reductions. The lack of complementarity may be due to the routine data collection and systems identified in this report. However, qualitatively, community members, KGH staff and PHU staff stressed that fewer pregnant women and under-five children are dying because of MSF interventions.

"The reduction of mortality, there was influx of patients with no bed capacity but with the establishment of MSF, that has reduced. It has reduced the burden and lessens our work."
(Interview 5, female, KGH staff)

"Since I came to this PHU for the past three years now, I have not witness maternal death, I pray that it doesn't even happen"
(Interview 11, female, PHU staff, Boajibu)

Disrupting the public health system

One unintended consequence of having an impactful ambulance service system was that it is colliding with the public ambulance system (NEMS). Participants from the government stated that MSF has overall been effective and positively impacted maternal and child outcomes, including filling in the gaps that the public health system is unable to manage. However, there was some disgruntlement about the successful ambulance system, noting that the community prefer MSF to the NEMS (government) ambulance, and there are cases when KGH successfully deploys ambulances to pick up community members but *"When our ambulance goes in terms of referrals, the people prefer to be delivered to the MSF hospital than coming to our KGH" (Interview 2, female, KGH staff).* At one PHU a provider noted that for referrals they first call NEMS (and not the MSF ambulance) and then it is up to NEMS to then take the patient to either the MSF hospital or KGH. They noted that this event started because the government was disgruntled that they were no longer having (complex case) patients, as patients now go to MSF. This is an example of a disruption in the public health system that may have complications for continuity and sustainability in terms of managing expectations and hesitations in the community.

Another impact finding here was a potential risk of 'doing harm'. Multiple participants expressed how community members make themselves and their children sick to be eligible for MSF-MCH services. Community members deliberately delay seeking care for their U5s or for themselves (maternity) so that they can meet the threshold needed to enter MSF-MCH. One of the reasons assigned for this was that people want the food and clean place to stay offered by the MSF hospital. One community gatekeeper additionally noted that the MSF hospital made an error by providing 'fancy' food in the hospital and people come to access this food. They call the hospital "*NEW LONDON when you enter there, even when night comes you won't know till you come outside".* According to some, if the MSF hospital provided local food instead of a higher standard, it might reduce the rather harmful practices to become admitted at the MSF hospital.

COHERENCE, CONTINUITY AND SUSTAINABILITY OF THE KENEMA PROJECT

In this evaluation, coherence refers to how well the project fit: its compatibility with other projects or interventions in Kenema and Sierra Leonne. **Internal coherence** addresses the synergies and interlinkages between the key project activities (Maternal, Paediatric, Outreach, Academy), as well as the consistency of these activities with the relevant international norms and standards to which MSF adheres. **External coherence** considers the consistency of the key project activities with other actors' interventions in the same context. This includes complementarity, harmonisation and co-ordination with others, and the extent to which the intervention is adding value while avoiding duplication of effort. (***Adapted from Source: OCED Evaluation Criteria: Adapted Definitions and Principles for Use)***. The guiding questions (see ToR) for this include:

a. Which kind of external and internal linkages have been established?
b. To what extent was internal coherence maintained?
c. Which barriers hindered the establishment and/or maintenance of external interlinkages, especially with the MoH?
d. How can internal and external coherence be improved?

These questions are further reinforced by exploring fidelity, quality, acceptability, and effect of the project activities, as well as understanding the project outcomes and the role of the context in which project activities where implemented (Annex I: Evaluation Matrix). The extent to which the benefits of the project activities will continue or are likely to continue were also explored as part of understanding continuity and sustainability.

Key Findings on Coherence, continuity and sustainability

- **Internal coherence between the outreach pillar and the MSF hospital can be strengthened** to better understand the effect and interconnectedness of the two and potentially improve reporting on indicators, and MCH outcomes themselves.
- **External coherence between the project and other MCH stakeholders as well as with MoH could be stronger** and should be prioritised as part of the handover activities and exit strategies.
- **Continuing the QoC (full staff component, readily available water and solar system, complete IPC measures, readily accessible, available and accommodative MCH care) established by the Kenema project is likely not feasible** and the project may need to consider a threshold of minimal standards of care as part of exiting the project

As already established, MSF excels in providing quality medical humanitarian care. However, this singular focus or priority has downplayed the need or even necessity for collaborating or co-implementing with other partners from the beginning, which could have had potential for supporting handover of the hospital to other partners in the MCH space (PIH, Last Mile Health, UNICEF, WHO) who may be able to sustain continuity of MSF investments in MCH post-2029. When we asked the question of who else (additional partners or organisations in the MCH ecosystem in Kenema and/or surrounding districts) MSF has been working with, the responses were quite sparse. For strategic positioning, these stakeholder relationships are critical for continuity, as well as an effective and efficient resource use, and should be considered as part of the exit strategy.

Interoperability of the project activities

Interoperability refers to how the project interlinks the three core components (hospital, outreach, and the MSF Academy) as part of its implementation approach. The findings reflected some siloed approaches which may be compromising project effectiveness. There are direct synergies between the hospital and the MSF Academy which trains the staff who work in the hospital, including incentivising for this training through credit and paid for hours. The MSF Academy also supports training of PHU staff in the outreach component but without the similar incentivisation processes or exposure to clinical mentor supervision and repeated trainings as those at the hospital.

On the other hand, the outreach component was designed as the entry point to hospital care, with outreach referrals being the primary eligibility criteria for the hospital to reduce delays in seeking and accessing care. This referral role of the outreach component has not been consistently executed as beneficiaries beyond outreach supported communities come to seek care. Additionally, the linkages between how the outreach activities feed into, improve or support the hospital are not well articulated, measured or tracked. The iCCM activities are supporting under-five health outcomes, but whether this has resulted in improved under-five health outcomes or better eligibility sensitisation cannot be determined by the current data systems. There is a need to integrate the outreach services to the MSF-MCH better.

The ambulance service was found to be highly appropriate, needed and relevant, with many stakeholders noting that the MSF ambulance is quick to respond and transport eligible patients, compared to the government ambulance system. So, the synergy between the hospital and ambulance service is strong. Outreach activities are also contributing to strengthening primary health care operations at the PHUs. This potentially reduces the need for patients/beneficiaries to go hospitals that support secondary and tertiary care, creating efficiencies in triaging care.

The MoH noted that the synergies between the MSF-MCH and KGH, as well as MSF outreach services and theirs, or access to the MSF Academy is weak, and could be stronger, especially considering the current integration approach for KGH to absorb the MSF-MCH hospital as its maternity wing. For the MSF Academy synergies, accessing the MSF Academy OPD programme outside of MSF project was not possible since MSF Academy programs only roll-out within an MSF setting as the curriculums are based on the needs found in the MSF projects, and are guided by MSF protocols. However, the Kenema

government stakeholders noted that they would have liked the MSF Academy to be structured for the Kenema health system so that their staff could also benefit from MSF Academy support, especially as the other project objective is to strengthen MCH HRH in Kenema, and not only in MSF projects within Kenema.

Critical interlinks with the public health system

According to Kenema District Government, MSF should have been cooperating with KGH from the beginning of the project. They made comparisons with another larger NGO, who have worked with district government and ensured their involvement from the beginning, which then helped with transitioning this NGO's project. According to district government staff, MSF should have worked collaboratively with the same doctors and patients from KGH. Desk review showed that this was the intention of the MSF Kenema Project from the beginning, but it was not necessarily implemented. KGH participants were concerned that when MSF leaves, they will not know what to do with not only the prefabricated and brick buildings, but also with the workers employed by MSF. For KGH, taking over this operation as it is, is perceived to be a burden. This finding was reinforced by other participants who noted that it may not be feasible for the government of Sierra Leone to take on this project, and efforts need to put into understanding what is feasible and then ensuring that it can be continued.

"Because the humanitarian and economic resources that we are spending in our hospital probably, it will be very difficult for the government. It cannot be able to spend the same amount now we need to be strategic and try to find an operating system that will be closer to the economic possibility of the government as well as preserving the high quality"

(Interview 14, male, MSF staff)

For outreach services, the coordination and collaboration with MoH is necessary**.** The MoH has been deprioritising the PHUs that are supported by MSF because MSF is supporting them. One PHU noted that the government no longer supplies them with medication because they expect MSF to provide those, and yet the agreement is that MSF does gap-filling and not full provision of essential drugs at supported PHUs. For MSF, such an event compromises their stock calculations to support such a PHU over the year period. At one PHU, the lack of government support is compounded by a large population drive with people who are not from the catchment area also coming to access services there, especially to support malnutrition and access to PlumpyNut.

Some of the outreach staff noted that there is a lack of external coherence at PHU level. For example, it was noted that MSF is not collaborating well enough with MoH, and other partners to know and understand who the other partners are, and the support they are providing to the PHUs. The PHUs do not want to share with outreach the support they are getting from other partners, and there is a current risk and likelihood of duplicated efforts (particularly supply of medication and PlumpyNut) that will be weaponised by the PHUs. As the outreach strategy is being reshaped, this understanding will be important to allow MSF to work more effectively and efficiently without duplicated efforts, reinforcing instead what other partners are doing or filling the gaps that other partners are not addressing.

"There was a time an NGO went to a PHU when we were there. The NGO do the malaria test and are expecting to give malaria drugs. However, the PHU uses the MSF drug that was meant for pregnant women and less than 5s was used for this NGO's activity. MSF staff took it up to the PHU staff. We need to know what other NGOs are doing so we can partner with them"

(Interview 6, male, MSF staff)

MSF processes: tensions for continuity and sustainability

The frequent changes in MSF leadership were reported to sometimes hinder continuity and progress**.** A veteran of the Kenema district government noted that because he has remained a constant, he has been able to view the disruptive effects of such constant changes over time, including how some activities that may have been agreed upon between government and MSF become sidelined or are not actioned because of these shifts in decision-makers.

The Kenema project offers free services, which may not be viable for the government. District participants reflected that the free services offered by the MSF operational model was not sustainable for them. The model offers free services, which is what should be normal with the FHCI; however, the model goes above and beyond to provide *"more than wrappers/blankets to new mothers"* which the government would not be able to take on. For the government, this is the main challenge about the transition and managing community expectations around it.

KGH staff reflected on their visit to the MSF hospital that MSF has stronger organisational policies as well as documentation compared to KGH and that is something they would want to adopt, learn from and carry on. Additionally, KGH leadership noted that one of the challenges in the public sector facilities is that the nurses lack the drive and their motivation to work is minimal. This is primarily driven by the fact that once a provider is pin coded, they cannot be fired. As such, there is limited incentive based on performance and providers tend to not perform. This may explain community members' reluctance to go to the public facilities and experience negative attitudes from the providers. Instead, they prefer to be supported at MSF hospitals, including making themselves sick enough to be eligible for MSF benefits.

"There you know that when you don't do the job you are fired. Here is a government job, I cannot fire, as I am in charge I can just caution you. There is an NGO and there are policies everything is purely based on performance if you don't perform you don't have a job. Unlike government the decision come from the top"

(Interview 5, female, KGH staff)

Staff at KGH also strongly felt that the Kenema Project should have invested in strengthening the KGH maternity. For them, all the resources that they put into the MSF hospital could have strengthened KGH instead for sustainability. According to them, MSF should have co-designed, collaborated and worked with the government to prioritise and address government needs around MCH in Kenema. The current state of the project, as well as a possible handover/strategy does not reflect such a mutual relationship.

"Providing the free health care, I don't have problem with that, but supporting the government institution, strengthen government institution was what they [MSF] should have been working on because if I have a 5-year programme that will exit, I work in strengthening and collaborating with the government institution which will not phase out anything related to obstetric, maternal child health"

(Interview 2, female, KGH staff)

Maintaining quality: a continuity challenge

KGH is currently engaged with MSF to design and deploy a transition strategy as MSF exits from the project. For the government, "*If the MSF hospital can be a children's hospital it's fine, but MSF is free. At government, not all services are free".* KGH stakeholders need MSF to address that shift in cost of services first, to the communities and beneficiaries of the hospital. That level of sensitisation and socialisation needs to happen in advance of the handover, with a focus on 'doing no harm' to the community.

When speaking about the MSF Academy, government participants articulated the need for MSF Academy linkages to the Sierra Leone tertiary education system. According to them, the project should have linked the Academy with the university and the tertiary education system in Sierra Leone as this would have enabled its transition and continuity as a tertiary health programme in the country and as part of medical institutional strengthening that benefits the human resource for health of Sierra Leone at large, and not just MSF staff. Staff at the KGH perceived that qualifications from the MSF Academy are not accredited and cannot be used at all government hospitals. When the evaluation was conducted, all the Nursing and OPD trainings were recognised by the Nurses and Midwifery Board, and the MSF Academy was working to have these accredited, as well as finalising the 'recognition' of the CHO competency certificate by the same Board.

Additionally, participants praised the training quality of the MSF hospital staff whose knowledge and expertise were also observed during the evaluation field visit. The project transition dilemma is that these highly skilled staff were employed by MSF, in part because they are not pin coded (unsalaried), and for the handover process there is currently no guarantee that the government has the capacity (financial resources) to pin code all these highly trained local national staff.

External Coherence with partners

KGH participants noted that MSF collaboration with them is limited and illustrated this in multiple ways. In one instance they noted that this was complicating patient care. One of these participants noted that since MSF does not do the follow-up visits for their former admitted patients, MSF needs to discuss diagnosis and treatment of such patients when/if they end up at KGH. In another instance, according to them, they send requests for support on drugs or materials and MSF *"send to us drugs that are at the tail end of expiration date, 3 to 4 months to expiring date, that's when they give us."* For them this comes off as disrespectful.

Additionally, one of the biggest challenges of this project that was articulated by the government is that "they set up a parallel system, that has its own management system outside of the national plan. For example, MSF's protocols on managing malnutrition or malaria in under five children is different from the national protocols, and there are differences even in IMCI". This approach was reflected as a complication to the handover process because deviating from validated national plans was an exercise in itself. As such, MSF's different protocols may not be relevant or will need to be adjusted at the time of the handover and/or exit.

The history of this MSF project in Sierra Leone

The project's complexity traces back to the historical context of the project, particularly the decision-making that resulted in a project of this magnitude and complexity.

Participants constantly brought up the MSF hospital in Bo, which was shut down and now stands decrepit. According to such participants, nothing shows that MSF was ever there, because no one could maintain and sustain what MSF had started, and the likelihood of the Kenema Project going in that direction is high and poses as a reputational risk for MSF.

Additionally, when the Kenema Project was conceived, MSF leased the land on which the hospital was built, and some participants reflected on how those who leased MSF the land-want the land returned to them at the 10-year mark, which is when MSF is exiting. This complexity is misaligned to the integration strategy as it means the government must convince the people to continue the lease, in service of MCH, but servicing that lease may be out of the government's scope.

Integrating MSF maternity and paediatrics into KGH

According to KGH staff the current challenges with the transition are that:

- The strategy aims to integrate the MSF CEmONC services into KGH but remain static at the MSF-hospital site. KGH noted that their maternity at KGH has a staff component of 90-100 in the unit, and it would make more sense if MSF outfitted the KGH maternity with the materials and processes at the MSF hospital so that the 90-100 staff at KGH can work well and provide quality services.
- For the CEmONC remaining at the MSF hospital site (as a part of the broader KGH-maternity), the government would need to incorporate and pin code the staff at MSF-hospital and absorb them, a process that is not straight forward as there are likely other non-pin coded health providers who may be 'in front of the line' for becoming salaried and that are not MSF staff.
- The integration decision, including the form in which it will take place, will need to be a directive given to KGH from the national-level authority. For them, nothing is likely to happen if that directive isn't provided.

Participants spoke about the end of the project and integration into the KGH as part of the handover and exit. Some noted that for this handover to be effective, MSF needed to first acknowledge that building this hospital, with its complexity and as a mostly parallel system to the public health one, was ill informed. If the inception of the project had considered that at some point it would need to be

handed over (an exit strategy) it is likely that the Kenema project would not have been designed and implemented in the way that it currently exists.

"We are in the embryogenic stage (of the integration phase). Also, we need to be sincere and intellectually honest. This is a mistake from the beginning. From the beginning of the hospital project, we need to have an exit strategy. From the beginning we need to build a project with an exit strategy."

(Interview 14, male, MSF staff)

As part of the integration process, MSF will need to manage community perceptions and expectations. The Kenema community has become aware that MSF activities will wind down and end, which is causing some anxiety and concerns.

"We are discouraged hearing that they are about to go back, because the facilities we do receive there, we can't get such facility in any of the other health facilities."

(FGD22, females, Gbanguima)

CONCLUSIONS

The initial stages of this evaluation included the consultative phase *(Section Aims and objectives> The consultative phase)* as well as the desk and literature review processes *(Section Methodology> Literature and desk review).* The outputs from this exercise, combined with the evaluation outcomes show that many of the findings from the evaluation were not unknown by the Kenema Project Team. Rather, this evaluation has served to collate, synthesise and package these findings in a manner that allows them to provide easily accessible learning and insights, as well as to inform decision-making on operationalising project activities for the remainder of the project timeline 2024 – 2029.

One of the outreach activities' core functions is to generate demand for the hospital services through health promotion activities that sensitise and socialise on quality MCH care. Quantitatively, there has been an increase in ED consultations and in hospital bed occupancy over time (2021 – 2023) (Table 1a), with 2023 (98%) surpassing the established target of 80-90%. Beyond the closure of one maternity ward, this increase may be linked to the effectiveness of outreach services, which qualitatively showed to be highly acceptable among the communities supported by MSF.

As shown in the quantitative analysis *(Section Main evaluation findings> Quantitative findings> Hospital bed occupancy),* the Kenema project adapted the availability of beds in the hospital wards in response to needs (receiving more patients). The project's responsiveness denotes its relevance, and the ability to adapt illustrates how the project established appropriateness by sometimes being receptive to the context, while deviating from implementation fidelity of specific bed counts.

In each year (2021 – 2023), consultations and admissions surpassed the hospital target. Paediatric admissions increased between 2021 – 2022 and then slightly decreased in 2023 *(Section Main evaluation findings> Quantitative findings> Emergency department consultations and admissions).* Several reasons may be attributed to this reach. Participants established that many women now wait until they or their U5s are sick enough to meet eligibility criteria for the hospital. Participants (both providers and community members) also articulated the effectiveness of the outreach services in ensuring they know when to refer to the hospital, as well as when to request MSF ambulance services. All these would contribute to increases in hospital admissions.

Among the under-five children admitted to the hospital, 82% were screened for malnutrition, against a hospital target of 100%. Within the community, malnutrition screening also decreased over time reaching a low 47% for screening at MSF supported PHUs. While iCCM is part of the highly acceptable and effective outreach activities, and contributes to screening and intervening for malnutrition in the community, part of quality medical care entails that every admitted child is screened for malnutrition at the hospital (100%) as well as part of iCCM and outreach activities (100%). In this case, the quality of care (QoC), which overall has been found to be relevant and implemented with high acceptability by MSF staff, is slightly reduced. It may be possible that if U5s are presenting in an emergency/complicated state, providers may be responding to address the emergencies, which would deprioritise a screening activity and hence not be recorded. However, considering that malnutrition

continues to be a significant mortality and morbidity factor, as well as the only determining condition on the eligibility criteria, the poor screening results need to be addressed.

The average monthly hospital deaths also increased over time with the overall hospital mortality rate consistently being 6% and higher than the target (<5%) across all three years under evaluation. This may be linked to the weak interoperability of the three key project activities that creates a discordance between the outreach services and the MCH hospital services. More specifically, the outreach activity that was qualitatively found to be most acceptable and relevant was the ambulance referral service. Such an activity does not necessarily reduce the continued late presentations of complicated cases as people could ask for the ambulance service already late and contribute to hospital deaths. It responds only to the delay factor in health seeking behaviours. Efforts to address late presentation may need to be strengthened as part of outreach activities. Additionally, the outreach work focuses on 6 PHUs at a time, but the MSF hospital's reach is currently beyond the 6 PHUs communities. It is also possible that the patients who continue to present late with complicated cases and are likely to contribute to hospital deaths, are not those exposed to the MSF outreach activities. This reinforces the relevance and appropriateness of the Kenema project's plans to provide support across all 134 PHUs in Kenema, as part of MSF's preparations to exit the project.

The highest mortality has consistently been in ICU, followed by ITFC and then IPD. This is reflective of the highest causes of mortality in children for Sierra Leone, which have included co-morbidities of different factors like malnutrition, pneumonia and diarrhoea (11, 16), and may again also be reflecting the continued delays in accessing care, suggesting that the Kenema project may not be fully addressing the root drivers of access to care.

The quantitative data showed that less than half of the expected deliveries are happening at the facility. This may reflect the continued prevalence of home births with TBAs as revealed in the literature (18). Within the project, TBAs showed an increased knowledge in identifying danger signs for complicated pregnancies *(Section Main evaluation findings> Quantitative findings> Outreach),* which may not necessarily translate to behaviour change in making the referrals early enough.

While medical quality of care (IPC, ready availability of hospital staff for example) was observed and noted to be of high quality, the routine hospital data showed that across all departments, most medical prescriptions were inappropriate. This finding was reinforced qualitatively as some government providers lamented that MSF tends to prescribe drugs that are not necessary, which complicates their ability to support these patients when they come to government facilities for follow-up. Other MSF staff also noted this same challenge as part of outreach follow-up activities. Overall, the findings showed that the QoC was mostly appropriate, but there are instances where it is compromised. It will be important to reinforce trainings on the medical guidelines to ensure appropriate prescriptions and subsequent care.

There were inconsistencies reflected both qualitatively and quantitatively in the support provided to PHUs and with outreach services more broadly. Outreach services are the PHC intervention in the Kenema project and are meant to be the referral point to the hospital. Strengthening or improving

PHC-level systems has been evidenced to contribute to reducing maternal and child mortalities and morbidities (45-47). At the time of this evaluation, the outreach activities strategy was being revised. The revised version should prioritise addressing the current challenges identified (making patients pay when MSF leaves, poor malnutrition screening in the community and PHUs, inconsistent essential drug supply to PHUs in need) as part of the integration process. Additionally, the project must place great importance on strengthening the internal coherence between the outreach and hospital pillars.

Lastly, a highlight finding in this evaluation was inadequate external coherence. The project and its staff often worked in siloes, or without adequate engagement and inclusion of other stakeholders in the maternal and child health ecosystem of Kenema. Improving external coherence and enhancing project buy-in would better facilitate, support and/or promote the handover and exit strategy implementation of the Kenema project.

LESSONS AND INSIGHTS

1. ***Communication and decision-making challenges**, and the implications on project level effectiveness, relevance, continuity and sustainability. Many of the significant findings in the evaluation could be attributed to poor information sharing, communication, and/or socialisation processes or structures about the project itself and/or decisions around activities, especially considering the high turnover rates of human resources in the project. This highlights the importance of adapting and streamlining these processes and structures for a complex intervention like the Kenema Project.*

2. ***Strengthening the district maternal and child health system** may have been a better approach compared to building a separate and parallel MCH hospital.*

3. *In future MSF project efforts, when deciding on a project direction, it would be **critical for MSF to consider the ecosystem around a societal health challenge** they wish to address and work with ecosystem actors to address root cause issues (for example agricultural organisations working to improve food security) that have direct effects on health outcomes or project operationalisation.*

4. *In future project efforts, an **implementation, learning and handover agenda should be considered for a project like this** and operationalised from the inception or project design and followed through during the implementation of the project itself.*

RECOMMENDATIONS

⇒ Recommendation 1: Establish robust data collection and management systems

In the remaining four years, the project has an opportunity to adequately magnify its contribution to reducing maternal and child mortality and morbidity, while also strengthening the health system by strengthening information systems. The process of standardising and improving the quality of indicators and their definitions has already begun and should include hospital targets and their rationales. This should also be supported by training data teams (in MSF and MoH) and training them on querying and interpretation of data. This process should be prioritised and completed, and the final output should be included in the exit strategy to handover to the MoH. As part of this process, the project began reporting into the MoH DHIS system in October 2024.

⇒ Recommendation 2: Strengthen documentation and knowledge management systems

As exemplified in the Kenema Project, MSF operationally has a high turnover of IMS who often are part of the decision-makers on key activities or changes. To minimise internal incoherences and possibly inefficiencies as well, it will be important to have a documentation and knowledge management system that shows key activities, decisions made, rationales for those decisions as well as the envisioned next steps. This would allow the next decision-maker to have a starting point, and increase the chances for continuity of activities, instead of necessarily starting new activities. This process has begun and will be instrumental in the integration and handover strategy of the project. The project has begun using a digital desk for information management as well as Power BI for medical indicators, which will support improvements in data driven decision making.

⇒ Recommendation 3: Strengthen the outreach service activities for handover and sustainability

At the time of the evaluation, the outreach activities strategy was being reassessed. The revised version should not only prioritise addressing the current challenges identified (making patients pay when MSF leaves, poor malnutrition screening in the community and PHUs, inconsistent essential drug supply to PHUs in need), but also focus on integration and ownership by MoH community health systems, capacity strengthening of community health providers, as well as advocacy to the MoH and other partners on maintaining medical stock supplies.

Recommendations 4-6 (of 8) →

⇒ Recommendation 4: Continued capacity building/strengthening efforts for health providers

While medical QoC was high in the hospital, there were instances of inappropriate medical prescriptions, as well as reduced malnutrition screening, that could be mitigated or addressed with adequate or reinforced training for the CHOs and staff responsible for making these prescriptions. The MSF Academy anchors capacity building and strengthening in the Kenema Project, and its current set of activities will stop being rolled out in Q2 2025. After this period, the MSF Academy activities will be supported by the PMR and will continue to support the Outreach programme as indicated in this report. As part of the exit strategy, the MSF Academy activities should prioritise the training of the MoH health providers who will be taking over medical care in the Kenema Project, and those at the PHUs in outreach.

⇒ Recommendation 5: Prioritise investing in the capabilities and capacities, needed for successful handover

Training, upskilling and/or reskilling government employees in health and operational skills for running a project such as this will be critical. Equipping these employees can be useful to not only improve KGH, but also the ministry of health's ability to take on similar projects with other development partners.

⇒ Recommendation 6: Focus on depth of existing activities and minimise breadth (introducing new activities) in the remaining project timeline.

To ensure an effective handover, the project may need to scale down activities in the upcoming years, focusing on improving or strengthening the ones shown to be effective and likely to be taken over, and limiting the introduction of new activities that may not be able to penetrate during a transitionary period. Alternatively, the project could consider a different handover timeline. The current strategy is to handover the MSF hospital in phases, beginning with the maternity handover in 2025, followed by the paediatrics handover in 2026 with MSF continuing to provide some ancillary support until 2028 when it exits. Considering the complexity of project activities, the need to continue providing MCH services while transitioning, and the preparatory steps that still need to occur, it might be necessary to extend the handover timeline to ensure that the project can continue beyond MSF.

Recommendations 7-8 (of 8) →

⇒ **Recommendation 7: Establish internal and external coherence**

For MSF to exit this project well and transfer it to another stakeholder (MoH) in the upcoming four years, strong coherence will be needed. The project team needs to dedicate resources (time, human, financial) to establishing this coherence. Activities to strengthen coherence can include intentionally sharing learning & insights with other MCH stakeholders, proactively collaborating and co-creating MCH activities with other stakeholders, and/or streamlining the relationship between outreach and hospital activities and staff.

⇒ **Recommendation 8: Shift decision-making abilities to local project management leadership**

The ability of this project to be contextually responsive may be compromised because decision-making systems have not adequately been informed by the local realities and understanding. For example, the decisions to partially use prefabricated Gaptek construction versus permanent structures for a project that was anticipated to exist beyond MSF's 10-year tenure or the decisions to build a separate and parallel hospital versus training and enhancing the already existing KGH, at likely lower costs. Having local, qualified and equipped staff as active decision-makers of what will or will not be strategic and operational objectives in Kenema is paramount to ensuring the longevity and continuity of projects like this one.

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ANNEXES

ANNEX I: EVALUATION MATRIX

Research Questions	ToR Questions addressed	Data source	Data Collection Method	Data Collection Tool	Indicators	Timeline
Implementation						
RQ1: Reach What proportions of individuals (maternal and newborn; etc.) engaged with the intervention?	⇒ Relevance- a ⇒ Effectiveness-a	⇒ DHIS2 ⇒ Project documents ⇒ MSF Databases	⇒ Routine MCH and maternity quantitative data ⇒ Routine Community engagement quantitative data	Excel spreadsheet	⇒ evidence of the target population being defined and the proportions reached w/ disaggregation	Jun-Aug '24

Research Questions	ToR Questions addressed	Data source	Data Collection Method	Data Collection Tool	Indicators	Timeline
RQ2: Fidelity Is the intervention being implemented as intended- this includes fidelity to ***adaptations*** made to improve the intervention?	⇒ Relevance-b ⇒ Appropriateness-a, b ⇒ Effectiveness-a,b ⇒ Efficiency- a, b,c ⇒ Coherence- b, c	⇒ Project documents and reports ⇒ MSF-hospital staff ⇒ PHU/CHC staff ⇒ Outreach staff ⇒ MSF-HQ staff	⇒ Routine MCH and maternity quantitative data ⇒ Semi-structured interviews ⇒ FGD ⇒ Field notes ⇒ Review notes	Topic Guides ⇒ MSF-hospital staff ⇒ PHU/CHC staff ⇒ Outreach staff ⇒ MSF-HQ staff Field notebook excel spreadsheet	⇒ evidence that project activities are being implemented as intended in the Project documents	Jun-Aug '24
RQ3 Quality: To what extent is the intervention delivered with sufficient quality as defined by MSF, the project stakeholders and beneficiaries?	⇒ Relevance-b, c ⇒ Appropriateness-b ⇒ Effectiveness-a,b ⇒ Efficiency- a, b,c ⇒ Coherence- b	⇒ Project documents and reports ⇒ MCH and maternity clients ⇒ MSF-hospital staff ⇒ PHU/CHC staff ⇒ Outreach staff ⇒ MSF-HQ staff ⇒ Stakeholders/ Partners	⇒ semi-structured interviews ⇒ FGD ⇒ Non-Participant Observation ⇒ Review notes ⇒ Field notes	Topic Guides ⇒ MSF-hospital staff ⇒ PHU/CHC staff ⇒ Outreach staff ⇒ MSF-HQ staff Field notebook	Evidence of ⇒ services followed MSF guidelines ⇒ strong & functional referrals & collaboration with stakeholders ⇒ effective community engagement	Jun-Aug '24

Research Questions	ToR Questions addressed	Data source	Data Collection Method	Data Collection Tool	Indicators	Timeline
RQ4 Acceptability: Is the intervention being implemented accepted by the staff implementing it; & the Kenema stakeholders?	⇒ Relevance-b, ⇒ Effectiveness-b ⇒ Efficiency- a, b,c ⇒ Coherence-c	⇒ MSF-hospital staff ⇒ PHU/CHC staff ⇒ Outreach staff ⇒ MSF-HQ staff ⇒ Stakeholders/ Partners	⇒ semi-structured interviews ⇒ FGD ⇒ Non-Participant Observation ⇒ Field notes	Topic Guides ⇒ MSF-hospital staff ⇒ PHU/CHC staff ⇒ Outreach staff ⇒ MSF-HQ staff ⇒ Field notebook	⇒ evidence demonstrating providers and stakeholders accept the intervention and want it to succeed	Jun-Aug ’24
Mechanisms of Change						
RQ5 Effect: How did the intervention stakeholders and beneficiaries (MCH clients, CBOs, project implementors, health providers, community members, Kenema government, etc), perceive, think about and engage with intervention aspects aspect of the intervention?	⇒ Relevance-a, c ⇒ Effectiveness-b ⇒ Coherence- b, c	⇒ MCH and maternity clients ⇒ Outreach clients ⇒ Community members ⇒ MSF staff ⇒ PHU/CHC staff ⇒ Stakeholders/ Partners	⇒ FGD ⇒ semi-structured interviews ⇒ Field notes	Topic Guides ⇒ MSF-hospital staff ⇒ PHU/CHC staff ⇒ Outreach staff ⇒ MSF-HQ staff ⇒ MSF-clients ⇒ PHU/CHC clients ⇒ Stakeholders/Partners ⇒ field notebook	⇒ Beneficiaries and stakeholders' perceptions, thoughts and experiences of the Kenema project	Jun-Aug ’24

Research Questions	ToR Questions addressed	Data source	Data Collection Method	Data Collection Tool	Indicators	Timeline
RQ6 Effect: What were the unintended consequences of the intervention?	⇒ Relevance-a, c ⇒ Effectiveness-b ⇒ Coherence- b, c ⇒ Impact- a, b	⇒ MCH & maternity clients ⇒ Outreach clients ⇒ Community members ⇒ MSF staff ⇒ PHU/CHC staff ⇒ Stakeholders/ Partners ⇒ Project documents ⇒ Routine data	⇒ FGD ⇒ semi-structured interviews ⇒ Review notes ⇒ field notes ⇒ Routine MCH and maternity quantitative data	Topic Guides ⇒ MSF-hospital staff ⇒ PHU/CHC staff ⇒ Outreach staff ⇒ MSF-HQ staff ⇒ MSF-clients ⇒ PHU/CHC clients ⇒ Stakeholders/Partners ⇒ field notebook	⇒ evidence of unintended outputs, impact, consequences or impact that were not part of the project's objectives or goals	Jun-Aug '24
Context						
RQ7: Context How did the Kenema community (sociocultural norms, values, behaviours) shape or affect the intervention?	⇒ Relevance-a ⇒ Appropriateness-a, b ⇒ Coherence-a	⇒ Community participants ⇒ MSF staff ⇒ Project documents and reports	⇒ semi-structured interviews ⇒ FGD ⇒ field notes ⇒ Review notes	Topic Guides ⇒ MSF-hospital staff ⇒ PHU/CHC staff ⇒ Outreach staff ⇒ MSF-HQ staff ⇒ MSF-clients ⇒ PHU/CHC clients ⇒ Stakeholders/Partners field notebook	⇒ Stakeholders' perceptions of whether strategies and activities adopted are contextually appropriate, responsive or acceptable	Jun-Aug '24

Research Questions	ToR Questions addressed	Data source	Data Collection Method	Data Collection Tool	Indicators	Timeline
RQ8: Context How did policies, legal, guidelines (community, national, global) influence implementation, and beneficiary or stakeholder engagement?	⇒ Relevance-c ⇒ Appropriateness-b ⇒ Effectiveness-b ⇒ Coherence-a	⇒ policy documents ⇒ Project documents ⇒ MSF-staff ⇒ Stakeholders/ partners	⇒ FGD ⇒ semi-structured interviews ⇒ field notes and summaries	Topic Guides ⇒ MSF-hospital staff ⇒ PHU/CHC staff ⇒ Outreach staff ⇒ MSF-HQ staff ⇒ Stakeholders/Partners ⇒ field notebook	⇒ evidence of interactions between the intervention and national, global and/ or local policies and guidelines	Jun-Aug ’24
Outcomes						
RQ9: Outcomes Do the evaluation findings provide understanding on whether the intervention worked or didn’t; and why?	⇒ Appropriateness- b, c ⇒ Effectiveness- a, b, c ⇒ Efficiency -a, c ⇒ Coherence-d	⇒ MCH & maternity clients ⇒ Outreach clients ⇒ Community members ⇒ MSF staff ⇒ PHU/CHC staff ⇒ Stakeholders/ Partners ⇒ Project documents ⇒ Routine data	⇒ FGD ⇒ semi-structured interviews ⇒ field notes	Topic Guides ⇒ MSF-hospital staff ⇒ PHU/CHC staff ⇒ Outreach staff ⇒ MSF-HQ staff ⇒ MSF-clients ⇒ PHU/CHC clients ⇒ Stakeholders/Partners ⇒ field notebook ⇒ excel spreadsheet	⇒ Evidence that suggests the project is effective	Jun-Aug ’24

Research Questions	ToR Questions addressed	Data source	Data Collection Method	Data Collection Tool	Indicators	Timeline
RQ10: Outcomes Are there contexts were the intervention worked?	⇒ Appropriateness- a, b, c ⇒ Effectiveness- c ⇒ Efficiency- a, c ⇒ Coherence-d	⇒ MCH & maternity clients ⇒ Outreach clients ⇒ Community members ⇒ MSF staff ⇒ PHU/CHC staff ⇒ Stakeholders/ Partners ⇒ Project documents ⇒ Routine data	⇒ FGD ⇒ semi-structured interviews ⇒ field notes & summaries	Topic Guides ⇒ MSF-hospital staff ⇒ PHU/CHC staff ⇒ Outreach staff ⇒ MSF-HQ staff ⇒ MSF-clients ⇒ PHU/CHC clients ⇒ Stakeholders/Partners ⇒ field notebook ⇒ excel spreadsheet	⇒ Evidence that suggests the project can work	Jun-Aug '24
RQ11: Outcomes Is the intervention transferable or replicable in the Kenema health system or within the MSF ecosystem?	⇒ Appropriateness- a, b, c ⇒ Effectiveness- b, c ⇒ Coherence- d	⇒ MCH & maternity clients ⇒ Outreach clients ⇒ Community members ⇒ MSF staff ⇒ PHU/CHC staff ⇒ Stakeholders/ Partners ⇒ Project documents ⇒ Routine data	⇒ FGD ⇒ semi-structured interviews ⇒ field notes & summaries	Topic Guides ⇒ MSF-hospital staff ⇒ PHU/CHC staff ⇒ Outreach staff ⇒ MSF-HQ staff ⇒ MSF-clients ⇒ PHU/CHC clients ⇒ Stakeholders/Partners ⇒ field notebook ⇒ excel spreadsheet	⇒ Evidence that suggest the project can be adapted to other settings and can continue. ⇒ Evidence that suggests the project is embedded within existing structures and continue	Jun-Aug '24

ANNEX II: TABLES AND FIGURES

Table 1a: Uptake of mother and child hospital services stratified by year

		Year, n (%)		
No.	Indicator	2021 (Target)	2022 (Target)	2023 (Target)
Paediatric Wards				
1	No. of ED paediatric consultations	5697 (3600)	6818 (4200)	6963 (4200)
2	No. of paediatric admissions at MSF Hangha Hospital	3729 (1920)	4767 (3720)	4657 (3720)
3	Red paediatric cases triaged and sent to ED for consultation, *n [(%]*	758 [6.5] *(≤ 7)*	6.3% (5 - 10)	7.3% (5 - 10)
3	Yellow paediatric cases triaged and sent to ED for consultation, *n [%]*	4891 [42.3] *(≤ 52)*	0.3% *(< 5)*	0.2% *(< 5)*
4	MSF Hangha hospital bed occupancy rate (%)	71 (80 – 90)	78.3 (80 – 90)	97.9 (80 – 90)
5	MSF Hangha hospital mortality rate among admitted patients (%)	6.0 (< 5)	5.7 (< 5)	6.4 (< 5)
6	Average consultations per child u5 in MSF-supported PHUs.	1.35 *(2)*	-	0.51 (0.5)
7	Facility deliveries out of expected deliveries in the area, *(%)*	46 (>70)	43.6 (>70)	44.3 (>70)
4.1	Under 5 children screened with malnutrition out of those admitted at Hangha hospital, *(%)*	95.9 *(100)*	93.1 *(100)*	82.3 *(100)*
4.2	Overall hospital mortality rate (excluding ED), (%)	6.0 *(<5)*	5.7 (<5)	6.4 (<5)
4.2	MSF Hangha hospital ED mortality rate, (%)	1 (<1)	0.9 (<1)	0.95 (<1)
4.5	Proportion of ITFC patients tested for HIV out of all patients admitted to ITFC, *(%)*	96.2 *(100)*	97.7 (100)	95.0 (100)
4.6	Proportion of admitted under 2 years with up-to-date immunization status at exit of out of all patients exiting MSF Hangha Hospital, (%)	81.9 *(>90)*	75.3 (>90)	73.8 (>90)
4.7	IPD malaria case fatality rate among admissions, (%)	3.4 *(<5)*	3.3 *(<5)*	4.2 *(<5)*
4.7	ITFC malaria case fatality rate among admissions, (%)	5.0 *(<5)*	8.3 *(<5)*	0.2 *(<5)*
4.8	Average length of hospital stays for ITFC patients, (days)	10.3 *(<12)*	8 (<12)	7 (<12)
4.9	Infants <6 months discharged exclusively breastfeeding, *n (%)*	-	82.6 *(>90)*	-
CEmONC				

4.2	CEmONC mortality rate (Obstetric), (%)	-	1.2 *(<1)*	1.1 *(<1)*
4.2	CEmONC mortality rate (Neonatal), (%)	-	10 (<15)	13.8 (<15)
4.11	Women admitted to MSF Kenema maternity fitting admission criteria, *n (%)*	-	-	99.9 *(>95)*
4.12	Women with unknown HIV status at postpartum or tested > 3 months, (%)	-	-	94.6 (100)
4.13	Still birth rate by breakdown (per/1000 births)	-	149 (<25.7)	120 (<25.7)
4.15	Cesarean section rate, (%)	-	50	27.8 (<40)
4.17	Partogram chart audit with adherence to MSF guidelines, *(%)*	-	-	-
4.18	Newborns vaccinated in the maternity, *(%)*	-	-	37.9 (100)
4.19	Pregnant women vaccinated with tetanus-diphtheria, *n (%)*	-	-	-
4.20	Pregnant women who receive FP counselling prior to discharge from maternity, *(%)*		-	82.7 (100)
4.22	Neonates breastfeed within the first hour of life, *(%)*	-	-	73 (>90)

ED: Emergency department.

CEmONC: Comprehensive Emergency Obstetric and Newborn Care services: ITPC: In-patient Therapeutic Feeding Centre

Table 1b: Quality control, IPC, referral, pharmacy, laboratory and environmental health indicators stratified by year

		Year, n (%)		
	Indicator	2021 (Target)	2022 (Target)	2023 (Target)
Quality control				
4.3	VT charts showing adherence to MSF guidelines, *(%)*	86.4 (>90)	87.8 (>90)	95.5 (>90)
4.3	FBM charts showing adherence to MSF guidelines, *(%)*	67 (>90)	86.8 (>90)	91.5 (>90)
4.3	FM charts showing adherence to MSF guidelines, *(%)*	71.4 (>90)	82.8 (>90)	92.3 (>90)
4.4	Hist. Lassa alert forms showing adherence to MSF guidelines, (%)	-	93.1 (>90)	95 (>90)
4.4	Clin. Lassa alert forms showing adherence to MSF guidelines, (%)	-	86.9 (>90)	91 (>90)
4.4	Lab. Lassa alert forms showing adherence to MSF guidelines, (%)	-	84.1 (>90)	86 (>90)
5.7	Medication prescribed appropriately in ED, *(%)*	-	-	0 (>90)
5.7	Medication prescribed appropriately in IPD, *(%)*	-	-	18 (>90)
5.7	Medication prescribed appropriately in ICU, *(%)*	-	-	35 (>90)
5.7	Medication prescribed appropriately in ITFC, *(%)*	-	-	34 (>90)
5.11	Antibiotic stewardship committee meets regularly, (*n)*	-	3 (6)	5 (6)
5.13	AEB followed up as per protocol, *(%)*	100	100	-
5.14	Staff contact tracing conducted per COVID-19 SOP, *(%)*	-	100 (100)	100 (100)
Infection Prevention Control				
5.1	Hand hygiene compliance health care staff (Hangha hospital), *(%)*	75.7 (75)	54.2 (>75)	50 (>75)
5.1	Hand hygiene compliance health care staff (Hangha- CHC), *(%)*	-	43.5 (>75)	39.5 (>75)
5.2	Cleaning compliance using reflective surface marker, *(%)*	65.5 (>75)	78.9 (>75)	80.5 (>75)
5.3	IV bundle compliance, *(%)*	58.5 (100)	90.9 (100)	88 (100)
5.4	Surgical site infections observed in post-operative maternity cases in MSF Hangha hospital, *(%)*	-	4.4 (<5)	5.2 (<5)
5.5	SIPCA assessment is observed in MSF Hangha hospital (>70%), *(%)*	30.8 (>80)	71 (>70)	92 (>70)
5.6	Cases of transmission-based precautions adhering to MSF guidelines, *(%)*	-	83.5 (>85)	82.5 (>85)
6.1	IPC plans initiated and completed for the quarter for KGH	Not done-30.8	Not done	Not done
Referrals				
6.5	Proportion of patients referred to KGH from MSF Hangha hospital with feedback recorded back out of all patients referred to KGH, *(%)*	48.9 (100)	98 (100)	100 (100)

6.6	Bimonthly coordination meetings with KGH hospital, *(%)*	75 (100)	7 (100)	-
Pharmacy				
5.8	100% of cold chain breakdowns are reported, *(%)*	-	100 (100)	-
5.9	Stock analysis in central stock and end-user units, *(%)*	-	-	31.7 (5)
5.10	Rupture of end-user items on MSL, *(%)*	100 (<5)	-	9.9 (<5)
Laboratory				
5.15	Patients receiving blood within 4 hours out of all patients in need of blood, *(%)*	100 (100)	100 (100)	99.4 (100)
5.16	No. of blood transfusion reactions reported, (n)	-	0 (<1)	2 (<1)
5.18	Positivity rate of blood culture, (%)	-	15.4 (10-15)	16.7 (10-15)
5.19	Contamination rate of blood culture	-	4.5 (<3)	5.6 (<3)
5.20	Blood culture and antibiogram reported within 48 hours, *(%)*	-	97 (100)	72.6 (80)
Environmental health				
5.22	Water tests with FRC 0.3 to 0.6 mg/L ot of all water tests conducted, *(%)*	99 (100)	100 (100)	100 (100)
5.23	Priority hospital waste incinerated at the appropriate temperature, *(%)*	100 (100)	100 (100)	75 (100)
5.24	Hospital beds with intact and properly made mosquito nets out of all hospital beds needing a mosquito net, *(%)*	88 (100)	70 (100)	79.7 (100)

VT: Vital signs audit; FBM: Fluid Balance Monitoring; FM: Feeding Monitoring chart audit;

Hist.: History assessment on admission assessed and documented correctly; Clin.: Major/minor clinical alert assessed and documented correctly; Lab.: Major lab alert criteria assessed and documented correctly

Table 1c: Mental health indicators by year

		Year, n (%)		
	Indicator	2021 (Target)	2022 (Target)	2023 (Target)
	Mental health			
3.7	ITC beneficiaries arriving for MH counselling service out of all beneficiaries referred, *(%)*	100 (100)	100 (100)	100 (100)
3.7	HTS beneficiaries arriving for MH counselling service out of all beneficiaries referred, *(%)*	100 (100)	99.7 (100)	71 (100)
3.8	Caretakers receive one psychoeducation session prior to discharge, (%)	-	27.4 (>80)	47 (>80)
3.9	Patients sent for HIV testing who receive full pre/post counselling, *(%)*	-	99.1 (100)	71 (100)
3.10	Patients admitted to ITFC who receive developmental milestone screening in MSF Hangha hospital, *(%)*	96.1 (100)	41.1 (100)	-

Table 1d: Outreach indicators in the catchment area of PHUs supported by MSF stratified by year

		Year, n (%)		
	Indicator	2021 (Target)	2022 (Target)	2023 (Target)
Nursing activities				
6	Average no. of consultations per under 5 child in the supported iCCM villages in the catchment area of PHUs supported by MSF, (n)	0.45 (0.5)	-	0.51 (0.5)
1.1	iCCM communities consulting at least 90 under 5 per quarter among all iCCM communities targeted by MSF, *(%)*	58.1 (>50)	-	78.7 (>50)
1.2	Under 5 treated for diarrhoea out of all under 5 diarrhea cases registered by CHWs in iCCM communities targeted by MSF, *(%)*	95.3 (100)	-	100 (100)
1.3	Under 5 treated for pneumonia out of all under 5 fever and chest indrawing cases registered by CHWs in iCCM communities targeted by MSF, *(%)*	-	-	100 (100)
1.4	Under 5 screened for malnutrition (CHWs), *(%)*	98.4 (100)	-	82.3 (100)
1.4	Under 5 screened for malnutrition (PHUs), *(%)*	80.7 (100)	89.7 (100)	47.4 (100)
1.5	Appropriate prescribing practice for positive RDTs, *(%)*	-	-	100 (95)
1.6	U5 children referred to primary health care out of all under 5 children registered by a CHW with at least one danger sign from iCCM communities targeted by MSF, *(%)*	-	-	100 (100)
1.7	U5 primary health consultations correctly referred to a secondary health care out of all u5 primary health consultations that needed referral to secondary health services at CHCs supported by MSF, *(%)*	58.4 (>70)	72.2 (>70)	99 (>70)
1.8	Correct antibiotic prescription according to IMCI guidelines in u5, *(%)*	83.5 (>80)	97.0 (>80)	95.7 (>80)
1.9	Sick u5 children who are RDT+ and prescribed an antimalarial drug correctly at PHUs supported by MSF, *(%)*	-	74.0 (>80)	98.0 (>80)
1.10	Average length of treatment per cured u5 in OTP/ATFC program, (weeks)	7.4 (<8)	8 (<8)	11 (<8)
6.8	PHUs with secure cold chain out of all PHUs supported by MSF, *(%)*	93.8 (100)	100 (100)	100 (100)
2.1	CHW's that demonstrates knowledge of identification of danger signs out of all CHWs in iCCM communities targeted by MSF, *(%)*	-	-	96 (>90)
SRH activities				
7	Maternal deliveries occurring in a facility out of total expected deliveries among catchment area of PHUs supported by MSF., *(%)*	46 (>70)	43.6 (>70)	44.3 (>70)

8	DOCs referred to secondary health care facilities, *(%)*	-	62.5 (100)	98.1 (100)
2.1	TBA's that demonstrates knowledge of identification of danger signs out of all TBAs in iCCM communities targeted by MSF, *(%)*	32.5 (>90)	74.2 (>90)	99.3 (>90)
2.2	PLWs and women of reproductive age referred by CHWs/TBAs for SRH services and are received at PHUs supported by MSF, *(%)*	61 (>80)	58.8 (>80)	89.4 (>80)
2.5	Postpartum women and their newborn receiving PNC1st visit within 7 days out of all post-partum women who gave birth at a facility supported by MSF, *(%)*	75.0 (100)	38.7 (100)	96.8 (100)
Pharmacy				
6.7	PHUs with all essential IMCI/iCCM and OTP drugs and supplies gap-filled by MSF out of all PHUs supported by MSF *(%)*	25 (75)	96 (75)	91.7 (75)
6.13	Stock-outs (rupture) of essential drugs for outreach activities *(%)*	75 (<5)	4 (<5)	9.9 (<5)
Environmental health				
6.9	PHUs with environmental assessment completed, gap-fill plan made, and implementation done *(%)*	96.5 (100)	77.7 (100)	96.3 (100)
6.10	PHUs with a verified water source out of all PHUs supported by MSF, *(%)*	93.4 (100)	100 (100)	100 (100)
6.11	Villages with access of safe water source (need water filters), *(%)*	-	96 (100)	66.5 (100)
6.11	Villages with access of safe water source (need hand-dug well re-deepening), *(%)*	-	100 (100)	72.8 (100)
6.11	Villages with access of safe water source (need newly hand-dug well), *(%)*	-	100 (100)	93.8 (100)
6.11	Villages with access of safe water source (need hand pump maintenance/repair), *(%)*	-	100 (100)	93.3 (100)
6.12	Villages with vector control preventive approach, *n (%)*	-	-	0 (100)

Table 1e: Health promotion and staff clinic indicators stratified by year

		Year, n (%)		
	Indicator	2021 (Target)	2022 (Target)	2023 (Target)
Health promotion				
3.1	Caretakers scoring ≥70% on message comprehension out of all caretakers tested at the MSF Hangha Hospital and communities, *(%)*	88.0 (>70)	85.9 (>70)	94 (>70)
3.2	Caretakers receiving admission orientation in MSF Hangha hospital, *(%)*	-	50.7 (>80)	87.3 (>80)
3.3	Community engagement sessions done at MSF-supported PHUs, (1 per PHU per quarter)	-	86.7%	17 (4 per PHU)
3.4	HP community referrals that arrive to PHUs supported by MSF out of all HP community referrals made, *(%)*	75.8 (>70)	96.7 (>70)	78 (>70)
3.5	Children from catchment area discharged from ITFC and residing in catchment areas of PHUs supported by MSF and Kenema city are enrolled into an available OTP/ATFC program, *(%)*	70.9 (90)	14.1 (90)	66 (90)
3.6	Caregivers receiving a blood donation session out of all caregivers whose child received a blood transfusion, *(%)*	83.5 (>80)	98.5 (>80)	95 (>80)
4.10	Caregivers assessed at MSF Hangha hospital that can describe correctly how to give the treatment of the prescribed medications to their children, *(%)*	59.6 (>80)	50.6 (>80)	91.3 (>80)
Staff clinic				
5.25	No. of consultations/consultant/day, (n)	-	25 (<50)	14 (<50)
5.24	Malaria positivity rate, (%)	-	47.0	57.5
5.25	Referral out rate	-	2.2	1.9
5.14	Staff contact traced after correct contact tracing SOP, *(%)*	-	-	100

Key

	Indicator not yet reported at that time point
	Missing data

Figure 1: Monthly hospital bed occupancy at MSF Hospital

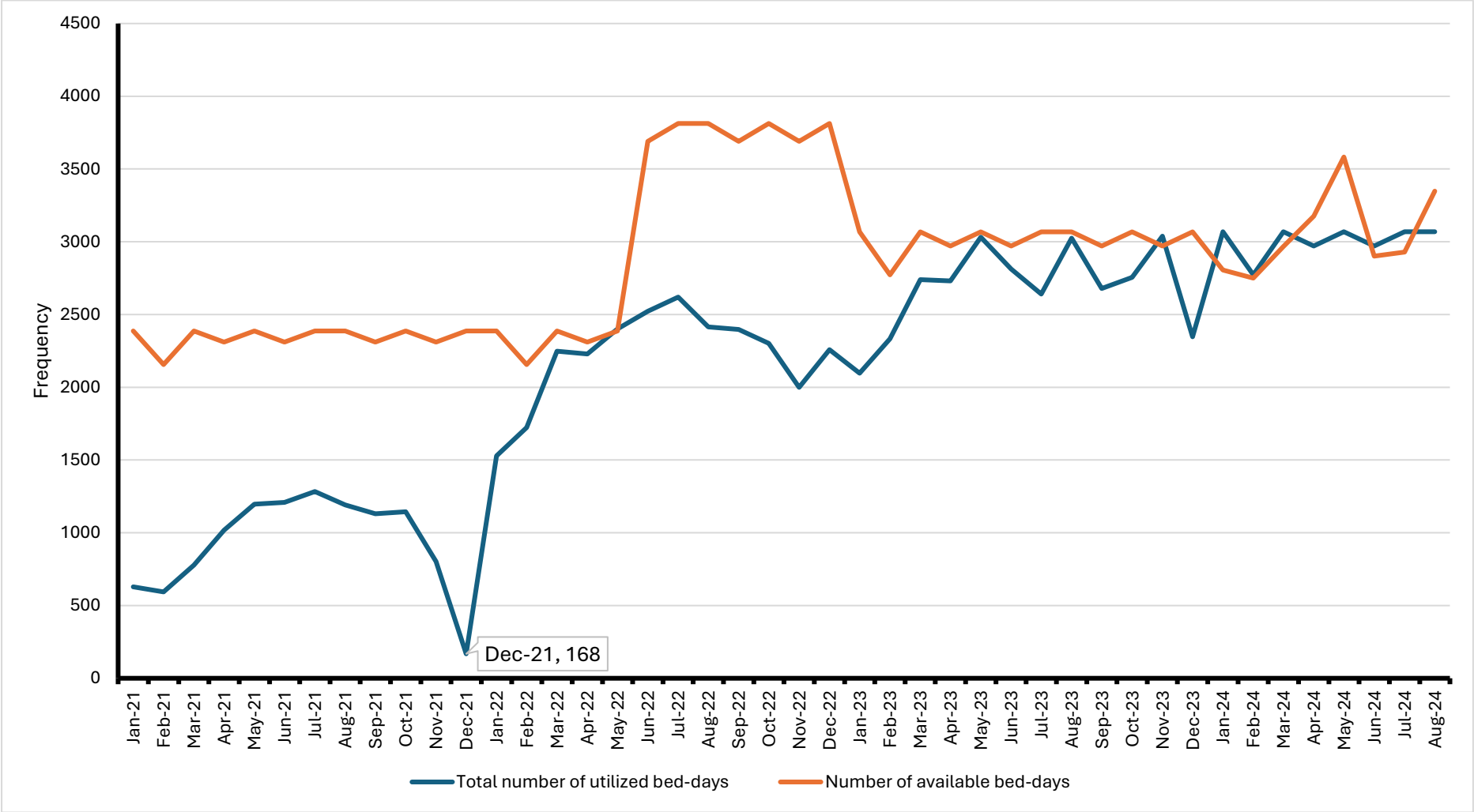


Table 2: Summary yearly estimates for number of available bed days vs utilised bed days

Indicator	2021 Median [Min, Max]	2022 Median [Min, Max]	2023 Median [Min, Max]	2024 Median [Min, Max]	p-value for trend
Average monthly number of available bed days in a year	2387 [2156, 2387]	3690 [2156, 3813]	3069 [2772, 3069]	3069 [2772, 3069]	<0.001
Average monthly number of utilised bed days in a year	1073 [168, 1284]	2280 [1528, 2620]	2735 [2096, 3038]	2945 [2751, 3582]	<0.001

Figure 2: Monthly ED paediatric consultations and admissions at MSF Hospital

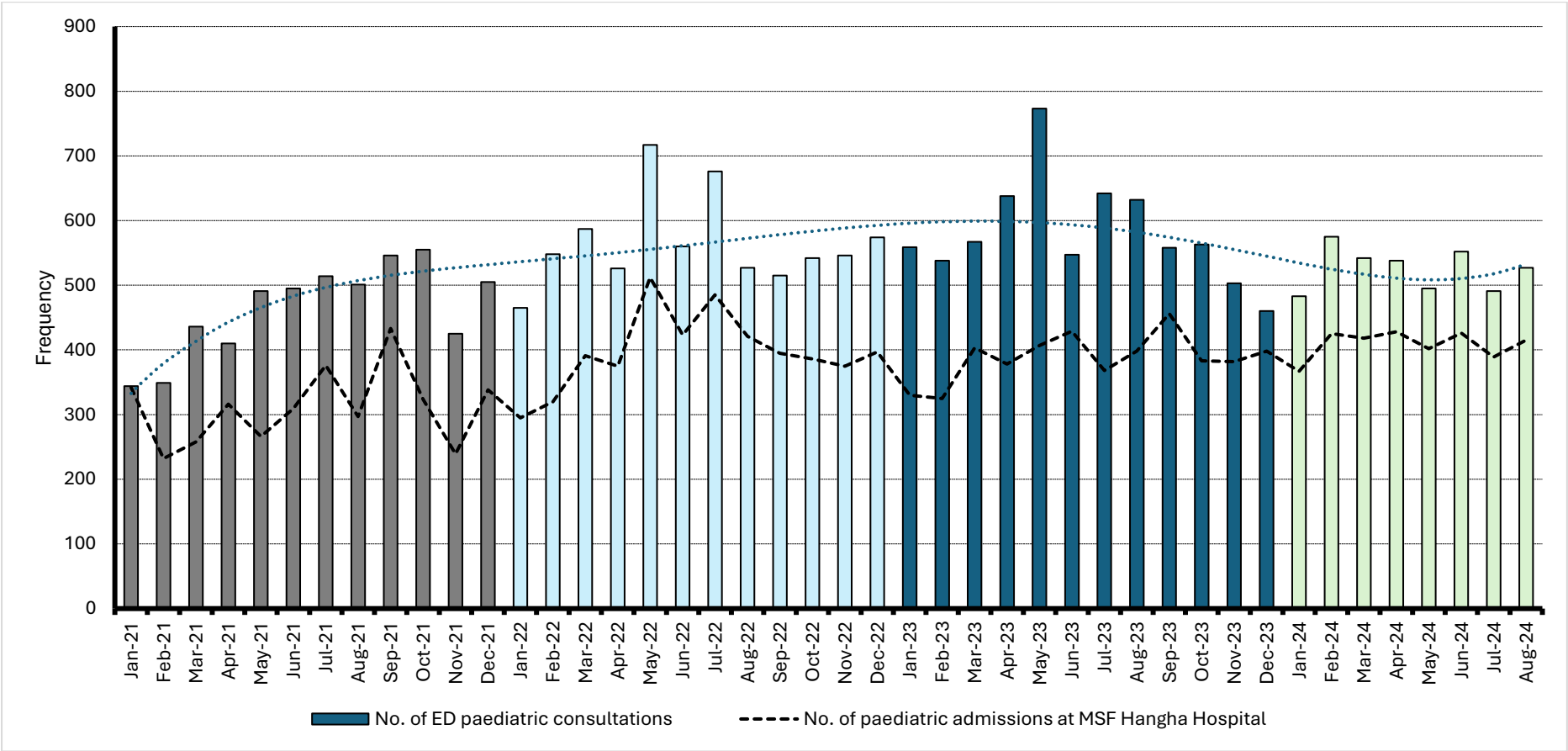


Table 3: Summary yearly estimates for ED paediatric consultations and admissions at MSF Hospital

Indicator	2021 Median [Min, Max]	2022 Median [Min, Max]	2023 Median [Min, Max]	2024 Median [Min, Max]	p-value for trend
Total ED paediatric consultations *(target)*	5571 (3600)	6783 (4200)	6980 (4200)	4203 (4200)	-
Total paediatric admissions *(target)*	3729 (1920)	4775 (3720)	4657 (3720)	3270 (3720)	-
Average monthly ED paediatric consultations in a year	493 [344, 555]	547 [465, 717]	561 [460, 773]	533 [483, 575]	0.016
Average monthly paediatric admissions in a year	313 [232, 433]	393 [295, 512]	391 [325, 456]	417 [367, 428]	<0.001

Figure 3a: Monthly hospital exits vs deaths at MSF Hospital

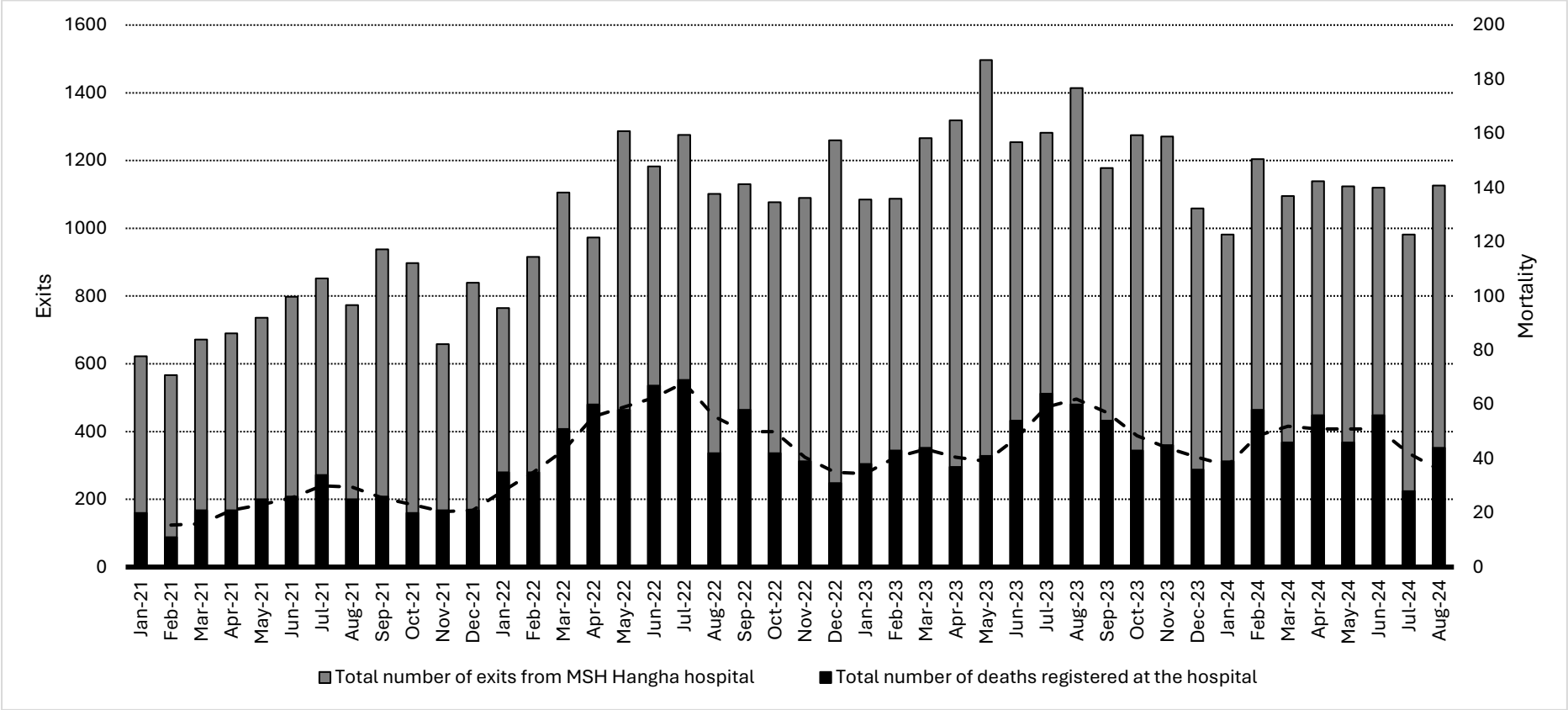


Figure 3b: Monthly hospital exits vs deaths in ED

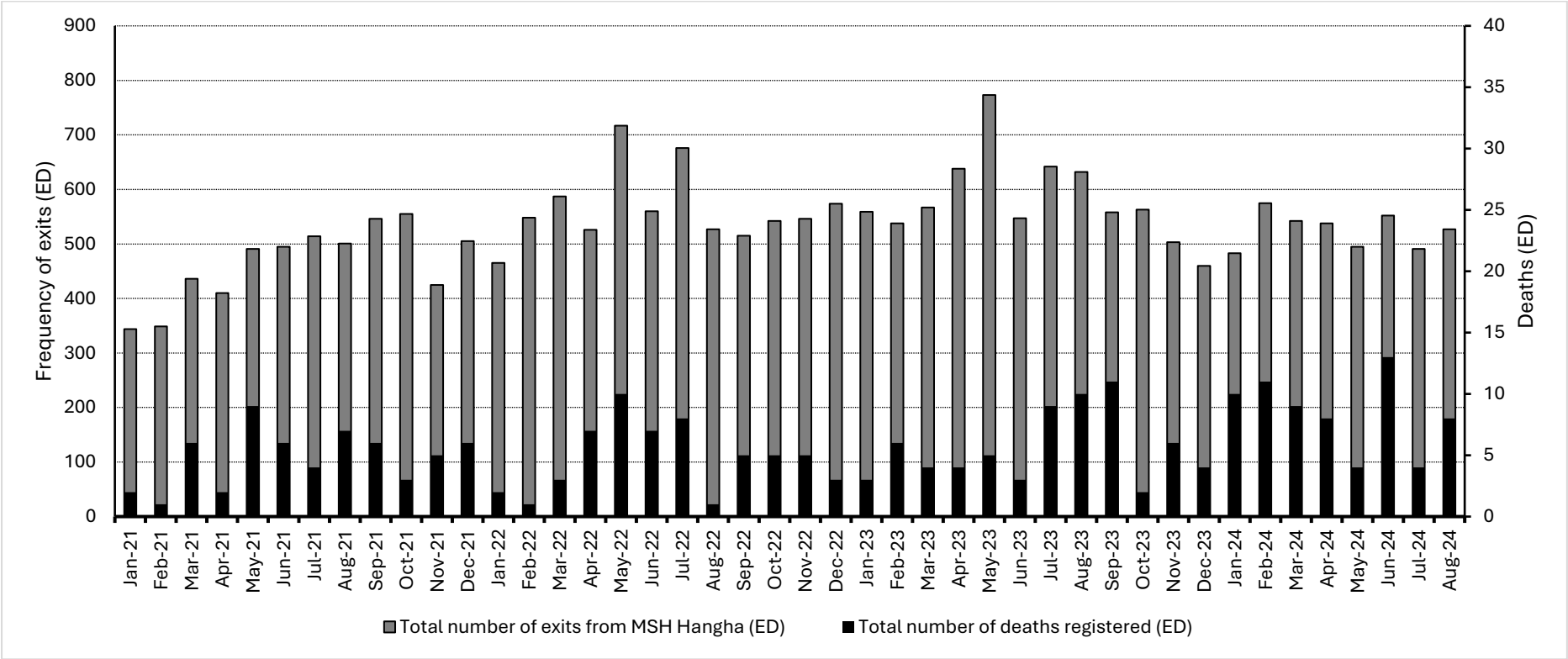


Figure 3c: Monthly hospital exits vs deaths in IPD

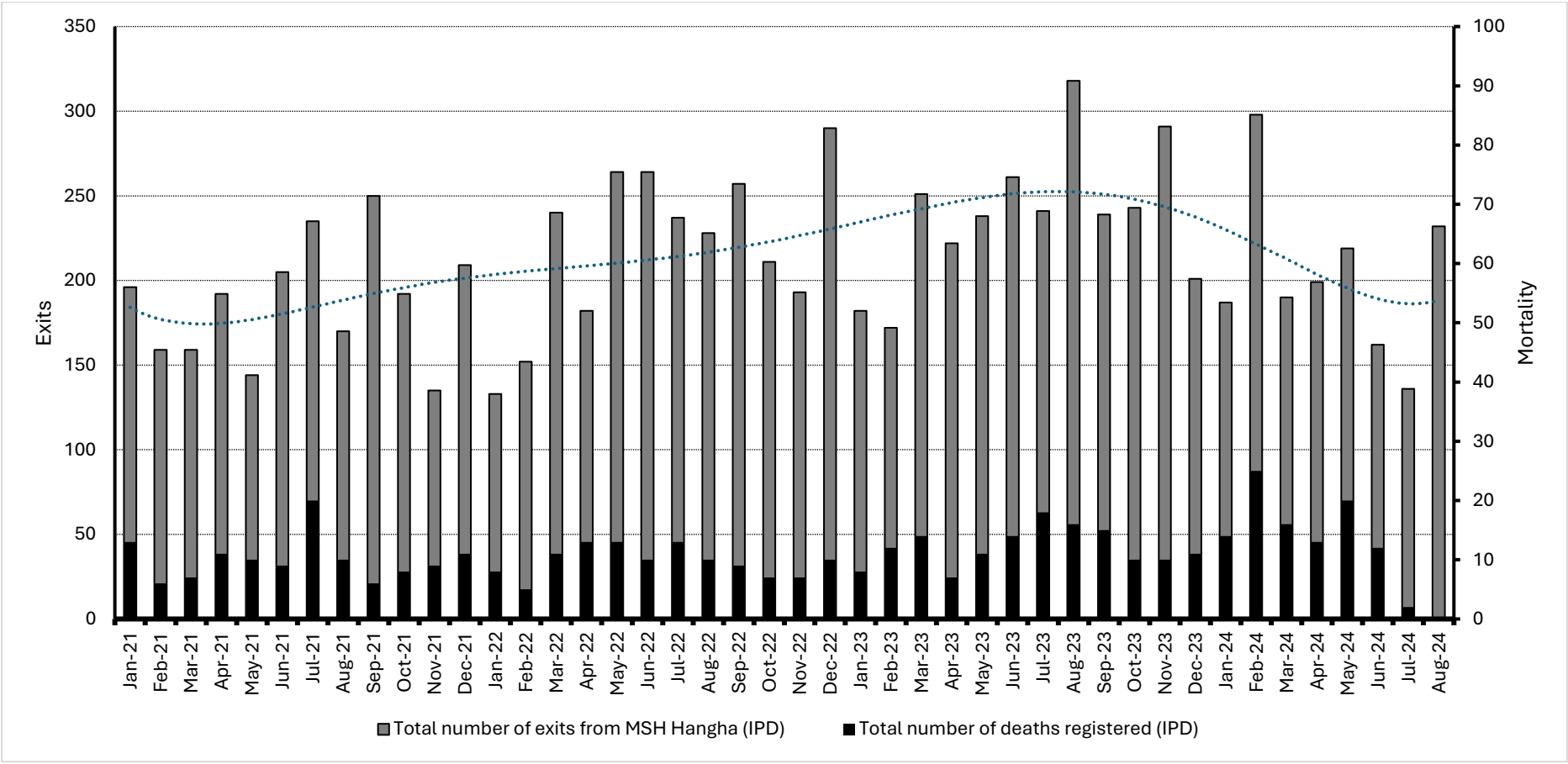


Figure 3d: Monthly hospital exits vs deaths in ICU

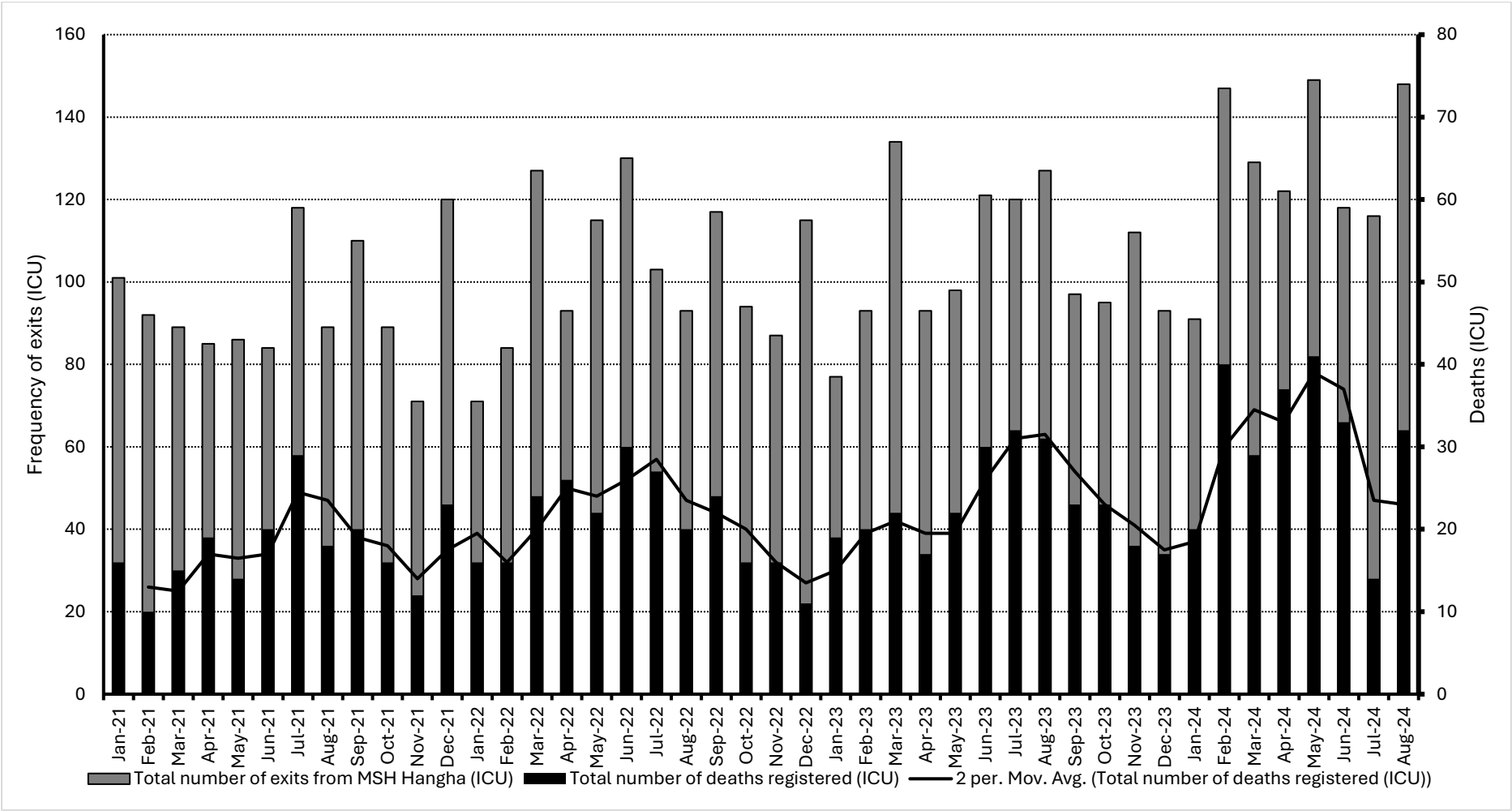


Figure 3e: Monthly hospital exits vs deaths in ITFC

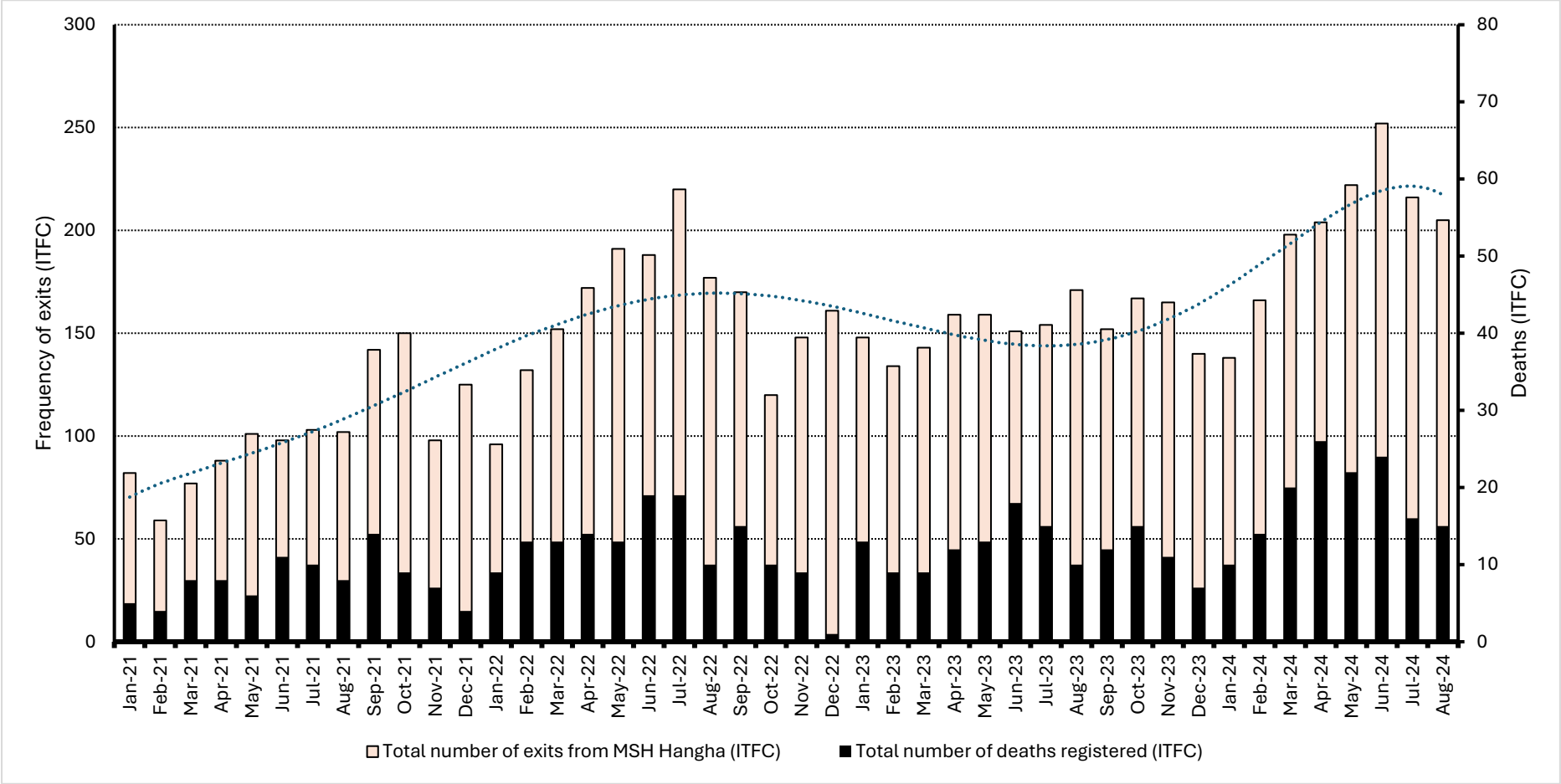


Table 4: Summary yearly estimates for exits and deaths by department

Indicator	2021 Median [Min, Max]	2022 Median [Min, Max]	2023 Median [Min, Max]	2024 Median [Min, Max]	p-value for trend
Average monthly number of hospitals exits from MSF Hangha in a year	755 [567, 938]	1104 [765, 1287]	1269 [1059, 1497]	1122 [982, 1204]	<0.001
Average monthly number of hospital deaths in a year	21 [11, 34]	47 [31, 69]	44 [36, 64]	46 [28, 58]	<0.001
Average monthly number of exits (ED) in a year	493 [344, 555]	547 [465, 717]	561 [460, 773]	533 [483, 575]	0.001
Average monthly number of deaths (ED) in a year	6 [1,9]	5 [1,10]	5 [2,11]	9 [4,13]	0.010
Average monthly number of exits (IPD) in a year	192 [135, 250]	233 [133, 290]	240 [172, 318]	195 [136, 298]	<0.001
Average monthly number of deaths (IPD) in year	10 [6, 20]	10 [5, 13]	12 [7, 18]	15 [2,25]	0.008
Average monthly number of exits (ICU) in a year	89 [71, 120]	99 [71, 130]	98 [77, 134]	126 [91, 149]	<0.001
Average monthly number of deaths (ICU) in a year	17 [10,29]	21 [11, 30]	22 [17, 32]	33 [14, 41]	<0.001

Average monthly number of exits (ITFC) in a year	100 [59, 150]	166 [96, 220]	153 [134, 171]	205 [138, 252]	<0.001
Average monthly number of deaths (ITFC) in a year	8 [4,14]	13 [1,19]	12 [7,18]	18 [10, 26]	<0.001

Figure 4: Comparison of monthly recorded mortality by department

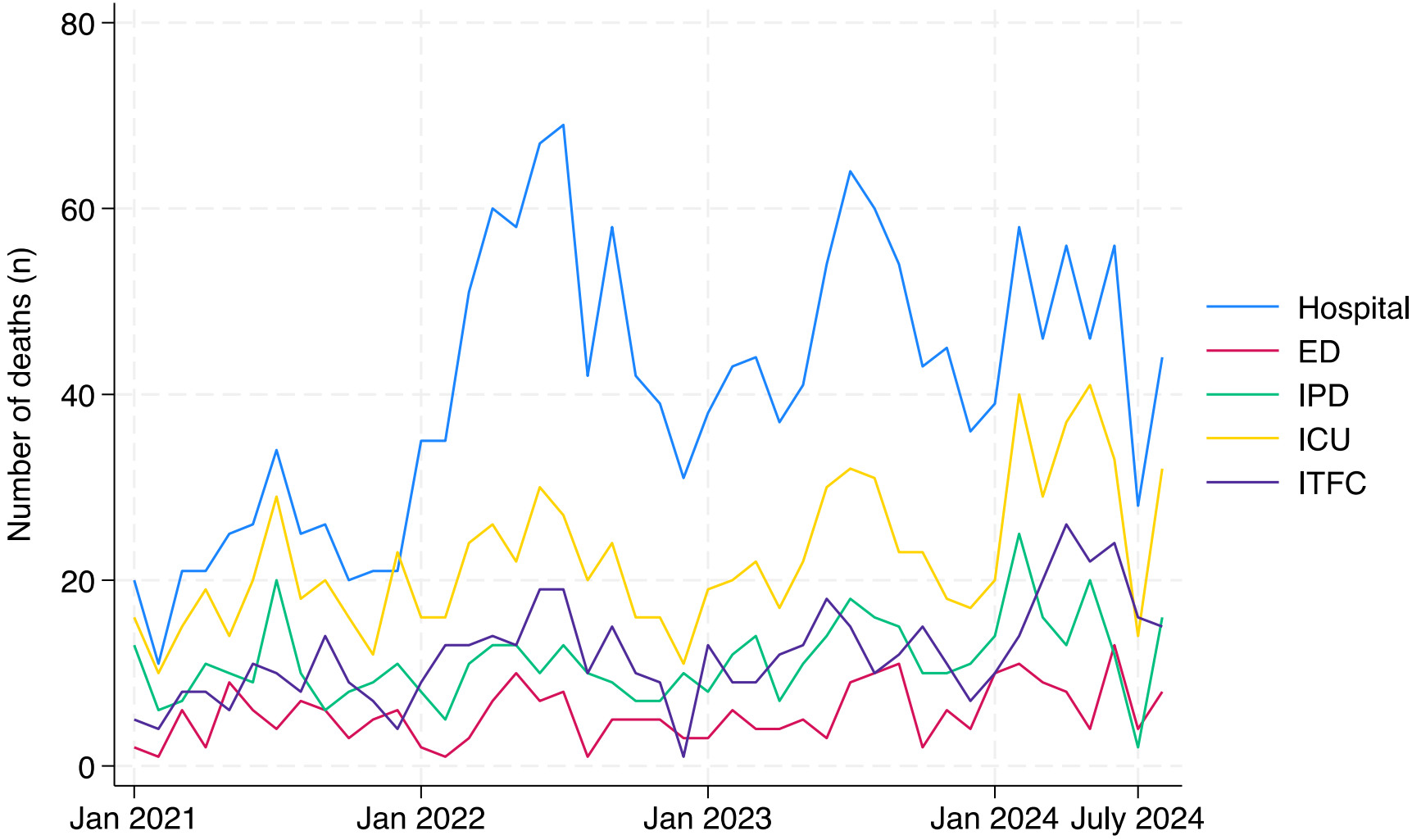
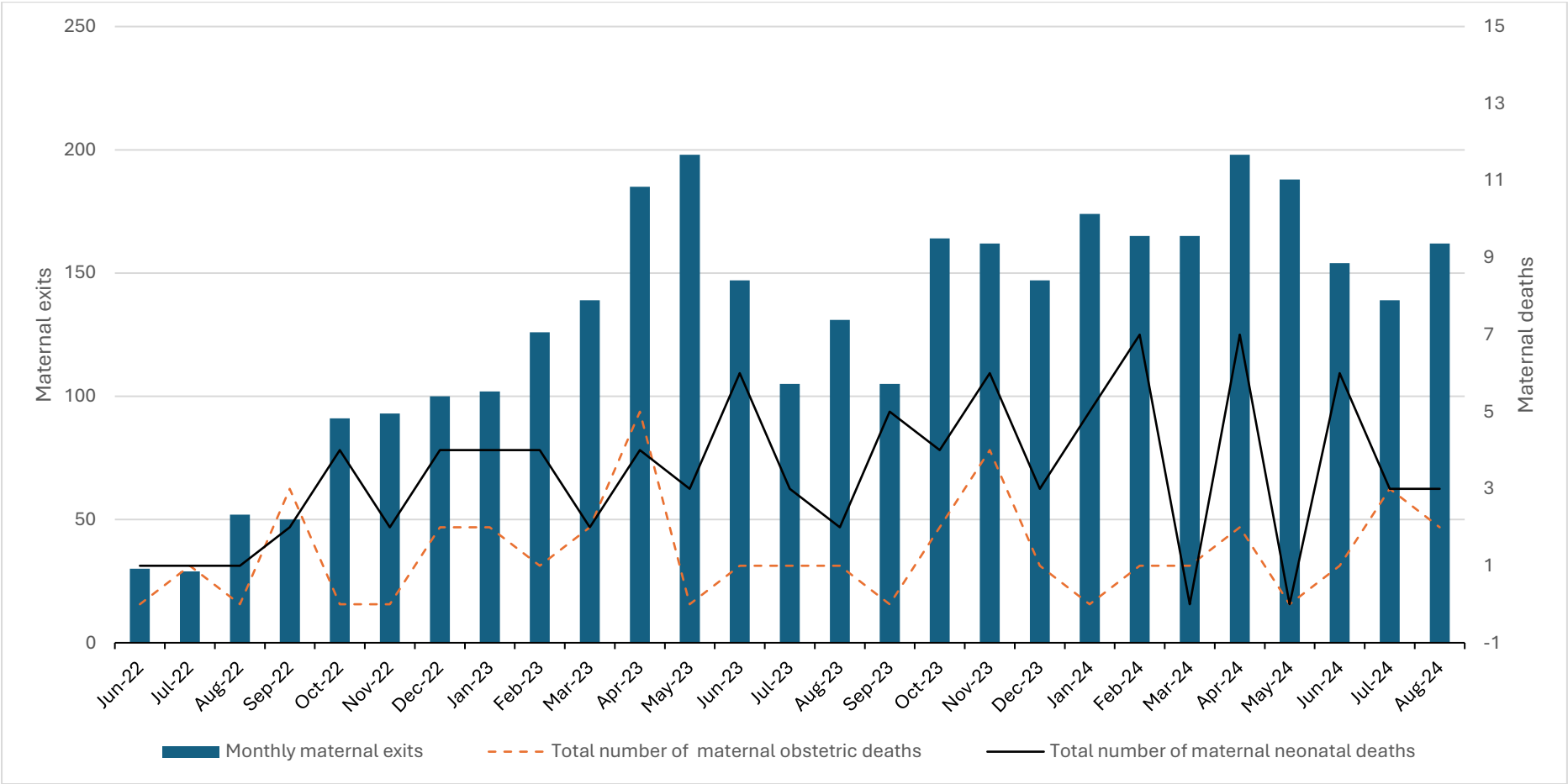
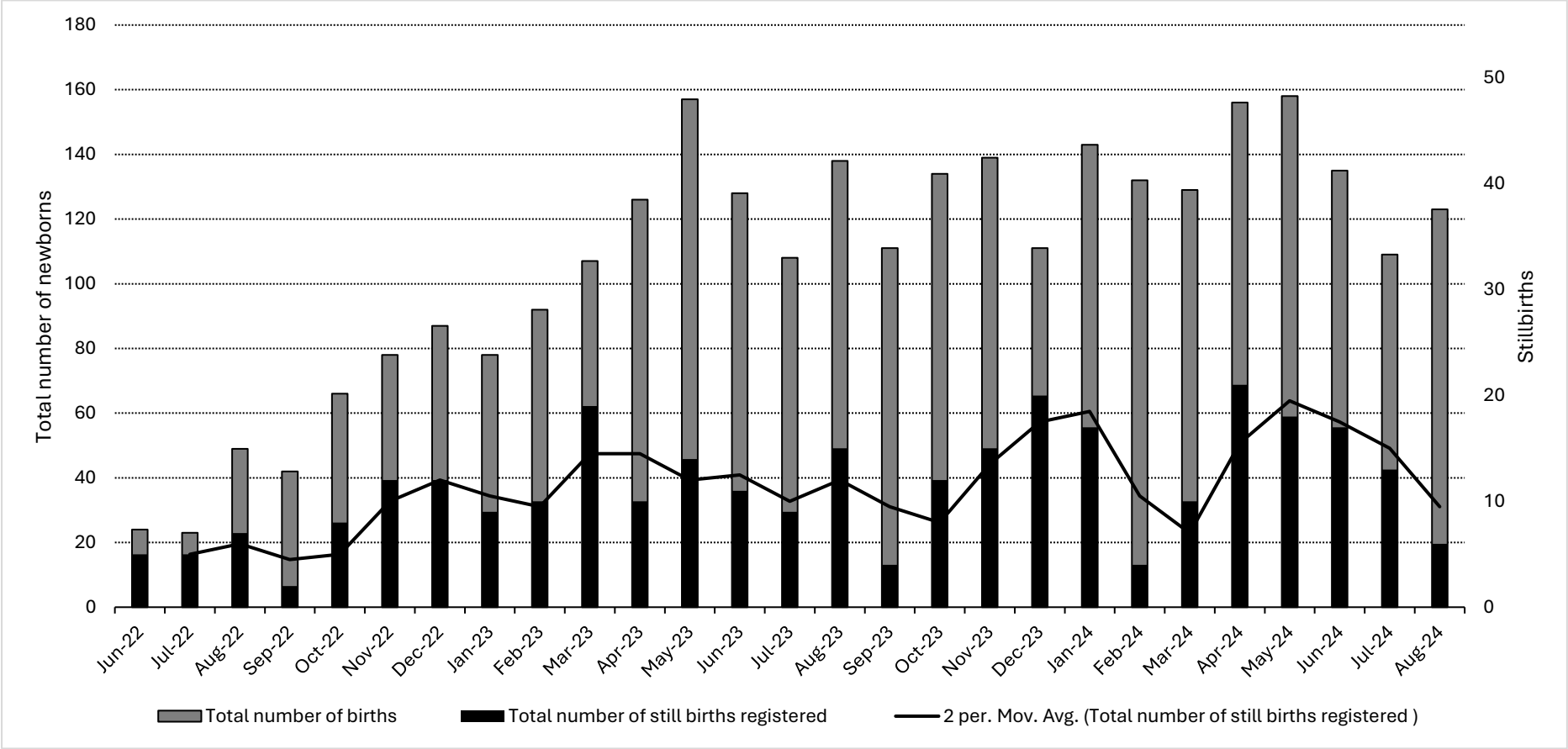


Figure 5: Comparison of maternal exits, maternal obstetric deaths and maternal neonatal deaths



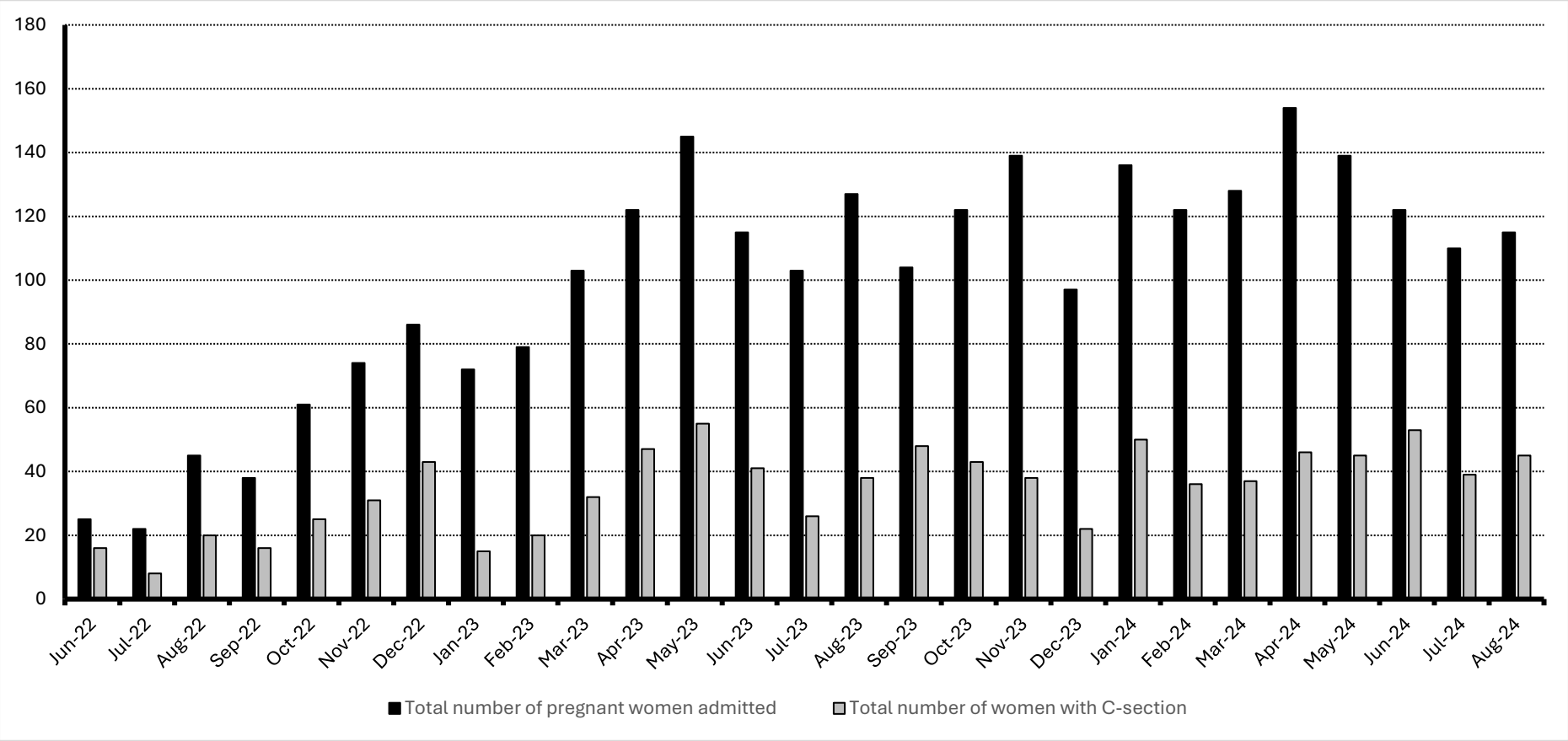
Data is missing prior to June 2022

Figure 6: Comparison between total number of births vs still births



Data is missing prior to June 2022

Figure 7: Comparison between admitted pregnant women and women who had a C-section

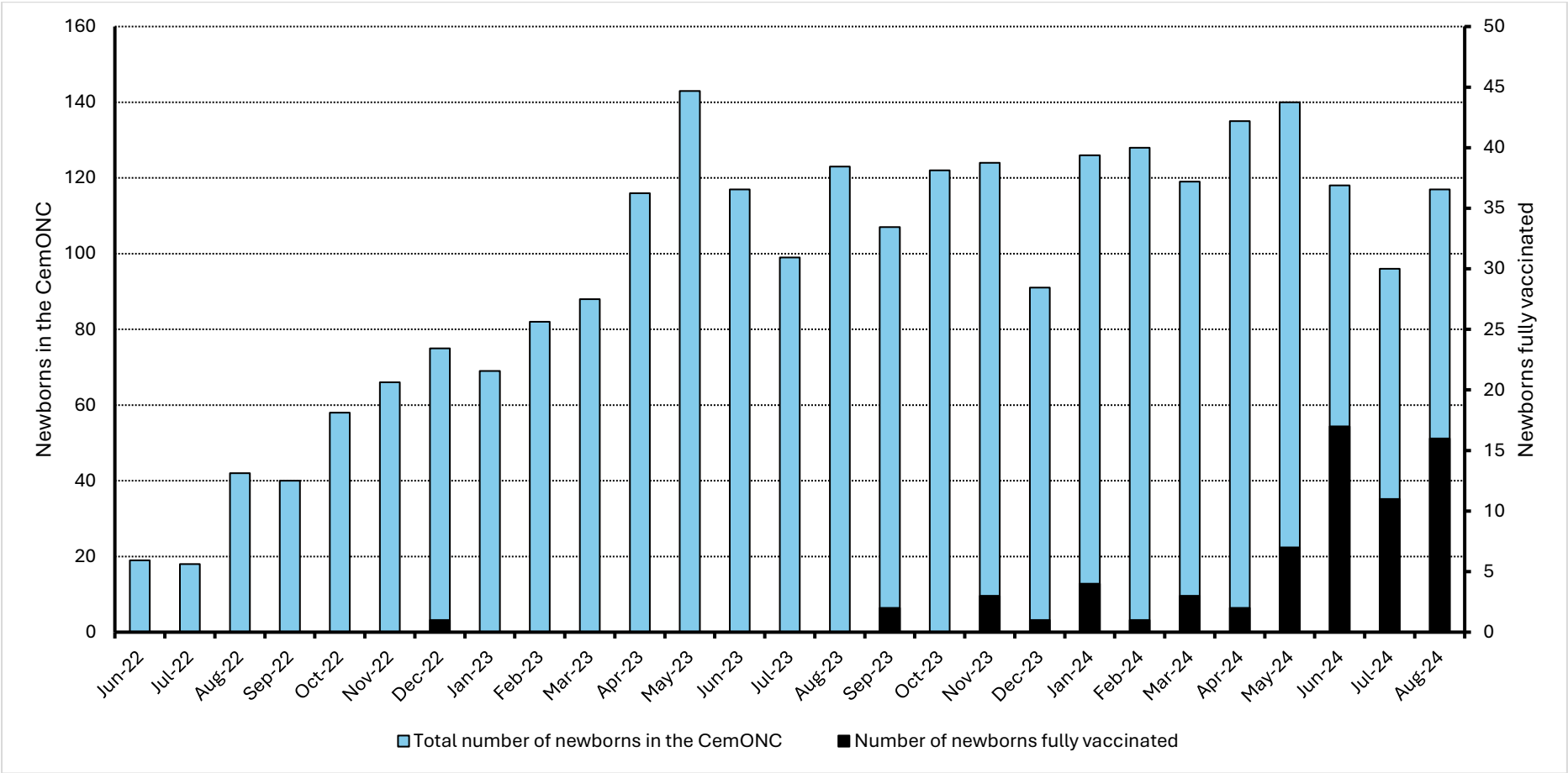


Data is missing prior to June 2022

Table 5: Summary yearly estimates for monthly number of pregnant women admitted and pregnant women who had a c-section

Indicator	2021 Median [Min, Max]	2022 Median [Min, Max]	2023 Median [Min, Max]	2024 Median [Min, Max]	p-value for trend
Average number of pregnant women admitted	-	45 [22, 86]	110 [72, 145]	125 [110, 154]	<0.001
Average pregnant women who had a C-section	-	20 [8, 43]	38 [15, 55]	45 [36, 53]	<0.001

Figure 8: Number of newborns in the CemONC vs those fully vaccinated



Data is missing prior to June 2022

Figure 9: Quarterly number of hand hygiene activities audited vs activities with a compliance among staff

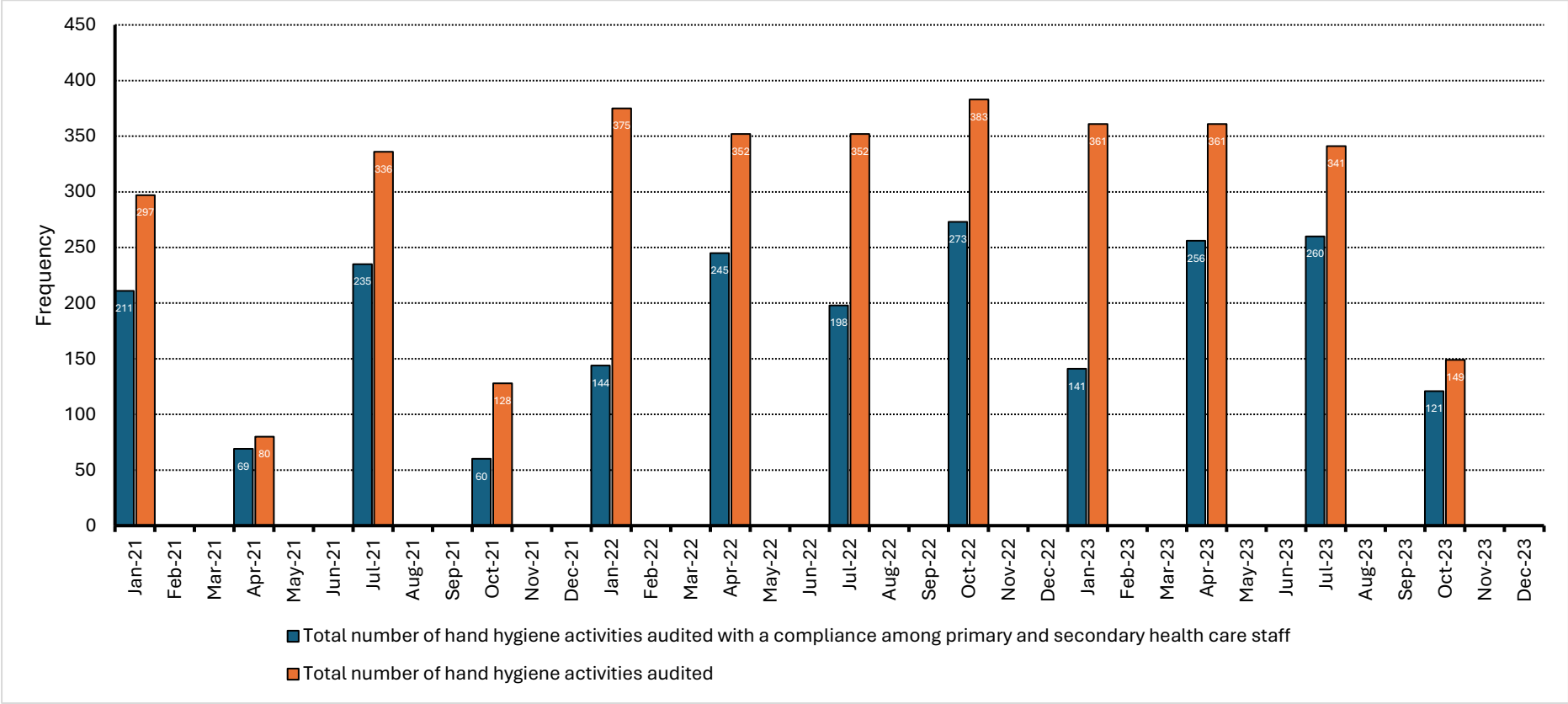
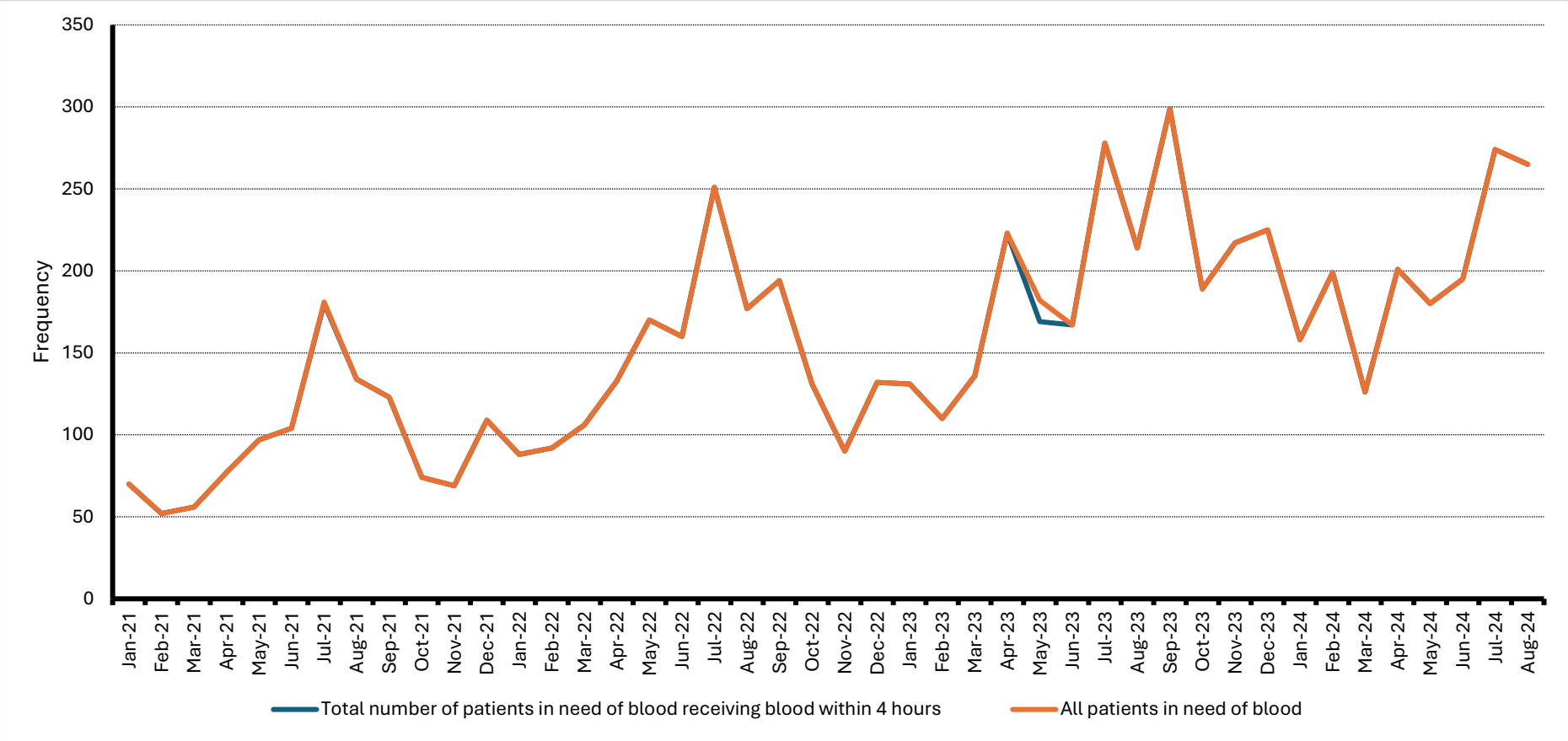


Figure 10: Number of patients in need of blood vs those who received it within 4 hours



The blue line is just showing the only time the number of patients receiving blood withing four hours fell short.

Table 6: Summary measurements for No. of patients in need of blood and those receiving blood within four hours

Indicator	2021 Median [Min, Max]	2022 Median [Min, Max]	2023 Median [Min, Max]	2024 Median [Min, Max]	p-value for trend
Average monthly no. of patients in need of blood per year	87 [52, 180]	133 [88, 251]	202 [110, 299]	197 [126, 274]	<0.001
Average monthly number of patients in need of blood receiving it within four hours/year	87 [52, 180]	133 [88, 251]	202 [110, 299]	197 [126, 274]	<0.001

Figure 11: Average number of consultations per u5 child in the supported iCCM villages

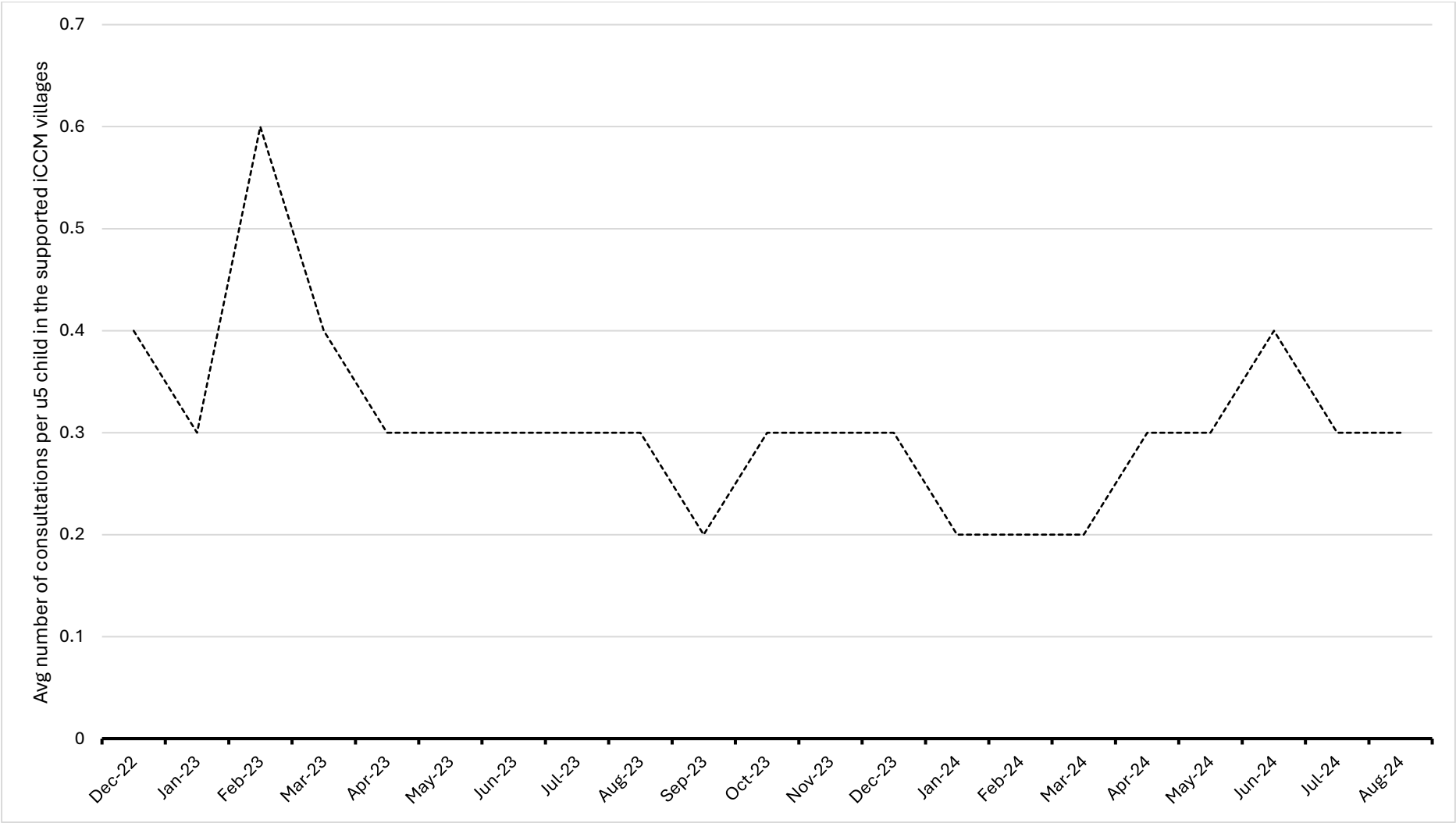
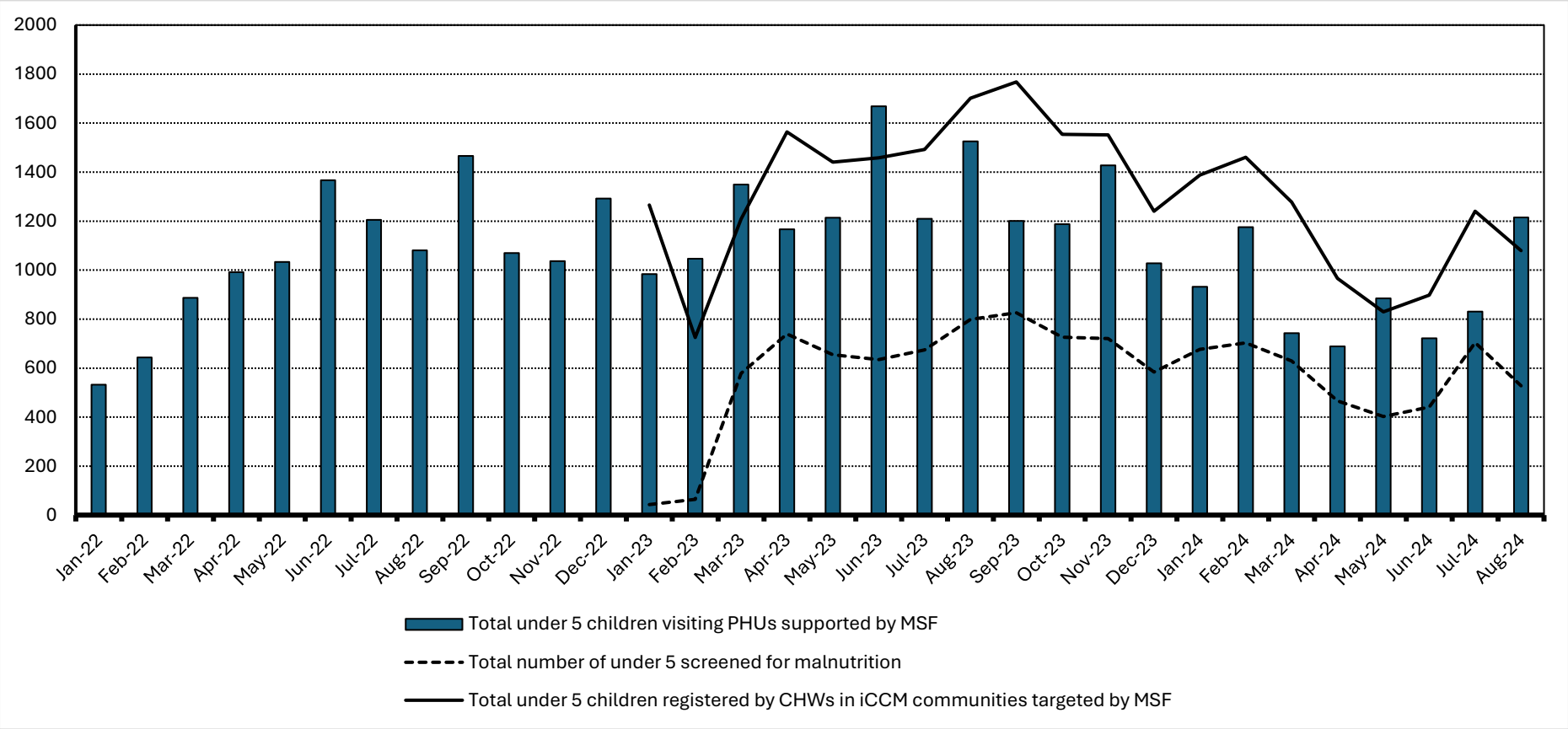


Figure 12: Comparison of u5 children screened for malnutrition, registered by CHWs in iCCM communities targeted by MSF and those visiting PHUs supported by MSF



Data is missing for the period prior to January 2022

Figure 13: Comparison of children discharged from ITFC and residing in catchment areas of PHUs supported by MSF and Kenema city are enrolled into an available OTP/ATFC programme supported by MSF vs children discharged from ITFC and residing in catchment areas of PHUs supported by MSF

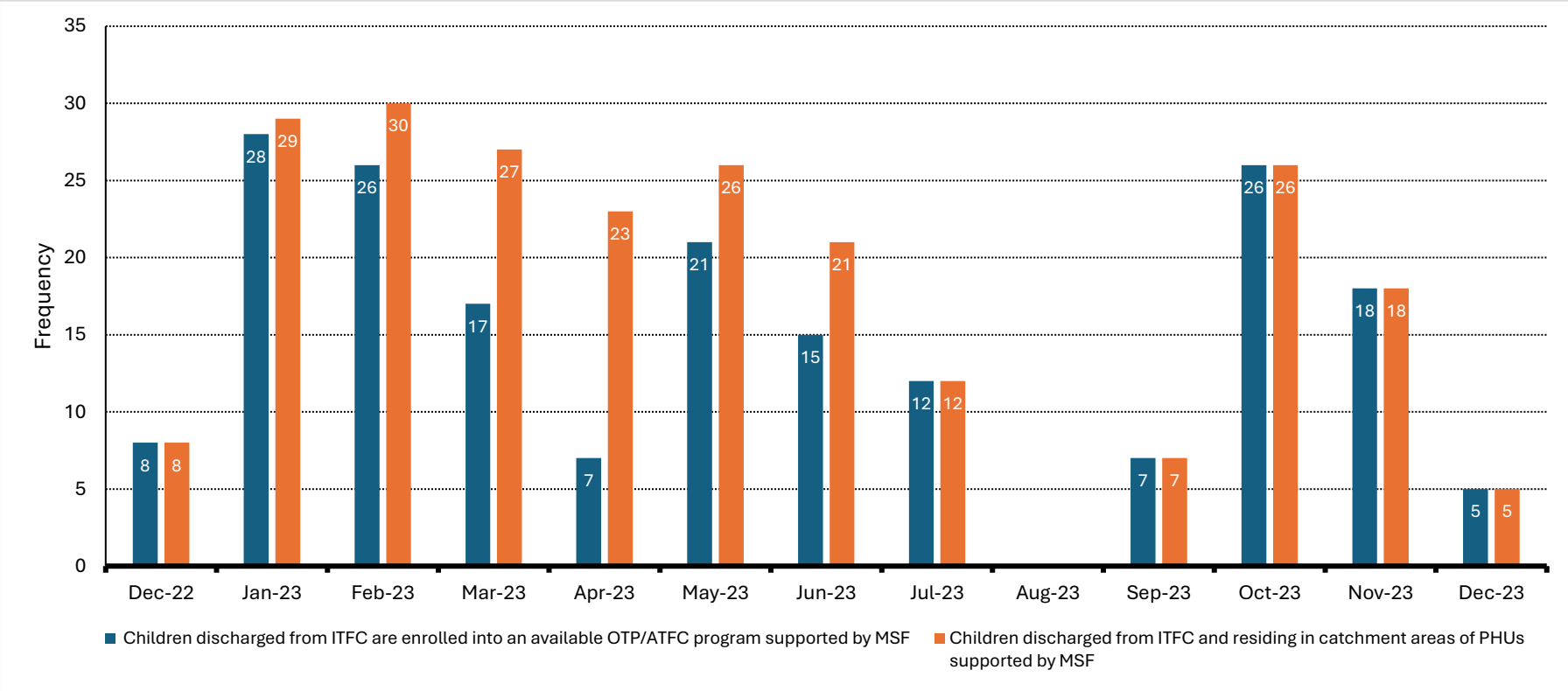


Figure 14: Frequency of ITFC admissions and ICU admissions

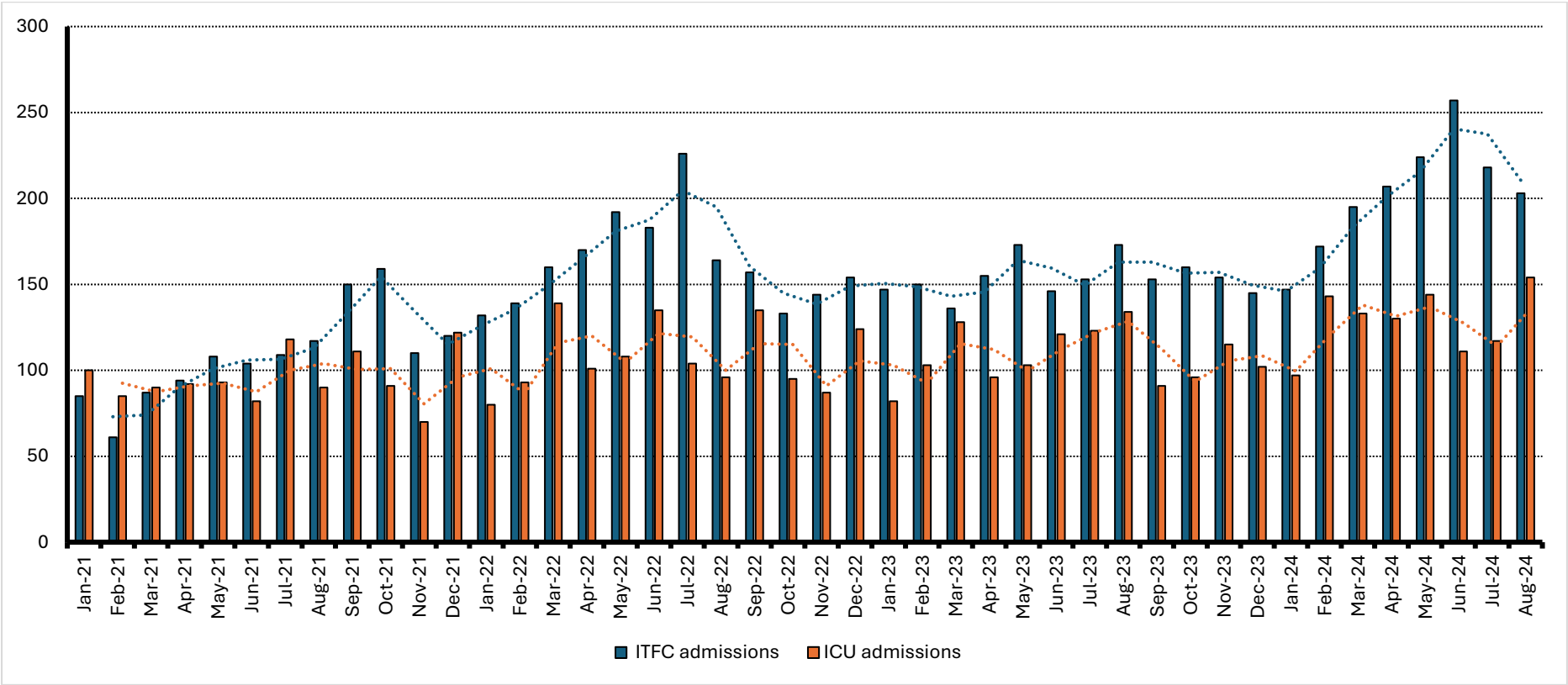


Table 7: Summary estimates for yearly ITFC and ICU admissions

Indicator	2021 Median [Min, Max]	2022 Median [Min, Max]	2023 Median [Min, Max]	2024 Median [Min, Max]	p-value for trend
Average monthly ITFC admissions in a year	109 [61, 159]	159 [132, 226]	153 [136, 173]	205 [147, 257]	<0.001
Average monthly ICU admissions in a year	92 [70, 122]	103 [80, 139]	103 [82, 134]	132 [97, 154]	<0.001

ANNEX III: TERMS OF REFERENCE

Médecins Sans Frontières (MSF) is an international medical humanitarian organization committed to providing quality medical care to people in crisis situations around the world, when and where they need it, regardless of their religion, ethnicity, or political views. Our core principles are neutrality, impartiality, independence, medical ethics, témoignage, and accountability.

The Stockholm Evaluation Unit (SEU), based in Sweden, is one of three MSF units responsible for managing and guiding evaluations of MSF's operational projects, and works mainly with the Operational Centre Brussels (OCB). For more information, visit our website: evaluation.msf.org.

Fostering a culture of evaluation is a strategic priority for accountability, continuous improvement, and organizational learning. MSF does not only evaluate because of external requirements, such as donor requirements. These terms of reference should be considered as a starting point for the evaluation process. The evaluator(s) are invited to challenge them and suggest, for example, different or additional perspectives, as they see fit during the creation phase. The evaluation process must be based on a sound methodology to achieve credible results and must also ensure that values and use are at the forefront. The evaluation must involve and include the different actors and counterparts adequately throughout the process.

Evaluation of MSF-OCB's Kenema project in Sierra Leone	
Start date:	May 2024
Duration:	Final report by October and last deliverable by November 2024
Requirements:	Interested applicants should submit: 1) A technical proposal 2) A financial proposal 3) CV(s) 4) A previous work sample
Deadline:	2359hrs CET on May 2nd, 2024
Apply to:	evaluations@stockholm.msf.org marked «KENEM2»
Note:	· We value quality over quantity. Providing only the requested and necessary documentation should prove your interest, capacity, and competency in the best possible manner. · This evaluation will require a site visit to the project, which will be planned during the initiation phase, through discussions with the project, the consultation group, and the SEU.

BACKGROUND

Kenema District lies in the Southeast of Sierra Leone and has an estimated population of 840,000 individuals in 2022[4], scattered in an area of 6,053 km^2. Kenema city is the capital of the district and is the second largest city in Sierra Leone with a population of 255,110 as of 2021.[5] The district is inhabited by different ethnic groups: the majority is Mende, other groups are Temne, Fullah, Limba and Kissi. The Ministry of Health and Sanitation (MoH) is the major health service provider of primary care, covering community health programs and secondary care which includes district and referral hospitals. In 2010, the Government of Sierra Leone adopted the Free Health Care Initiative (FHCI) which aims to ensure that health care for under-fives and maternal care should be free of charge, an initiative that is dependent on external global funding.

Despite massive progress over the past 23 years, in 2020 Sierra Leone still ranked 18th in the list of countries with the highest maternal mortality globally. In 2021, 443 maternal deaths per 100,000 live births and an under-five mortality rate of 104.7 deaths/1000 live births were estimated.[6] For both women and children there are several factors influencing access to healthcare including health-seeking behavior, financial barriers, lack of health staff at primary and secondary level, lack of equipment etc.[7] Many of these were exacerbated by the Ebola outbreak that hit the country in 2014. Lassa fever is a considerable public health problem in the region. In Kenema district, the first outbreak was declared in 1996 and Lassa fever has since been considered as endemic. The Kenema Governmental Hospital (KGH) is the only referral hospital for Lassa fever patients in Sierra Leone and beyond. Following the Ebola outbreak Sierra Leone launched a 5-year health sector recovery plan and although more than five billion dollars were pledged by the international community, donors have failed to deliver. Out of fear of corruption, donors work mainly through implementing partners (UN agencies and NGO's), with only a small amount of funding (allocated for monitoring purposes) going directly to the government. The government of Sierra Leone is currently covering 16% of total health expenditure, the rest is financed by donors (13%), and private household contributions (71%).[8] This model of financing results in a kind of privatization of health service delivery, meaning the state is not the main service provider but an administrator of health service delivery by a mix of public and private providers.

[4] Kenema - Sierra Leone - Area Database - Global Data Lab

[5] Kenema (District, Sierra Leone) - Population Statistics, Charts, Map and Location (citypopulation.de)

[6] WHO, UNICEF, UNFPA, World Bank Group, and UNDESA/Population Division. Trends in Maternal Mortality 2000 to 2020. Geneva, World Health Organization, 2023

[7] Saez, A.M. 2013. Accessibility Strategy for the Health Care System of the District of Koinadugu, Sierra Leone. Ayuntamiento Zaragoza;
MSF OCB 2015. Health Seeking Behavior and Perception on Public Health Facilities in Kenema District.
MSF OCBA 2016. Delivery is a secret: Health seeking behaviour and sexual reproductive health in Koinadugu district, Sierra Leone.

[8] MoHS 2021. SIERRA LEONE RMNCAH STRATEGY 2017 – 2021, Sierra LEONE NATIONAL Reproductive, maternal, newborn, child and adolescent health Strategy 2017 - 2021 (who.int)

Sierra Leone has been suffering from health worker shortages and this has worsened since the Ebola disease outbreak in 2014. The MoH has made significant efforts to rebuild the health sector and strengthen the health workforce. Nevertheless, additional challenges are leading to continued shortages in skilled health care forces. Among them an unequal distribution of human resources skewed to urban areas and partially volunteering health care staff that is not on payroll.[9]

Project History and Strategic Orientation

Under the main objective to reduce under-five and maternal morbidity and mortality in Kenema district, MSF-OCB started operations in 2017/18 by initiating two projects in Gorama Mende and Wandor chiefdoms and in Nongowa chiefdom, supporting three Peripheral Health Care Units (PHU) (Largo, Nebako, Hangha). In 2018, MSF decided to additionally build its stand-alone secondary health care hospital, MSF Mother and Child Hospital (MSF MCH), a 168-bed paediatric and maternity hospital in Hangha village. By the end of 2019 the primary health care activities in Nongowa were merged with the MCH hospital project. The support in Gorama Mende and Wandor chiefdoms was reduced and ended in 2022. The support for the PHU in Hangha has continued partially up to the moment.

The current Kenema project consists of several components centering Maternal and Child Health as well as capacity building. Considering the need to ensure quality of care and the challenges in recruiting health personnel, the project was designed to start-up activities in phases. The ***first phase*** included the establishment of Emergency Room, Intensive Care Unit (ICU), Intensive Therapeutic Feeding Centre (ITFC), Inpatient Paediatric Department (IPD) and ancillary departments (including laboratory, radiology, pharmacy, and others) that were opened in March 2019. In 2020/21, the ***second phase*** kicked off with an increase of capacity in the paediatric IPD, ITFC and ICU departments and the opening of a Lassa Fever Isolation Unit. In April 2021, a ***third phase*** initiated with the roll out of an integrated Community Case Management (iCCM in 43 villages) and the support of 6 PHUs, in partially new chiefdoms, to provide community based medical care and with the objective to ensure continuity and quality of care throughout all health care levels. Activities in up to 90 villages include malnutrition screening and treatment, immunization (EPI), Sexual and Reproductive Healthcare (SRH) services covering ante- and postnatal care (ANC, PNC), safe delivery, Family Planning (FP), care to victims of Sexual and Gender-Based Violence (SGBV) as well as the support of an existing but weak referral system. This phase further included the construction of the maternity department (CEmONC services), that was opened in May 2022. In 2023, Mobile Clinic activities were initiated as part of the community-based component of the project. The community outreach strategy is currently being revised.

Training and capacity building of the staff is one of the central objectives of the project, mainly provided by the MSF Academy. This MSF governed learning entity organizes and implements training for locally hired MSF staff working in various roles and areas of the project. It started with

[9] MSF Kenema Project Document ARO 2024.

scholarships to Ghana for 62 Sierra Leone Health staff, followed by the roll out of several curriculums, the main being the basic clinical nursing care (BCNC) training.

In 2023, Kenema project was budgeted with 6.6 MEUR, and more than 840 people were employed. In the years 2019-2022, MCH has registered monthly between 700-1,000 admission. In 2023, between 90-190 monthly CEmONC admissions were recorded, 635 consultations at mobile clinics and 116 live saving referrals from supported villages. Since 2019, 153 health care workers completed a program of the MSF Academy, and 198 staff are currently enrolled.

The whole project was designed for at least 10 years (2019-2029). With the opening of the maternity services in 2022 onwards, the project should not increase its activities but focus on consolidation and stability through continuous capacity building of the staff, strengthening of the management team and maintaining quality of care. The interventions stand out from most other projects in its size, high technical and medical ambitions, the complexity of the project's context and setup and its historical evolution that included several strategic redirections and managerial adaptations. A long-term defined exit strategy of handing over the structure is planned either partly or completely, to the MoH by 2027-2028. This requires a close, continuous, and complementary partnership with MoH, and particularly with the Kenema Government Hospital (KGH). MSF has a Service Level Agreement (SLA) on national level. In 2023, a Memorandum of Understanding (MoU) was agreed on district level to ensure a clear framework of partnership.

Embedded in the exit plans and based on MSF budget constraints, it has been decided in late 2023 to integrate CEmONC services from MCH hospital into MoH structures (KGH), while other services and components of the project will continue. This integration process is currently being designed and aims at a scale up of support of CEmONC services in MoH structures, including IPC, logistic rehabilitation, medical supply, referral system, human resources, and capacity building. A detailed plan of the integration process is developed in joint discussions with the MoH, the District Health Management Team (DHMT) of Kenema and the Direction of KGH, to ensure visions are aligned and sustainable.

PURPOSE AND INTENDED USE

PURPOSE. This mid-term evaluation aims at assessing the success of the Kenema project so far in reaching its set objectives. It should provide a description of the evolution of the project, identify lessons learned and provide recommendations for potential adaptations and/or reorientations of the project's components.

INTENDED USE. The evaluation findings as well as the evaluation process will be useful primarily for MSF-OCB management in Sierra Leone to inform upcoming operational decisions and the general direction of the project. It will additionally feed into the upcoming design process of the exit phase of the project. The results may also be used more broadly within MSF-OCB as a learning opportunity and to inform projects in other similar complex contexts.

EVALUATION QUESTIONS

1. ***To what extent is the project relevant in the operational context?***
   a. To what extent is the project responding to the needs of the targeted populations?
   b. Has the project been in accordance with the priorities of MSF-OCB?
   c. How does the project align with the priorities of the relevant local authorities?

2. ***To what extent was the project implemented appropriately to its operational setting?***
   a. Was the organizational, strategic set up (fe. human resources, functional/hierarchical matrix, project components) and the deployed resources flexible enough to respond to changes in the project?
   b. To what extent were limitations and barriers of access to health services known and appropriately considered in the design and/or at a later stage of the project?
   c. Which opportunities can increase the project's appropriateness?

3. ***To what extent has the project been effective in reaching its objective?***
   a. What are the set objectives and expected results in the historical evolution of the project?
   b. What are enablers and barriers (expected or unexpected) that were influencing the achievement of the set objectives?
   c. What opportunities can be identified to make the project more effective?

4. ***To what extent was the project efficient in reaching the set objectives?***
   a. What kind of resources have been invested to achieve the results assessed?
   b. Were resources used timely and efficiently in the context of changes in the project?
   c. How could resources have been used more economically and timelier to achieve results?

5. ***To what extent does the project influence larger contributions (impact)?***
   a. What do target beneficiaries and stakeholders perceive as wider contributions of the project?
   b. Which unintended consequences (positive or negative) can be identified?

6. ***To what extent is the project coherent with its operational context?***
   a. Which kind of external and internal interlinkages have been established?
   b. To what extent was internal coherence maintained?
   c. Which barriers hindered the establishment and/or maintenance of external interlinkages, especially with the MoH?
   d. How can internal and external coherence be improved?

The six main questions should be in the center while conducting the evaluation. MSF is open to consider adaptations to the secondary questions in case the evaluator(s) discover the need for it in the inception phase.

EXPECTED DELIVERABLES

1. **Inception Report**

   Based on conducting initial document review and preliminary interviews, the inception report should include a detailed evaluation proposal, including methodology and analysis.

2. **Draft Evaluation Report**

   The report should answer the evaluation questions addressing the set objectives and intended use of the evaluation. It should include analysis, findings, and conclusions and, where applicable, lessons learned and recommendations.

3. **Working Session(s)**

   As part of the analysis and report writing process, the evaluator(s) will present (preliminary) findings, collect attendances´ feedback and validation and will facilitate discussion on lessons learned with the commissioner and consultation group members.

4. **Final Evaluation Report**

   The final report should consider comments and feedback received during the working session. An additional short version of the final report can be requested.

5. **Dissemination**

   To be defined in a separate dissemination plan, can include presentations, learning sessions, meaning-making exercises, or other communication materials with partners, or other affected stakeholders (communities, patients, or others).

We expect the evaluator(s) to be flexible in considering additional deliveries that might be necessary to successfully proceed in the evaluation process. Each deliverable is reviewed by the SEU and approved by the Evaluation Commissioner.

TOOLS AND METHODOLOGY PROPOSED

In addition to the initial evaluation proposal submitted as part of the application, a detailed evaluation protocol will be prepared by the reviewers during the initial phase, following access to the documentation and initial discussions with the evaluation consultation group. The initial report will include a detailed explanation of the proposed methods and their rationale based on validated theories. It will be reviewed and validated as part of the creation phase in coordination with the SEU. Valid and robust participatory approaches that can increase the process learning outcomes are welcomed by the SEU.

RECOMMENDED SOURCES FOR SECONDARY DATA

- Routinely collected medical data (raw and aggregated from MSF, MoH).
- MSF and OCB strategic and project documents (project proposals, logical frameworks, annual reports, project visit and end-of-mission reports, evaluation reports etc).
- National, regional, and global strategies, documentation, and guidelines.
- External literature, research, and documentation.

PRACTICAL IMPLEMENTATION

Number of evaluators	TBD
Timing of the evaluation	May – November 2024
Dates for the data collection at project level	It will take place after the approval of the inception report, exact date TBD

The SEU engages a Consultation Group (CG) in this evaluation process with the goal of increasing understanding, buy-in, process learning, and the quality and utility of the evaluation. The CG is headed by a commissioner and contributed to the finalization of this ToR.

PROFILE/REQUIREMENTS

Requirements:

- Degree or formal education in Evaluation (-logic, -methodology, -approaches), or similarly strong knowledge
- University level degree in public health, health service management, or related areas
- Expertise in project and/or service management in a medical area of the Kenema project (specifically Maternal and Child Health or pediatrics)
- Fluency in English (spoken and written)
- Experience in conceptualizing complexity in humanitarian aid projects
- Expertise in multifaceted project or program evaluation
- High communication and interpersonal skills
- Experience in engaging stakeholders with diverse interests

Assets:

- Experience and/or deep level understanding of MSF organizational structures
- Professional experience in the Western Africa region, specifically Sierra Leone
- Expertise in Health System Programming
- Medical expertise/competences related to the project's focus
- Experience in participatory approaches
- Knowledge of local languages (ie. Mende, Krio)

APPLICATION PROCESS

The application should consist of a technical proposal (including evaluation approach, methodology, and analysis), a budget proposal, CV(s), and a previous work sample. The proposal should include reflections on how adherence to ethical standards for evaluations will be considered throughout the evaluation. In addition, the evaluator/s should consider and address the complexity and sensitivity of the project at hand in the methodology as well as be reflected in the team set-up. Offers should include a separate quotation for the complete services, stated in Euros (EUR). The budget should present a consultancy fee according to the number of expected working days over the entire period,

both in totality and as a daily fee. Travel costs, if any, do not need to be included as the SEU will arrange and cover these. Do note that MSF does *not* pay any per diem.

Applications will be evaluated based on whether the submitted proposal captures an understanding of the main deliverables as per this ToR, a methodology relevant to achieving the results foreseen, and the overall capacity of the evaluator(s) to carry out the work (i.e. inclusion of proposed evaluators' CVs, reference to previous work, certification et cetera).

Interested teams or individuals should apply to **evaluations@stockholm.msf.org** marked "**KENEM2"** no later than by **2359hrs CEST on May 2nd, 2024**. We would like the documents being submitted as separate attachments (in particular the budget separate from the other). Please include your contact details in your CVs and indicate in your email application on which platform you saw this vacancy.

MSF is committed to applying responsible data protection principles in all its activities, including assessments, respecting both humanitarian principles and the European GDPR. During the assessment process, you will potentially have access, collection, storage, analysis, and possibly disposal of MSF's and its patients' sensitive and personal data and information (SPDI). Please take particular note of the SEU's ethical guidelines when preparing your proposal, taking into account the tools and solutions you will use, how you will work to mitigate any data incidents, and how you will dispose of the data collected once the evaluation is complete.

ANNEX IV: QUALITATIVE DATA COLLECTION TOOLS

ANNEX IV – A - TOPIC GUIDE FOR MSF PROJECT STAFF IN KENEMA

Understanding and mapping the MSF-MCH project in Kenema and developing a comprehensive evidence-informed recommendations for the continuation, transitioning and sustainability of project activities.

MSF Project Staff are anyone who works for MSF in Kenema- and is working on the Kenema Project (or at the MSF-academy)

Introduction

Welcome and thank you for joining this interview. I'm [XXX], a consultant supporting MSF to evaluate its project in Kenema, mapping project activities through identifying and understanding challenges or bottlenecks as well as enablers or facilitators of the project; and then use that understanding to develop evidence-informed recommendations for the continuation, transitioning and sustainability of such a project in Kenema. The project is currently mapping its way forward, such that the findings from this evaluation will contribute to shaping the upcoming four years, as well as potential handover and/or transition strategy for when MSF departs.

We understand that you have been a part of the Kenema project in one form or another and your role support and/or engages with the project. In this regard, we'd like to interview you to hear about and understand your experiences regarding the Kenema project. It is voluntarily and confidential to participate. You do not have to respond to a question if you do not want to- we can skip it. You can withdraw your permission to participate at any time, including after the interview and we will erase and destroy any information we have from you. I will be recording this interview so that I can listen again later and make notes. Is this acceptable and are you happy for us to proceed?

General Questions

1. Can you start by telling me about your background: your current role and responsibilities within MSF's MCH project or MSF activities here in Kenema?
   Probes
   - In what ways does your role contribute to MSF's MCH project activities and their implementation- and do you think the role is effective in advancing project outcomes?
   - What are some of the challenges you face in doing your role?
   - What are some of the enablers or strategies that you utilise to be able to do your job well?
   - How do you think your role or position could be made more effective to achieve project outcomes and impact?
2. From your understanding and knowledge, can you describe the Kenema Project activities, and intended outcomes or impact?

Probe: How have these evolved over time, from project inception to status?
Probe: Can you tell me about the MCH components, the outreach and community work components, the Human Resources and capacity-strengthening components, the advocacy components of the project?

Implementing the Kenema Project, within context

3. Thinking about your experiences working in the Kenema project, can you reflect on what has worked and what has not worked with regards to project activities?
   Probe:
   - What aspects of this project do you consider to be the most critical or important?
   - What do you think are this project's contributions to MCH in Kenema, as well as in Sierra Leone more broadly?
   - Are there any challenges that you or the project face in implementing its activities and supporting the intended beneficiaries?
   - Are there any MCH services that are not offered within the project? If so, where and how do pregnant women access said services?
   - Can you tell me how the different project components/ activities feed into each other to achieve overall impact?
   - How does the decision-making system for which project activities will be implemented and when- work, within MSF more broadly and within the Kenema project itself?
   - Where, and how do you refer or link project beneficiaries for other services or interventions beyond what your organisation offers?

Project activities

Some of the questions may not be relevant to your role. Please pass on any questions that you do not feel comfortable responding to.

4. The MSF-MCH hospital has a lot of SOPs, guidelines and checklists that are meant to assist staff in providing adequate and quality services to clients. How do you find these documents to be acceptable and useful in easing your job?
5. The project also has an SRH strategy that guides and anchors operation in Kenema. Can you tell me about what you know about the SRH strategy and how it is being operationalised?
   Probe:
   - How do you find the strategy to be useful in improving maternal and child health outcomes?
     a. How does the project provide SRH, family planning, and/or SGBV services? Is this working in meeting the SRH needs of the Kenema community?
6. Can you tell me about the role and contribution of the MSF academy to the other project activities, and in Kenema more broadly?
   a. Do you think the academy is effective, when considering other educational, capacity-building or tertiary institutions in SL or Kenema?
   b. How do staff access MSF academy opportunities?
   c. Do you think staff members who have engaged with the academy are skilled or equipped to provide services in the project?

   d. Do you think there are areas of improvement or alternatively areas that you think should be kept/expanded (are working) from the MSF academy to the other MSF Kenema Project activities?

7. One of the planned activities is to integrate MSF SRH activities into the Ministry of Health's Kenema General Hospital maternal facility. How has this integration been going?

   Probe:

   - What are you learning about the processes of integrating MSF activities into the government systems?
   - What have been the challenges and/or enablers of doing this integration exercise?

8. The outreach activity support 6 out of a possible 136 PHUs, can you tell me about how the 6 PHUs were selected to be part of the project?
   a. What are some of the benefits as well as challenges of operating with these PHUs? What do you think are some of the lessons learned from doing outreach activities to these PHUs, that can be scaled or transferred to other PHUs or even to other districts?
9. As part of child health, and supporting the PHUs, the project uses iCCM- can you tell me about how iCCM works in the project and which services it supports?
   a. How do you see/find ICCM activities- are they effective in meeting maternal and child health needs in the community?

Collaborations for Continuity

10. Can you tell me about other stakeholders (organisations and/or sectors and/or government) that are supporting MCH within Kenema or work with MSF's Kenema project to?

    Probes

    - What role do these stakeholders play in improving maternal and child mortality and morbidity? What MCH services do they provide for people in Kenema?
    - Could you tell me how the work of these stakeholders intersects, is linked and/or has synergies with MSF's Kenema Project? Can you tell me about any relationship that MSF has with these other stakeholders?
      - Are some of the beneficiaries of MSF's project, also getting services or support from these organisations?
      - What are some of the enablers or facilitators of these relationships? What are some of the challenges?
      - How can these linkages be utilised to increase the efficiency or effectiveness of MSF's Kenema activities?

Sustainability

11. Can you reflect on the notion of the MSF-Kenema project ending in 2029. What do you think about the project ending after ten years of operations?

    Probes

    - Do you think the project has achieved its intended outcomes and impact so far? Why or why not?

- How can the project best prepare for its eventual ending? Which stakeholders or entities need to be involved and why?
- How do you think MSF should transition out of Kenema, if at all?
- What are some of the enablers or strategies that you think could be utilised for continuity of the project, beyond MSF?
- What are some of the anticipated challenges of this transition, and how do you think they can be mitigated for?

12. Based on the work that you do? What does an ideal MCH service in Kenema look like?

    Probe: How do you think such a service can contribute to better maternal and child outcomes in Kenema?

13. Lastly, taking a more macro-level viewpoint? Do you think there are any national laws, policies or guidelines that enable or hinder quality MCH in Kenema and/or Sierra Leone?

    Probes

    - What laws, polices, guidelines are there that support (or hinder) access to and uptake of MCH services or interventions that might improve outcomes?
    - What national coordination, training and/or facilitation mechanisms exist that enable or support access to MCH services and how has MSF utilised these national mechanisms?

14. We are at the end of the interview now, do you have anything else that you would like to add at this point of the interview

Thank you for the time you have taken to participate in this interview

ANNEX IV – B - TOPIC GUIDE: KEY INFORMANT INTERVIEWS

Understanding and mapping the MSF-MCH project in Kenema and developing a comprehensive evidence-informed recommendations for the continuation, transitioning and sustainability of project activities.

Key Informants are participants who are at the MSF HQ, the HoM, Kenema Government officials like the District Medical Officer or Superintendant etc.

Introduction

Welcome and thank you for joining this interview. I'm [XXX], a consultant supporting MSF to evaluate its project in Kenema, mapping project activities through identifying and understanding challenges or bottlenecks as well as enablers or facilitators of the project; and then use that understanding to develop evidence-informed recommendations for the continuation, transitioning and sustainability of such a project in Kenema. The project has a is mapping its way forward, such that the findings from this evaluation will contribute to shaping the upcoming four years, as well as potential handover and/or transition strategy for when MSF departs.

We understand that you have been a part of the Kenema project in one form or another and your role support and/or engages with the project. In this regard, we'd like to interview you to hear about and understand your experiences regarding the Kenema project. It is voluntarily and confidential to participate. You do not have to respond to a question if you do not want to- we can skip it. You can withdraw your permission to participate at any time, including after the interview and we will erase and destroy any information we have from you. I will be recording this interview so that I can listen again later and make notes. Is this acceptable and are you happy for us to proceed?

General Questions

1. Can you start by telling me about your background: your current role and responsibilities either within MSF, within the Kenema project, or in your organisation more specifically?
   Probe: In what ways does your role contribute to the Kenema project - and do you think the role is effective in advancing project outcomes?
2. From your understanding and knowledge, can you describe the Kenema Project activities, and intended outcomes or impact?
   Probe: How have these evolved over time, from project inception to status?
   Probe: What shaped the decision to have the MSF-Maternity in Kenema?
   Probe: Can you tell me about the MCH components, the outreach and community work components, the Human Resources and capacity-strenghthening components, the advocacy components of the Kenema Project?

Implementing the Kenema Project, within context

3. Thinking about your experiences working in the Kenema project or interacting with the Kenema Project, can you reflect on what has worked and what has not worked with regards to project activities?

   Probe:

   - What aspects of this project do you consider to be the most critical or important?
   - What do you think are this project's contributions to MCH (or other outcomes) in Kenema, as well as in Sierra Leone more broadly?
   - What are some of the challenges that you or the project face in implementing its activities and supporting the intended beneficiaries?
   - Are there any MCH services that are not offered within the project? If so, where and how do pregnant women access said services?
   - Can you tell me how the different project components/ activities feed into each other to achieve overall impact?
   - Can you tell me about the role and contribution of the MSF academy to the other project activities, and in Kenema more broadly?
     - Do you think the academy is effective, when considering other educational, capacity-building or tertiary institutions in SL or Kenema?
   - How does the decision-making system for which project activities will be implemented and when- work, within MSF more broadly and within the Kenema project itself?
   - Where, and how do you refer or link project beneficiaries for other services or interventions beyond what your organisation offers?

4. Can you tell me about other stakeholders (organisations and/or sectors and/or government) that are supporting MCH within Kenema or that engage with MSF to implement activities?

   Probes

   - What role do these stakeholders play in improving maternal mortality and morbidity? What MCH services do they provide for people in Kenema?
   - Could you tell me how the work of these stakeholders intersects, is linked and/or has synergies with MSF's Kenema Project? Can you tell me about any relationship that MSF has with these other stakeholders?
     - Are some of the beneficiaries of MSF's project, also getting services or support from these organisations?
     - What are some of the enablers or facilitators of these relationships? What are some of the challenges?

5. Can you reflect on the notion of the MSF-Kenema project coming to an end in five years (2029). What do you think about the project ending after ten years of operations?

   Probes

   - Do you think the project has achieved its intended outcomes and impact so far? Why or why not?
   - How can the project best prepare for its eventual ending? Which stakeholders or entities need to be involved and why?
   - How do you think MSF should transition out of Kenema, if at all?

- What are some of the enablers or strategies that you think could be utilised for continuity of the project, beyond MSF?
- What are some of the anticipated challenges of this transition, and how do you think they can be mitigated for?

6. Based on the work that you do? What does an ideal MCH service in Kenema look like?
   Probe: How do you think such a service can contribute to better maternal and child outcomes in Kenema?
7. Lastly, taking a more macro-level viewpoint? Do you think there are any national laws, policies or guidelines that enable or hinder quality MCH in Kenema and/or Sierra Leone?

   Probes

   - What laws, polices, guidelines are there that support (or hinder) access to and uptake of MCH services or interventions that might improve outcomes?
   - What national coordination, training and/or facilitation mechanisms exist that enable or support access to MCH services and how has MSF utilised these national mechanisms?
8. We are at the end of the interview now, do you have anything else that you would like to add at this point of the interview?

Thank you for the time you have taken to participate in this interview

ANNEX IV – C - PARENTAL/GUARDIAN CONSENT AND ASSENT FORM

Contact Team: MSF Kenema Project

What you should know about this project:

- We give you this consent form so that you may read about the purpose, risks, and benefits of this evaluation project.
- We cannot promise that this project will benefit your child. The main goal here is to gain knowledge that may improve maternity and child health services and information in Kenema.
- You have the right to refuse to allow your child to take part or agree for your child to take part now and change your mind later.
- Whatever you decide will not affect your child's care.
- Please review this consent form carefully. Ask any questions before you decide.
- Your choice to allow your child to participate is voluntary.

PURPOSE:

We are conducting a project to help us improve and/or shape MSF's activities or interventions in Kenema. We have found that MSF has been operating in Kenema for over five years now, and the project has been changing over time. We believe that young people who have benefitted from, been supported by or engaged with these activities, can help us understand how this project should work to serve others like them. Your child was selected as a possible participant in this project because she/he is aged between 10-15 years and has potentially engaged with MSF activities. We are asking for consent for your child to participate in this project.

PROCEDURES AND DURATION:

If you allow your child to participate in this project, a member of the recruitment team will explain the project to you and your child, and you may choose whether to allow your child to participate in this evaluation study. If you and your child agree, we will ask some questions about your child's age, gender, and where they stay. Your child will then be asked some questions about what they think and know about MSF's work in Kenema, including any services or activities that they have accessed through MSF. They will also be asked about where they have gotten support, which programs or health services they have visited and/or the kind of support they would desire- specifically MCH support. These questions will be asked either in a group setting or a one-on-one interview with a trained member of the project team. This will happen at a venue that is convenient to them; and will take approximately 30-45mins.

We may also ask you (as the guardian) to participate in a brief interview on your thoughts and experience of MSF's interventions; as well as what you think are the MCH programs or interventions that your communities or you, would want to see provided. You have the right to decline to participate in this interview, even if you agree for your child to participate. All the information you share will not have your name or personal information and will remain confidential to the evaluation team.

RISKS AND DISCOMFORTS:

Talking to your child about their experiences and thoughts about programs, activities or interventions related to MCH and SRH should not pose any risks to your child. Nevertheless, some questions may cause anxiety, and the trained project team member who will be interviewing the child will thoroughly explain the project's aims and objections and inform your child, they are allowed to not answer any questions that may make them anxious or uncomfortable.

BENEFITS AND/OR COMPENSATION:

Taking part in this project will not cost you anything. We cannot and do not guarantee or promise that your child will receive any benefits from taking part. Your child and other children could benefit in the future from the findings of this evaluation. A small snack will be provided at the end of each interview.

CONFIDENTIALITY:

If you indicate your willingness for your child to participate in this project by signing this document, all information obtained will be for project purposes only, and will be held securely and stored on paper and password protected computer files. No one outside of the project team will have access to any of the information that you give us.

VOLUNTARY PARTICIPATION:

Participation in this project is voluntary. If you decide not to allow your child to participate in this study, your decision will not affect you or your child's future relations with the staff and service in any activities from MSF. If you decide to allow your child to participate, you and your child are free to withdraw your consent and assent and discontinue participation at any time without penalty.

OFFER TO ANSWER QUESTION

Before you sign this form, please ask any questions on any aspect of this evaluation that is unclear to you. You may take as much time as necessary to think it over.

AUTHORIZATION

YOU ARE MAKING A DECISION WHETHER OR NOT TO ALLOW YOUR CHILD TO PARTICIPATE IN THIS PROJECT. YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTOOD THE INFORMATION PROVIDED ABOVE, HAVE HAD ALL YOUR QUESTIONS ANSWERED, AND HAVE DECIDED TO ALLOW YOUR CHILD TO PARTICIPATE.

- I have read the information sheet concerning this evaluation [or have understood the verbal explanation] and I understand what will be required of my child and what will happen to him/her if he/she takes part in it.
- I understand that my child will be asked questions about their thoughts or experiences on MCH services or activities provided by MSF in Kenema
- I understand my child may withdraw from this study at any time without giving a reason and without affecting his/her normal care and support.

I agree that my child may take part in this project. YES/ NO

I (the guardian) agree to take part in a discussion about MCH programs or activities in my community YES/ NO

Consent from parent/guardian/legally authorized representative:

Name of Guardian (Print) _____ Date _____

Signature _____

Relationship to Participant _____

Participant Assent (Children 10-15 years only):

My participation in this project is voluntary. I have read [or been explained] and understood the information. All my questions have been answered and I agree to take part in this project.

Name of Participant (Print) _____. Date_____

Signature of Participant _____

Name of Project Staff_____

Signature of Evaluation Staff _____. Date_____

If participant gave verbal assent, enter name of the person who witnessed the assent, and signature.

Witness Name: _____ Witness Signature: _____

YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM TO KEEP

If you have any or more questions concerning this project or consent form, including questions about the research, your rights as a research subject or research-related injuries; or if you feel that you have been treated unfairly and would like to talk to someone other than a member of the project team, please feel free to contact the MSF Kenema Project Team.

ANNEX IV – D - GROUP DISCUSSION GUIDE: PROJECT BENEFICIARIES

Understanding and mapping the MSF-MCH project in Kenema and developing a comprehensive evidence-informed recommendations for the continuation, transitioning and sustainability of project activities.

Project beneficiaries refer to community members who are in communities were MSF project activities are happening. These community members may be directly engaging with MSF activities, or they may not be.

Introduction

Welcome and thank you for joining this interview. I'm [XXX], a consultant supporting MSF to evaluate its project in Kenema, mapping project activities through identifying and understanding challenges or bottlenecks as well as enablers or facilitators of the project; and then use that understanding to develop evidence-informed recommendations for the continuation, transitioning and sustainability of such a project in Kenema. The project is currently mapping its way forward, such that the findings from this evaluation will contribute to shaping the upcoming four years, as well as potential handover and/or transition strategy for when MSF departs.

We understand that you have interacted with or engaged with MSF's project activities here in Kenema in one form or another as a beneficiary of its maternity and or outreach services. In this regard, we'd like to speak with you to hear about and understand your experiences regarding the Kenema project. It is voluntarily and confidential to participate. You do not have to respond to a question if you do not want to- we can skip it. You can withdraw your permission to participate at any time, including after the interview and we will erase and destroy any information we have from you. I will be recording this interview so that I can listen again later and make notes. Is this acceptable and are you happy for us to proceed?

Introduction

Everyone please introduce yourself by any name that you want us to refer to you as during this discussion; and then tell us one thing you are currently excited about?

General questions

1. Can anyone of you tell me about any MSF project activity or service or intervention that you have been a part of or that you know about?
    a. Can you tell me what you think have been the most important parts of MSF's work in Kenema?
    b. What do you like about MSF's work in Kenema? Can you give examples of what you like?
    c. What do you not like about MSF's work in Kenema?
2. In your own words, can you describe what activities or programs that MSF does in Kenema?
    a. How do you find the programs/activities to be relevant and/or acceptable?
    b. How do you think MSF could improve on any of the activities that they are implementing in Kenema?

c. In what ways does MSF work with or collaborate with other organisations or stakeholders (like MoH) in Kenema?

For those who have accessed MSF-Maternity or MSF-MCH services

3. Can you tell me about your experiences accessing MSF-MCH hospital services?

Probes

- Can you describe how you came about utilising MSF-maternity services?
    - Can you tell me about the process you had from other hospitals or clinics to MSF-Maternity or vice versa?
- What services did you receive at the hospital, and did you find them to be adequate and acceptable?
- What do you think is working, and what is not working about the services that are provided at MSF-Maternity?
- What other services do you think should be provided at the Maternity hospital, and why do you think this?
    - What do you like about this organisation's services/activities? What don't you like?
    - Where else do people in your community fo to access services?
- If you were referred for other services or from other services, what are some of the enablers or strategies that worked in this referral pathway.
- What are some of the challenges that you faced accessing and utilising MSF-MCH services? How are these challenges different or the same to other health facilities?
- Are there services that you have felt you needed or wanted but there was no way for you to access or get these services? If so, can you tell me about them?

4. Thinking back on your experiences and everything we have shared so far, what would an ideal Maternal and Child Health service look like for you and your community?

   Probes: How do you think such a service can contribute to better maternal and child outcomes in Kenema?

   Probe: How do you think MSF can contribute to achieving such a service?

5. We are at the end of the interview now, do you have anything else that you would like to add at this point of the interview

Thank you for the time you have taken to participate in this discussion.

ANNEX IV – E - DEMOGRAPHIC INFORMATION SHEET

Date	Interview/ FGD #	Participant Initials	Organization/ Village/	Position at Organization/in Community	Age	Sex	Type of Interview (KII/Project staff/ Government Staff/ Project Staff/ another stakeholder)

ANNEX IV – F - TOPIC GUIDE: OTHER STAKEHOLDERS (KENEMA GOVERNMENT/CBOS/NGOS)

Understanding and mapping the MSF-MCH project in Kenema and developing a comprehensive evidence-informed recommendations for the continuation, transitioning and sustainability of project activities.

Other stakeholders as participants included staff from KGH, Hangha CHC, the PHUs, other NGOs and CBOs

Introduction

Welcome and thank you for joining this interview. I'm [XXX], a consultant supporting MSF to evaluate its project in Kenema, mapping project activities through identifying and understanding challenges or bottlenecks as well as enablers or facilitators of the project; and then use that understanding to develop evidence-informed recommendations for the continuation, transitioning and sustainability of such a project in Kenema. The project is currently mapping its way forward, such that the findings from this evaluation will contribute to shaping the upcoming four years, as well as potential handover and/or transition strategy for when MSF departs.

We understand that you have interacted with MSF's Kenema project in one form or another and your role support and/or engages with the project. In this regard, we'd like to interview you to hear about and understand your experiences regarding the Kenema project. I will be recording this interview so that I can listen again later and make notes. Is this acceptable and are you happy for us to proceed?

General Questions

1. Can you start by telling me about your background: your current role and responsibilities within your organisation (government/NGO/CBO/other stakeholders) here in Kenema?
   Probes
   - In what ways does your role contribute to or engage with MSF's project in Kenema?
   - What are some of the challenges you face when it comes to your role and its interactions with MSF activities?
   - What are some of the enablers or strategies that you utilise to be able to do your job well?

The MSF Kenema Project

2. From your understanding and knowledge, can you describe the MSF Kenema Project activities, and intended outcomes or impact?
   Probe:
   - What do you think about MSF-MCH being operationalised in Kenema?
   - How have the project activities evolved over time, from project inception to its current status?
   - How do you think the activities are addressing maternal and child health challenges in the district? Do you think these activities are effective or working? What can be improved?

- How do you think you or your organisation or your clinic benefitted from the MSF activities?
- What are the differences between MSF-MCH services and the maternity services from KGH or from other the maternal and child health clinics/health units/health posts?
- How do the Kenema project activities collaborate with other services like your organisation, or other government clinics, for example with government health facilities or with Kenema general hospital?
    - What are the challenges with the current set up of engagement or collaboration?
    - What are some of the opportunities?
    - How can this working relationship be improved to support both healthcare staff, as well as the women who need to deliver; and neonatal and child health outcomes?

Continuity and Sustainability

3. MSF has been operating the Kenema Project since 2018. How do you think such a project should be continued in Kenema, and/or scaled to other parts of Sierra Leone?
4. How you think such a project, as it is currently operating can be taken over and sustained by the government and/or other partners?
5. We are at the end of the interview now, do you have anything else that you would like to add at this point of the interview

Thank you for the time you have taken to participate in this interview