STOCKHOLM EVALUATION UNIT

MEDECINS SANS FRONTIERES LÄKARE UTAN GRÄNSER

EVALUATION OF

MSF'S DECENTRALIZATION INITIATIVE IN BANGUI, CENTRAL AFRICAN REPUBLIC

IMPROVING THE AVAILABILITY AND ACCESSIBILITY OF SRH AND HIV SERVICES

JULY 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 adhere to the SEU Ethical Guidelines for Evaluations.

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TABLE OF CONTENTS

LIST OF ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BEmOC	Basic Emergency Obstetric and Neonatal Care
CAR	Central African Republic
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CHWs	Community health workers
CRHC	Cambridge Reproductive Health Consultants
CHUC	Centre Hospitalier Universitaire Communautaire
DRC	Democratic Republic of the Congo
ERB	Ethics Review Board
IDI	In-depth interview
PICT	Provider-Initiated Counselling and Testing
HIV	Human Immunodeficiency Virus
KII	Key informant interview
LTFU	Lost to follow-up
MoH	Ministry of Health
MSF	Médecins Sans Frontières
MSF-OCB	Médecins Sans Frontières- Operational Centre Brussels
NGO	Non-governmental organization
OECD	Organization for Economic Co-operation and Development
OI	Opportunistic infections
PLWHA	People living with HIV/AIDS
SDGs	Sustainable Development Goals
SEU	Stokholm Evaluation Unit
SOPs	Standard operating procedures
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TB	Tuberculosis
ToR	Terms of reference
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS
UN	United Nations
WASH	Water, sanitation, and hygiene
WHO	World Health Organization

LIST OF TABLES

LIST OF FIGURES

EXECUTIVE SUMMARY

INTRODUCTION

This evaluation assessed the decentralization of sexual and reproductive health (SRH) and human immunodeficiency virus (HIV) services implemented under the Project Bangui initiative in Central African Republic from mid-2021 to early 2025. The project aimed to shift service provision closer to communities by strengthening primary health centres and reducing reliance on the central hospital (CHUC). Structured around the Organisation for Economic Co-operation and Development (OECD) evaluation criteria, the assessment explored seven key areas: Relevance, Coherence, Effectiveness, Efficiency, Impact, Sustainability, and Stakeholder Engagement and Ownership. Each criterion was linked to specific evaluation questions outlined in the terms of reference. The report assesses how decentralized SRH and HIV services were implemented, how they were experienced by clients, and the extent to which health outcomes and system integration improved over the implementation period.

METHODS

We used a mixed-methods approach to collect and analyse data. The evaluation included a desk review of reports, quantitative service utilization data which captured trends in maternal health outcomes, neonatal vaccination, HIV testing and treatment, and contraceptive service uptake. The client flow observations (n=150) were also undertaken and followed with exit surveys (n=134), and in-depth interviews (IDIs) with clients (n=12), frontline health workers across two case study sites (n=9), and the broader decentralisation initiative (n=8) in Bangui. The survey and IDIs with clients captured socio-demographic profiles, service satisfaction, perceived accessibility, and experiences with provider interaction while the IDIs with frontline workers explored various aspects of service delivery, including challenges faced by providers, workforce capacity, and strategies for engaging patients. The evaluation also involved key informant interviews (KIIs) with stakeholders from MSF (n=7) and the Ministry of Health (MOH) (n=3) to explore their perspectives on the initiative's relevance, sustainability, and potential for replication.

FINDINGS

The findings were presented by evaluation criteria and respective questions, integrating the qualitative and quantitative findings. In terms of scope, the decentralization initiative supports six selected health facilities and community points of care across Bangui to deliver a targeted package of SRH and HIV interventions. The initiative has proven both contextual relevance and appropriateness by directly addressing critical HIV/AIDS and SRH-related medical needs of the population. Secondary data analysis and the exit survey with the case study sites also indicate that the foundational elements necessary for effective SRH and HIV service delivery were largely in place. However, the initiative has shown mixed coherence with the national public health framework and evolving priorities to address critical HIV and SRH challenges, including maternal and child health in Bangui. On the one hand, it demonstrates intentional strategic alignment with national and international health goals, while on the other hand, its operational choices partially integrate services and rely on fragmented delivery mechanisms, significantly

limiting its overall coherence. In terms of efficiency, the initiative supports the availability of essential maternal and newborn health commodities, diagnosis and treatment of advanced HIV disease, and SRH complications. However, the presence of a parallel reporting system for reporting and supervision compromises efficiency. Furthermore, the findings indicate limited engagement and weak ownership of the initiative by key stakeholders, including the MOH (both in the design and implementation), hence limiting the prospects for sustainability and replicability. Lastly, in terms of outcome, despite improvements in various aspects of maternal healthcare, trends indicate a potential persistent rise in adverse maternal deaths.

RECOMMENDATIONS

To strengthen the implementation of the decentralization initiative, the following recommendations are to be considered:

1) Strengthen the geographic and programmatic responsiveness of the decentralization initiative to improve its relevance.
2) Strengthen retention and monitoring systems to improve HIV care effectiveness within the supported health centres.
3) Enhance quality and timeliness of emergency obstetric care to reduce early maternal deaths.
4) Advocate for the institutionalization of key components of the decentralization initiative to ensure sustainability and enable replication.

INTRODUCTION

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS AND HIV/AIDS CHALLENGES IN THE CENTRAL AFRICAN REPUBLIC

The Central African Republic (CAR) has experienced prolonged armed conflict for over a decade, which has had devastating effects on the health and well-being of its population (OCHA, 2024). While the security situation has become relatively more stable in recent years, the country continues to grapple with the long-term consequences of conflict, including a fragile healthcare system struggling to recover from years of disruption. These deficiencies, compounded by poorer social determinants of health in the country, have adversely affected the delivery of and access to essential healthcare, resulting in poor health outcomes for the population.

Specifically, the country is one of the most affected by the HIV/AIDS pandemic in West and Central Africa, with a prevalence rate of 3.4% in 2023 (UNAIDS, 2024), and Bangui reported the highest rate at 6.2% (UNICEF, 2023). Yet, among the 10,000 individuals who tested positive for HIV in 2024 in the country, 76% were on antiretroviral therapy (ART), and fewer than 30% achieved viral load suppression (UNAIDS, 2024; World Bank, 2024). The situation is even more concerning for children under 15, pregnant women, and their exposed infants. Among those under 15 who were aware of their HIV status in 2024, fewer than 35% were on treatment (UNAIDS, 2024). Similarly, only an estimated 54% of pregnant women who tested positive for HIV received treatment that year (UNAIDS, 2024; World Bank, 2024). Exposed infants face significant challenges due to limited follow-up from birth to 18 months, leading to high HIV seroconversion rates (Songo-Kette et al., 2023). The parent-to-child HIV transmission rate remains alarmingly high at 4%, highlighting the urgent need for strengthened interventions and support to reach the country's commitment to a zero-transmission target by 2030 (UNAIDS, 2024).

On the other hand, the country faces critical challenges in maternal and newborn health. In 2023, the maternal mortality ratio was 835 deaths per 100,000 live births, a notable decline from 1,315 per 100,000 live births in 2000 (République Centrafricaine, Ministère de la Santé et de la Population, 2023). However, this figure remains the second-highest in the world (République Centrafricaine, ministère de la Santé et de la Population, 2024). The neonatal mortality rate in 2023 stood at 28 deaths per 1,000 live births, while the infant mortality rate reached 99 deaths per 1,000 live births, underscoring persistent gaps in healthcare services for mothers and newborns (République Centrafricaine, Ministère de la Santé et de la Population, 2023).

Furthermore, in 2023, the use of modern contraceptives among women of reproductive age (15 to 49 years) remained lower at 14.4% in CAR (MICS 2018-2019) than the regional average of 34%, limiting progress in maternal health and family planning goals in the country (UNFPA, 2024). Similarly, the unmet need for contraception was high at 27%, indicating that nearly one-third of women who wish to avoid pregnancy lack access to contraceptive methods (UNICEF, 2019). Rural women and displaced populations face even greater barriers due to service disruptions, pervasive cultural norms, and financial constraints

(Doctors Without Borders, 2023). Meanwhile, provider bias, stockouts of contraceptive supplies, and pervasive gender norms continue to hinder access (Lerch, 2024).

NATIONAL EFFORTS TO COMBAT THE HIV EPIDEMIC AND ADDRESS MATERNAL AND CHILD HEALTH CHALLENGES: PRIORITIES AND IMPLEMENTATION BARRIERS

To address the HIV epidemic and key maternal and child health challenges, the CAR has implemented several policies and strategic frameworks aimed at strengthening maternal and child health and the HIV/AIDS response and related health outcomes. The country has endorsed the UNAIDS 95-95-95 goals for HIV/AIDS elimination, which aim to ensure that 95% of people living with HIV know their status, 95% of those diagnosed receive sustained ART, and 95% of those on treatment achieve viral suppression (Centre National de Lutte contre le VIH-SIDA [CNLS], 2023). The National Strategic Plan for HIV/AIDS Response prioritizes prevention, early diagnosis, and comprehensive care, with a particular focus on eliminating parent-to-child transmission (Central African Republic Ministry of Health, 2022). Additionally, the new HIV law enacted in 2022 includes provisions to eliminate the requirement for parental consent for adolescents to access HIV testing, reducing the consenting age from 18 to 12 years (Central African Republic, 2022).

Regarding pressing maternal and infant challenges, the CAR government has enacted policies and commitments to reduce maternal and child mortality. The country has endorsed the Sustainable Development Goals (SDGs), particularly Goal 3.1, which includes targets to reduce maternal mortality to less than 70 deaths per 100,000 live births and neonatal mortality to below 12 deaths per 1,000 live births by 2030 (UNICEF, 2023). Additionally, CAR has adopted universal health coverage (UHC) principles to enhance access to essential health services, particularly for marginalized populations. The UHC principles, outlined in the "Dossier d'Investissement 2024-2026" framework, emphasize equitable access to quality healthcare, financial protection, and comprehensive services for mothers, under-fives, and adolescents (Dossier d'Investissement pour la SRMNIA-N 2024-2026).

Despite these policy commitments, several structural and systemic barriers continue to hinder the effective implementation of maternal and child health services and the HIV response framework in the CAR. Chronic underfunding of the healthcare system restricts the expansion and quality of maternal and child healthcare, leading to gaps in essential services such as prenatal care, skilled birth attendance, and postnatal follow-up (WHO, 2020). Political instability and economic hardship have exacerbated the shortage of trained healthcare professionals, particularly midwives and obstetricians, resulting in limited access to emergency obstetric and newborn care (UNFPA, 2021).

Inadequate healthcare infrastructure and frequent stockouts of critical supplies, including oxytocin, magnesium sulfate, and neonatal resuscitation equipment, compromise the ability of facilities to effectively manage obstetric emergencies and newborn complications (Médecins Sans Frontières [MSF], 2020). Many maternity wards and rural health centres operate under substandard conditions, lacking essential water, sanitation, and hygiene (WASH) amenities necessary for safe deliveries (UNICEF, 2019).

Geographic and financial barriers further limit access to maternal and newborn care, particularly for women in remote and conflict-affected areas. Despite being officially free countrywide, maternal healthcare services often involve indirect costs—including under-the-table payments, transportation expenses, and lost income due to time off work. These indirect costs create significant financial and logistical barriers that discourage many women from accessing antenatal, delivery, and postnatal care, thereby increasing the risk of maternal and neonatal complications (World Bank, 2020). Additionally, individual factors contributing to the three delays—delays in recognizing danger signs and deciding to seek care, delays in reaching a health facility, and delays in receiving appropriate care upon arrival—exacerbate these challenges (Thaddeus & Maine, 1994). The population's overreliance on traditional birth attendants further hinders timely access to life-saving interventions (WHO, 2021).

Similarly, several structural, community, and individual barriers continue to hinder progress in combating HIV/AIDS. Limited healthcare infrastructure, shortages of trained personnel, and inconsistent availability of HIV lab commodities and drugs impede access to timely diagnosis and treatment (UNAIDS, 2021). Stigma and discrimination against people living with HIV (PLVIH) discourage individuals from seeking prompt testing and care, while traditional beliefs and misconceptions about HIV transmission reinforce treatment hesitancy (WHO, 2020). Financial constraints, fear of disclosure, and low health literacy prevent many from taking preventive measures and adhering to treatment (Pulerwitz et al., 2019).

Given the urgent need for enhanced sexual and reproductive health and rights and HIV services in Bangui, Médecins Sans Frontières - Operational Centre Brussels (MSF-OCB) is implementing the Bangui Project to bolster CAR's fragile health system. In Bangui, MSF provides technical expertise and operational support to selected public health centres, enhancing their capacity to deliver high-quality and impactful sexual and reproductive health (SRH) care and HIV/AIDS services. Through these efforts, MSF collaborates with local health authorities to reinforce SRH and HIV/AIDS service delivery within the Bangui healthcare system.

EVOLUTION OF THE BANGUI PROJECT: FROM AN EMERGENCY RESPONSE TO A DECENTRALIZED AND INTEGRATED SUPPORT TO THE BANGUI PRIMARY HEALTHCARE SYSTEM

MSF-OCB has been present in CAR since 1997 (see Fig. 1). In 2013, it launched the Bangui Project to provide emergency medical assistance to populations affected by the conflict following the Seleka-led coup d'état. As the crisis escalated, pregnant women were increasingly deprived of essential care, prompting MSF to set up an emergency obstetric unit on the tarmac of Bangui airport. This temporary facility provided life-saving obstetric and neonatal care, laying the groundwork for what would later become the Bangui SRH Project in 2014. In 2016, MSF-OCB expanded its scope by officially launching HIV/AIDS response activities, addressing the growing needs of PLHIV.

Following the closure of the displaced persons camp near Bangui airport in 2015, and in collaboration with the CAR health authorities, MSF-OCB relocated its obstetric and neonatal services from the airport to the maternity ward of the OPD Castors Urban Health Centre (in the health district 3). In parallel, recognizing the specific barriers faced by Muslim women in accessing maternity services—particularly those residing

in the PK5 area—MSF also established a maternity unit at the Gbaya Ndombia Health Centre. This facility was strategically selected to offer respectful, accessible, and culturally appropriate childbirth services to women from the predominantly Muslim community who experienced mobility restrictions and heightened vulnerability due to insecurity and social marginalization. By operating two complementary sites, MSF aimed to expand access to skilled birth attendance and neonatal care while addressing both geographic and socio-cultural barriers to care. Later, the project expanded the scope of its intervention to include the management of sexual violence and the provision of comprehensive contraception services, including condoms, implants, oral contraceptive pills, and tubal ligation. By 2019, MSF-supported facilities under the Bangui Project had provided care for 4,000 survivors of sexual violence and assisted in 11,000 facility-based births. Over time, what began as a maternal care initiative gradually evolved into a comprehensive SRH project, reflecting MSF's commitment to addressing the diverse and intersecting health needs of women and girls in Bangui.

In addition to SRH services, MSF launched in 2016 HIV-related activities to support the national HIV/AIDS response. However, it temporarily withdrew its support for HIV-related activities during a period of limited collaboration with local authorities. This withdrawal created a gap in service provision that was particularly felt among vulnerable populations. In 2019, as the demand for advanced HIV treatment increased, MSF-OCB relaunched an HIV/AIDS initiative at the Centre Hospitalier Universitaire Communautaire (CHUC), a tertiary hospital in Bangui, to help reduce morbidity and mortality among PLHIV. The deteriorating security situation had severely disrupted access to HIV care, with frequent stockouts of ART drugs in health facilities and insecurity preventing many patients from seeking prompt treatment. As a result, many PLHIV progressed to advanced stages of the disease (3 and 4), leading to worsening health outcomes. At the CHUC, where MSF-OCB supported the internal medicine department and laboratory for HIV-related care, nearly half of all hospital admissions were HIV-positive patients, and one in five hospitalized patients died from HIV-related complications.

To address these challenges, MSF-OCB provided technical and logistical support to CHUC, including medical equipment, staff training, and technical supervision, ensuring continuous access to free HIV care. Services included medical treatment for advanced HIV/AIDS patients, many of whom were co-infected with tuberculosis (TB), as well as HIV testing, consultations, and ART initiation for newly diagnosed patients.

Initially managed as a standalone project, the HIV response was implemented alongside a separate SRH initiative. However, in 2022, MSF made a strategic shift to merge these two vertical programs into a single, integrated project, known as the "Bangui Project". This merging aimed to strengthen continuity of care and improve service delivery by addressing the interlinked health needs of patients—particularly women, newborns, PLVIH, and key populations—through a holistic approach that combines HIV testing and treatment, maternal care, contraception, and management of STIs at the health centres levels, with referral for advanced care at the CHUC. Complementing this effort, MSF also reinforced its community-based health promotion activities to boost awareness and increase the uptake of both SRH and HIV/AIDS services, particularly among underserved and at-risk populations.

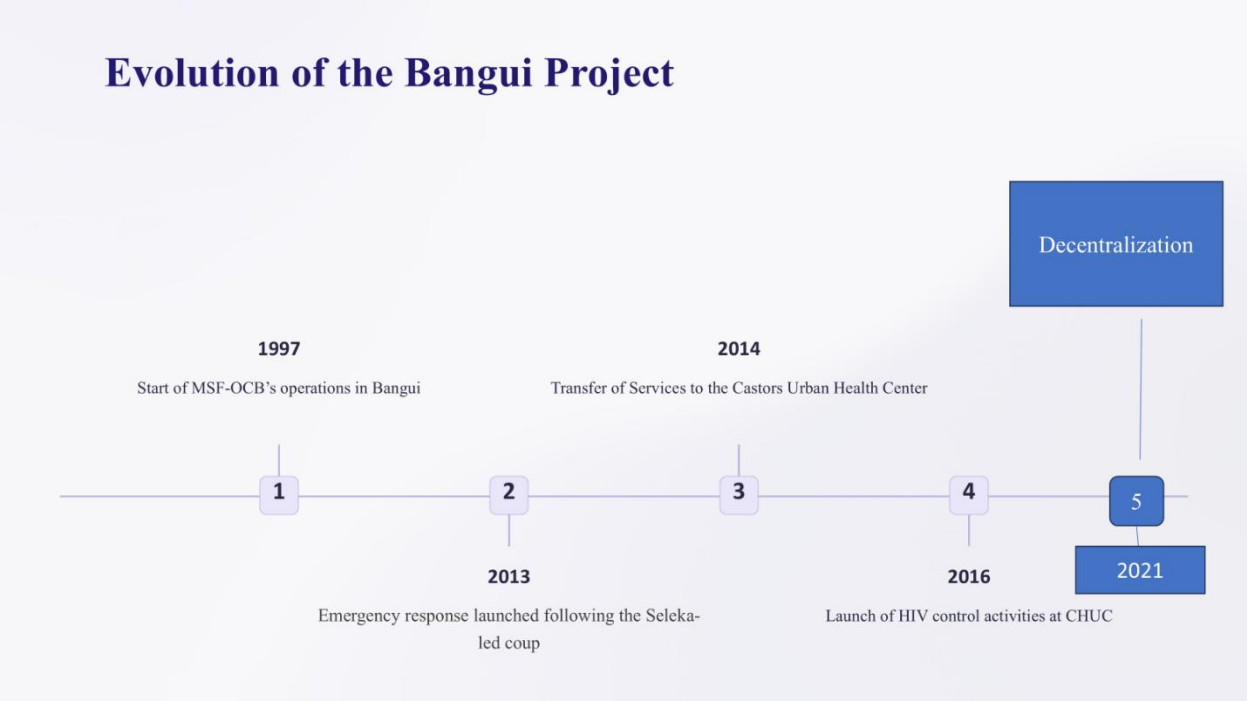


Figure 1: Evolution of the Bangui project — From launch to decentralization

RATIONALE FOR THE DECENTRALIZATION OF MSF'S SUPPORT TO THE PRIMARY HEALTHCARE SYSTEM IN BANGUI, CAR

Operational considerations primarily drove MSF's decentralization and integration of support to the primary healthcare system in Bangui, ***hereinafter referred to as the decentralization initiative***. These include the need to optimize SRH services and HIV/AIDS healthcare accessibility, and overall service delivery. More specifically, it sought to reduce the patient burden at the OPD Castor Health Centre, which had become overwhelmed due to consistently high demand. OPD Castor Health Centre, operated solely by MSF in Bangui, served as a key hub for essential medical services, including obstetric care. Patients came from across the city to seek treatment there. In addition, the CHUC, which MSF partially supports, was designed as a referral hospital but also became a primary care facility for many. A significant number of PLVIH bypassed their assigned local health centres and sought care directly at CHUC. They were drawn by the perceived higher quality of care, greater confidentiality, and access to specialized services. This bypass phenomenon contributed to service congestion at CHUC and exacerbated geographic and logistical barriers for patients living in peripheral or underserved areas.

To address these challenges, the Bangui project introduced a decentralization initiative. As in other crisis settings where MSF-OCB works, this approach aimed to reduce overcrowding at OPD Castor Health Centre and CHUC by strengthening nearby primary health centres, thereby supporting the delivery of quality healthcare services closer to the population in need. MSF has successfully implemented similar models in countries such as Haiti, South Sudan, and the Democratic Republic of the Congo (DRC), where high patient

volumes at MSF-run health facilities often resulted in care delays, long travel distances, and inefficiencies in service delivery (MSF, 2022a).

The Bangui project aimed to improve access to vital HIV and SRH services, including maternal and child health, by decentralizing and integrating MSF's support to specific health centres within the city, bringing care closer to the communities that need it most. It sought to optimize service delivery and promote a more sustainable, locally embedded response to the ongoing maternal, child health, and HIV/AIDS challenges in the Central African Republic. Figure 2 below presents an illustration of the rationale behind the decentralization initiative.

Figure 2: Rationale for the decentralization and integration of MSF's support in Bangui's Healthcare System

Currently, through its decentralization initiative, the project supports six primary healthcare centres, focusing on sexual and reproductive health (SRH) and HIV/AIDS interventions, as described in Table 1 below. In addition to supporting health facilities, the decentralization initiative also enhances community outreach by deploying mobile teams and trained Health promotion workers who provide door-to-door education on HIV and ISTs. Additionally, condoms and other contraceptives are made available at supported community points of care (See Table 2 below). These outreach efforts are tailored to reach underserved populations, including adolescents, women of reproductive age, and key populations at higher risk.

Table 1: Health centres supported under the decentralization initiative and their provided health services package (as of March 2025)

Name of health facility	Sexual and reproductive health services	HIV-related health services
1. Boy Rabe Health Centre	- Basic Emergency Obstetric and Newborn Care (BEmONC) services to manage common childbirth complications and ensure safe delivery and newborn care. - HIV testing at first antenatal care (ANC) visit to ensure early linkage to treatment and prevent transmission from mother to child - Abortion-related complication care - Family planning/Contraception services - 24-hour ambulance referral and counter-referral to CHUC for CEmONC	No support for HIV-related services
2. Castors Health Centre	No support for SRH-related services	- Index testing for contact of HIV positive clients, and Provider-Initiated Counselling and Testing - Initial consultation and initiation of anti-retroviral therapy - Supply of HIV/AIDS medications - TB/HIV Co-infection management - Laboratory tests for HIV/AIDS monitoring - Referral to CHUC for advanced care
3. Bede Combattant Health Centre	- BEmONC - HIV testing at ANC1 - Family planning/Contraception: New cases: after delivery, abortion, and on request - Birth skill attendance - Abortion-related complication care - 24-hour ambulance referral and counter-referral to CHUC for CEmONC	
4. Begoua Health Centre	- BEmONC - HIV testing at ANC1 - Family planning/Contraception: New cases: after delivery, abortion, and on request - Birth skill attendance - Abortion-related complication care - 24-hour ambulance referral and counter-referral to CHUC for CEmONC	
5. Les Amis d'Afrique Health Centre	- No SRH-related services at this facility	
6. Ouango Health Centre	- No support for SRH-related services	

Table 2: Community mobile clinics under the decentralization initiative and their package of care

Name of community site	Package of activities offered	Corresponding health facility	Health district
Site com. KOKOLO 3	- Awareness-raising on family planning, STIs, and sexual violence, and MSF promotion - Family planning activities (all methods except implants and IUDs) - Referral to OPD Castors for cases of sexual violence, and advanced contraceptive methods. - Referral to the corresponding health facility for STI cases - STI management, HIV screening and referral for management of HIV-positive cases, FP, and awareness-raising.	CDS MAMADOU MBIKI	Bangui 2
Site com. BEGOUA	- Awareness-raising on family planning, sexually transmitted infections, and sexual violence, and MSF promotion - Family planning activities (all methods except implants and IUDs) - Referral to OPD Castors for cases of sexual violence, and advanced contraceptive methods. - Referral to the corresponding health facility for STI cases	BEGOUA HOSPITAL	BEGOUA
Site com. GBAKASSA		CDS KOKORO BOEING	BIMBO
Site com. CTE SINAI		CDS GUITANGOLA	BIMBO
Site com. 92 LOGEMENTS		CDS PETEVO	BANGUI 2

EVALUATION OBJECTIVES AND JUSTIFICATION

The Bangui project commissioned this mid-term evaluation to assess the progress and relevance of its decentralization initiative toward achieving its intended objectives. These objectives focus primarily on improving the availability and accessibility of SRH services, including maternal and child health and HIV-related services, and STIs for target populations in Bangui. Ultimately, the initiative aims to reduce morbidity and mortality linked to maternal and child health and HIV-related conditions.

According to the evaluation terms of reference (ToR), (see Appendix 4.1), the findings of this mid-term evaluation could help the Bangui project team gain a deeper understanding of the challenges and opportunities for enhancing the availability and accessibility of maternal and child health services, as well as HIV care and support, within the specific context of Bangui. Specifically, the Bangui project could use the results to inform strategic discussions on the project's direction.

EVALUATION QUESTIONS AND CONCEPTUAL FRAMEWORK

Drawing from the questions outlined in the evaluation ToR and insights gathered from initial interviews with the commissioner and key MSF staff during the inception process, the evaluation team has adopted the Organization for Economic Co-operation and Development (OECD) evaluation framework to structure and inform this evaluation (OECD, 2019). Based on these specific evaluation questions, the evaluation team has selected and applied the following OECD criteria:

1. **Relevance**: This criterion assesses whether the decentralization initiative addresses the medical needs of the target population in Bangui. It also examines if there are any unmet SRH or HIV needs within specific population groups (**evaluation question 1, as outlined in the ToR**).
2. **Coherence**: This criterion evaluates the alignment of the decentralization initiative with the context and existing SRH and HIV-related policies and public health frameworks. It also considers whether the program is missing opportunities (**evaluation question 2, as outlined in the ToR**).
3. **Effectiveness**: This criterion measures the success of the decentralization initiative in achieving its objectives, particularly in enhancing the availability and accessibility of key SRH and HIV services in supported health centres within Bangui. By improving these services, the initiative aims to reduce mortality and morbidity rates related to HIV/AIDS and adverse maternal and infant events. It also examines whether any elements of care, strategies, or groups within the target population have been excluded from the decentralized initiative and the impact of such exclusions (**evaluation question 4, as outlined in the ToR**).
4. **Impact**: This criterion assesses the contribution of the decentralization initiative and integration support component to the capacity of MSF partners (PHMs, individual health facilities, and communities) in achieving progress toward the project's long-term goals of reducing morbidity and mortality **(evaluation question 5, as outlined in ToR).**

5. **Sustainability**: This criterion assesses whether the approach taken to provide the decentralized support component for SRH and HIV services can be replicated by the Ministry of Health or in partnership with another actor (**evaluation question 6**, **as outlined in the ToR).**
6. **Efficiency**: How effectively has the decentralization initiative enhanced service delivery by optimizing available resources? **(evaluation question 7, as outlined in the ToR).**
7. Additionally, this evaluation **assesses the involvement of local health authorities** and partners (PSM, Communities) in the design and implementation of the program. Whether these stakeholders feel a sense of ownership and belonging, key factors for the successful replication of the decentralization initiative by the local health authorities (**evaluation question 3, as outlined in the ToR**)

METHODS

STUDY DESIGN

We employed a mixed-methods approach to comprehensively assess the decentralization initiative, combining qualitative and quantitative data collection techniques. Specifically, the evaluation team utilized the following sources of data to ensure a robust assessment of the initiative:

DESK REVIEW

We reviewed relevant policies, guidelines, and documents at the local, national, and international levels. This review included SRH and HIV-related policies, procedures, frameworks, and relevant documents from the decentralization initiative (see the list of key documents reviewed in Appendix 4). The desk review contextualized MSF's decentralization initiative within national health policies and international best practices, providing a foundational understanding of its relevance and coherence with broader health sector goals and roadmaps. This review first enlightened our understanding of the decentralization initiative, including its scope of intervention, implementation approach, challenges, and logical framework. By examining these aspects, the review highlighted how the initiative integrates with existing healthcare systems and addresses specific needs within the target population. It also identified key areas for improvement and potential barriers to effective implementation and success, offering valuable insights for optimizing the initiative's impact on healthcare delivery.

SECONDARY ANALYSIS OF ROUTINE DATA

We analysed routine data from health centres supported by MSF under the decentralization initiative, using Tier.Net for HIV-related indicators and the SRH database for sexual and reproductive health data. This analysis aimed to generate quantitative insights into the initiative's effectiveness, efficiency, and potential impact. It included, among other aspects, an assessment of service utilization trends and improvements in maternal, child, and HIV/AIDS-related outcomes over time.

KEY INFORMANT INTERVIEWS

We conducted semi-structured interviews with key stakeholders, including MSF staff, Ministry of Health (MOH)representatives, the health district management team, and healthcare providers from MSF's supported health centres. These interviews provided expert perspectives on the initiative's relevance, sustainability, and potential for replication within Bangui's broader health system. Additionally, these interviews offered valuable insights into key challenges encountered and lessons learned throughout the implementation of the decentralization initiative.

CASE STUDY ANALYSIS OF TWO HEALTH CENTRES

A detailed case study approach was used to examine the implementation of the decentralization initiative at **Boy Rabe Health Centre** and **Bédé Combattant Health Centre**. This analysis provided an in-depth understanding of service delivery, resource allocation, and patient experiences. The case study incorporated:

a) **Secondary analysis of service utilization data:** This involved examining trends in patient volume, service provision, and health outcomes over time. By analysing existing data, the evaluation team could identify patterns and changes in how services were utilized and their impact on patient health.

b) **In-depth interviews with healthcare providers:** These interviews explored various aspects of service delivery, including challenges faced by providers, workforce capacity, and strategies for engaging patients. Healthcare providers shared their experiences and perspectives, offering valuable insights into the operational aspects of the initiative.

c) **Patient flow observation:** This method assessed the accessibility of services, waiting times, and the efficiency of referral processes. Observing patient flow helped measure how effectively services were delivered and identify areas for improvement in service delivery efficiency.

d) **Client exit survey** used both quantitative and qualitative techniques. The quantitative component involved structured interviews with a subset of participants in the client flow observation, gathering insights on service delivery. This approach provided measurable insights into patterns and trends in patient care and service delivery. Following these interviews, a subset of participants was selected for in-depth qualitative interviews, which explored their experiences, perceptions, and challenges related to the healthcare services they received. The qualitative approach offered a richer understanding of patient care, capturing personal stories and insights that quantitative data alone could not reveal. This multifaceted approach provided an in-depth assessment of whether the decentralization initiative improved the availability and accessibility of maternal and child health services, as well as HIV-related care.

STUDY POPULATION, SELECTION CRITERIA, AND SAMPLING METHOD

The study population consisted of three key groups: clients (beneficiaries of SRH and HIV services), healthcare providers, and community health workers from the case-study sites. Additionally, we interacted with key informants from the Ministry of Health and MSF.

We employed a non-probabilistic sampling approach to select both the case study sites and respondents, ensuring the most relevant insights for the evaluation. The Boy Rabe and Bèdè Combattant health centres were purposively selected to capture a diverse and in-depth understanding of the decentralization initiative's implementation and impact (Crowe et al., 2011). These sites were selected based on their comprehensive SRH and HIV service offerings. They anticipated high client flow, providing a representative sample of study participants and reflecting key dynamics in service delivery.

At the case study sites, all clients aged 15 and over who accessed maternal and child health and HIV services during the data collection period were eligible for the study, along with all healthcare providers. Key informants from MSF and the MoH were targeted based on their ability to offer deeper insights into our evaluation questions

DATA COLLECTION PROCEDURES

Primary data collection for this evaluation was conducted from March 17 to 27, 2025. Two evaluation team members travelled to Bangui to gather data during this period. Additionally, programmatic data collected from mid-June 2021 to April 2025 were extracted from the project datasets for their secondary analysis.

CLIENT FLOW ANALYSIS AND EXIT SURVEYS

The client flow analysis involved the direct observation of 150 patients accessing SRH and HIV/AIDS care at the two case study sites. To avoid disrupting service delivery and to maintain client confidentiality, trained healthcare providers, rather than the evaluation team members, completed the observation forms. This approach also helped to mitigate potential power imbalances between patients and external observers, as providers were already trusted figures within the health facility setting. Participants represented a mix of service users, including pregnant women, mothers with children, adolescents, and individuals living with HIV. Basic demographic characteristics, such as age group, gender, and service entry point, were noted where possible, without compromising patient anonymity.

Healthcare providers recorded each patient's movement across various service delivery points, capturing data on wait times, services received, and any internal referrals. The analysis aimed to assess service availability and accessibility, while also identifying bottlenecks, inefficiencies, and gaps that may hinder effective service delivery. By using a provider-led, anonymized observation process, the analysis ensured ethical safeguards and minimized the influence of observation on patient behaviour or staff performance.

After receiving care, participants were invited to complete an exit survey assessing their satisfaction, perceived quality of care, and barriers to accessing services. Surveys were administered in a private setting at the case study sites by two local research assistants, who were trained in the evaluation procedures and

research ethics to ensure confidentiality and minimize bias. The survey was conducted using the offline version of the KOBO Toolbox®, lasted approximately 30 minutes, and was administered in either Sango or French, based on each participant's preference. We reached a total of 134 clients in the two case study sites.

In addition to the quantitative exit survey, the study team conducted in-depth interviews with a purposively selected subset of 12 survey participants to gain deeper insights into their experiences. These participants represented a diverse mix of service users, including pregnant women(n=5), postpartum mothers (n=2), and adolescent girls(n=2) and adults living with HIV (n=3), reflecting the range of clients accessing SRH and HIV/AIDS services at the two case study health centres. Efforts were made to ensure diversity in age, gender, and service type accessed (e.g., antenatal care, family planning, HIV treatment).

The interviews explored participants' perceptions of the quality of care received, the nature of their interactions with healthcare providers, and any barriers they faced in seeking or continuing care. This qualitative component was essential for understanding client experiences beyond quantitative measures, offering a more nuanced view of the accessibility, responsiveness, and person-centredness of services provided under the decentralization initiative.

The interviews, guided by a tool specifically developed for this evaluation, were conducted in either Sango or French, depending on the participant's preference, audio-recorded with consent, and lasted an average of 30 minutes.

HEALTHCARE PROVIDERS AND COMMUNITY HEALTH WORKERS

We conducted semi-structured face-to-face interviews with key informants at their workplaces, using a semi-structured guide specifically elaborated for this evaluation. The evaluation team members conducted all interviews in French, audio-recorded them (with verbal consent), and they lasted approximately 30 minutes.

Nine interviews were conducted, five at Boy Rabe and four at Bede Combatant Health Centre, respectively. These interviews involved two(n=2) physicians, three (n=3) midwives and nurses, two (n=2) HIV/TB service providers, and four (n=4) psychosocial support agents.

KEY INFORMANT INTERVIEWS

The evaluation team conducted a total of twelve (n=12) in-depth interviews with key informants. This included two representatives of the MoH —one from the National HIV/AIDS Program and another from the Family Health Program—as well as one representative from the District Health Management Team. In addition, nine MSF staff members were interviewed, representing global, regional, and project-level perspectives.

Those interviews were conducted with participants at their workplaces or virtually, as necessary, using a guide developed explicitly for this evaluation. Each interview lasted approximately 30 minutes and was audio-recorded with the participants' verbal consent.

DATA ANALYSIS

QUANTITATIVE DATA ANALYSIS

The evaluation team applied descriptive statistics, including frequencies and percentages, to analyse respondent characteristics and assess a range of variables that reflected the effectiveness and impact of the decentralization initiative. These included, amongst other variables, SRH and HIV/AIDS service availability, accessibility, quality, and changes in client health outcomes. We constructed composite indices for availability, accessibility, and quality by assigning unweighted scores to multiple service components (see Appendix 4 for a detailed description of the data analysis approach). We assessed changes in client health outcomes over time (June 2021 to April 2025) using key indicators drawn from the decentralization initiative's performance framework and global standards on HIV programming monitoring (see Appendix 3). Additional variables related to service delivery efficiency, user satisfaction, and perceived system responsiveness were also considered to provide a more comprehensive evaluation of the decentralization initiative.

Quantitative data, including programmatic data, client flow observation data, and quantitative data from the exit survey, were analysed using Microsoft Excel, tailored to meet specific analytical requirements. Continuous variables were summarized using means, medians, or ranges, depending on their type. Cross-tabulations examined relationships between key variables and factors such as client demographics (e.g., age, gender, residence) and health centre characteristics (e.g., patient volume, location).

We use tables, charts, and pie charts, where relevant, to visually represent our quantitative findings, ensuring clarity and ease of interpretation. Specifically, we use tables to compare key indicators and track variations across categories and times. Meanwhile, we rely on pie charts to illustrate proportions and distributions within specific indicators, clearly representing the relative share of their respective components.

QUALITATIVE DATA ANALYSIS

Two members of the evaluation team transcribed the interviews conducted in French verbatim. In contrast, the two local research assistants transcribed the interviews conducted in Sango verbatim, while simultaneously ensuring their translation into French. Qualitative data, including interview transcripts, field notes, and memos, were imported into NVivo for data coding and organization. Two members of the evaluation team analysed the data using a predefined codebook. This codebook included a-priori codes based on the OECD evaluation criteria and new codes that emerged from our data. We employed deductive and inductive thematic analysis techniques to examine the coded data (Braun & Clarke, 2006).

Information from various sources (both quantitative and qualitative data) was triangulated to ensure the reliability of our conclusions.

ETHICAL CONSIDERATIONS

ETHICAL APPROVAL

This evaluation protocol received ethical approval from the Ethics Committee Board of the Faculty of Health Sciences in Bangui (December 2024). It was also reviewed and formally exempted from MSF's internal Ethics Review Board (ERB), as the evaluation focused on quality improvement of a project under implementation and posed minimal risk to participants.

ETHICAL PRINCIPLES GUIDING THE EVALUATION

As the evaluation involved collecting empirical data from human subjects, including healthcare service users and key informants, the evaluation team strictly adhered to the Canadian Tri-Councils requirements for research ethics (Canadian Institutes of Health Research, 2022). These requirements included upholding participants' autonomy, justice, and the principle of doing no harm.

Specifically, we applied the principles of autonomy by ensuring that all participants were fully informed about the study's objectives, their rights, and the voluntary nature of their participation. We upheld autonomy by obtaining verbal informed consent, allowing participants to decide whether to participate in the study without coercion.

For individual interviews with adolescents aged 15–17, we first obtained consent from a parent, guardian, or caregiver, followed by the adolescent's consent. The evaluation team did not include children under 15 years of age and individuals unable to provide informed consent (due to illness, mental disability, or refusal).

We informed all participants that their participation was voluntary, anonymous, and confidential. They were also advised of their right to decline to answer questions and to withdraw from the study at any time without consequence.

We ensured justice by selecting participants fairly and equitably, ensuring no group was excluded or disproportionately burdened. The do-no-harm principle was applied by designing data collection methods that minimized psychological or emotional distress, maintained confidentiality, and ensured that sensitive topics were approached with care and professionalism (Lalando et al., 2020).

Further, the evaluation team complied with the SEU ethical guidelines by upholding the core principles of intentionality, integrity, respect for dignity and rights, and accountability throughout the evaluation process. This included ensuring that the evaluation was designed and conducted with a clear purpose, providing tangible benefits to stakeholders. The team has maintained honesty, transparency, and independence in all evaluation activities and communications. Particular attention was taken to safeguard the dignity, privacy, and well-being of participants, with attention to informed consent and confidentiality. Additionally, the team remained accountable for the quality, utility, and ethical conduct of the evaluation, including the responsible dissemination of findings (MSF SEU Ethical Guidelines for Evaluations, 2022b).

POTENTIAL RISKS TO PARTICIPANTS

Although this assessment posed a minimal risk, clients, including HIV-positive people, were asked to share their experiences with SRH and HIV care, which may have caused psychological discomfort when

discussing sensitive topics. To minimize these risks, the evaluation team adopted client-centred approaches (Lalando et al., 2020):

1. Designing the interview process to prioritize participant comfort.
2. Emphasizing the voluntary nature of participation and the right to withdraw at any time.
3. Reassuring participants that their participation would not affect their eligibility for current or future health services.
4. Providing access to psychological support, where available, for participants experiencing distress.

POTENTIAL BENEFITS

Participants did not receive any direct benefits from this evaluation. However, its findings could contribute to improving SRH services and HIV interventions, ultimately benefiting all target populations of the decentralization initiative.

CONFIDENTIALITY AND DATA PROTECTION

The evaluation team implemented rigorous data protection measures to ensure strict confidentiality and protect the privacy of all participants. We did not collect personal or identifiable information, including names, phone numbers, or addresses. Instead, only anonymized and aggregated data were collected, analysed, and reported to prevent any breach of confidentiality.

We took additional precautions to safeguard the anonymity of qualitative interviews. Any quotes used in this report were carefully reviewed and anonymized to remove any potentially identifiable details, such as names, specific job positions, organization names, or any contextual markers that could inadvertently reveal an individual's identity. These measures align with ethical research standards and best practices for data security, ensuring that the privacy of all participants is thoroughly maintained throughout the evaluation process (Orb, Eisenhauer & Wynaden, 2001).

We upheld impartiality by employing a rigorous and unbiased data collection approach, ensuring that diverse perspectives, especially from vulnerable populations, were adequately represented. The team also used standardized tools and verification methods to cross-check findings and minimize potential biases. All data were carefully documented to ensure accuracy, then analysed using validated methodologies and, when necessary, reviewed by team members who had not participated in the data collection process. Furthermore, findings were shared with key stakeholders for validation, allowing them to provide feedback and ensure that the conclusions drawn reflected the realities on the ground.

Finally, the evaluation team declared no conflicts of interest and upheld the highest professional ethical standards throughout the evaluation process.

FINDINGS

We first outlined the scope of SRH and HIV-related interventions implemented under the decentralization initiative. Then, we presented the findings by evaluation criterion and their respective questions using a weaving approach (Fetters, Curry & Creswell, 2013), where qualitative and quantitative data are integrated throughout the narrative to address each criterion. Insights from the qualitative component are presented alongside and complemented by quantitative evidence where relevant, or vice versa, depending on the strength and availability of data. This method enables continuous triangulation, enhancing the credibility and depth of the analysis and providing a comprehensive understanding of the decentralization initiative's performance across multiple dimensions.

SCOPE OF INTERVENTIONS IMPLEMENTED UNDER THE DECENTRALIZATION INITIATIVE

As part of its implementation strategy, the decentralization initiative supports six selected health facilities across Bangui (see Table 1 above) to deliver a targeted package of SRH and HIV interventions. These efforts aim to enhance the availability and accessibility of SRH services, including family planning services, post-abortion care, STI management, quality maternal and child health services, while strengthening HIV prevention, diagnosis, and treatment. As part of the decentralization initiative's PMTCT support, all pregnant women attending their first antenatal care (ANC1) receive routine HIV testing, with those testing positive referred for ART initiation and continued follow-up. Infants born from HIV-positive mothers are also given antiretroviral prophylaxis and tested for HIV around using PCR 6 to 8 weeks post-partum. The initiative also supports facility-based deliveries to ensure skilled birth attendance, as well as immunization for mothers and newborns. It integrates a structured referral mechanism from primary health centres to the CHUC for Comprehensive Emergency Obstetric and Newborn Care (CEmONC).

Regarding HIV services, the initiative supports the implementation of provider-initiated testing and counselling (PITC) and the index testing approach to enhance case detection and linkage to care. Patients diagnosed with HIV are enrolled in ART with ongoing follow-up, active tracing of clients with interrupted treatment (ITT)—defined as patients who missed a scheduled clinical contact and do not return within 28 days, without being recorded as having died, transferred out, or officially stopped treatment.—and those lost to follow-up (LTFU), refers to HIV-positive patients on ART who have not returned to the clinic or pharmacy for ≥90 days after their last expected contact and have no documented outcome such as transfer, death, or stopping ART.[1] The initiative also supports health facilities with SOPs and tools to conduct psychosocial counselling for clients at treatment initiation and to reinforce medication compliance. Routine biological monitoring provided includes on-site testing for tuberculosis co-infection, PIMA for CD4 count, and viral load testing performed at the Pasteur Institute in Bangui. Additionally,

[1] WHO 2021 consolidated guidelines

patients with advanced HIV/AIDS are referred to CHUC for specialized care, including management of HIV/TB co-infection and other opportunistic infections (OI).

Beyond direct service provision, the initiative strengthens the health system through capacity-building efforts, including training and mentorship programs for healthcare providers. A buffer stock of essential medical commodities is maintained to enhance service continuity and mitigate stockouts of essential drugs provided through the national supply-chain mechanism. Furthermore, the initiative invests in health facility infrastructure improvements, focusing on WASH amenities and renovation efforts to create a safer and more functional healthcare environment.

The initiative also incorporates community outreach activities to enhance service uptake and strengthen linkages between health facilities and the communities they serve. The initiative has trained and supported a network of community health workers (CHWs) who play a key role in raising awareness about SRH and HIV services, promoting antenatal care attendance, encouraging facility-based deliveries, and family planning uptake. The health promotion team also provides critical family planning methods for women in the community, including injectable contraceptives, self-managed subcutaneous injectable option, emergency contraceptive pills, and other short-acting contraceptive methods that can be administered outside the healthcare setting by lay healthcare providers.

Community outreach initiatives focus on reducing stigma and misinformation surrounding HIV/AIDS and SRH services and providing family planning methods. Through community dialogues and sensitization campaigns, the CHWs foster trust in the healthcare system and empower individuals to seek timely care. By integrating community outreach with facility-based interventions, the decentralization initiative aims to bridge gaps in service accessibility and improve health outcomes across the continuum of care for SRH and HIV. The diagram below depicts the intervention pathways and expected outcomes of the decentralization initiative.

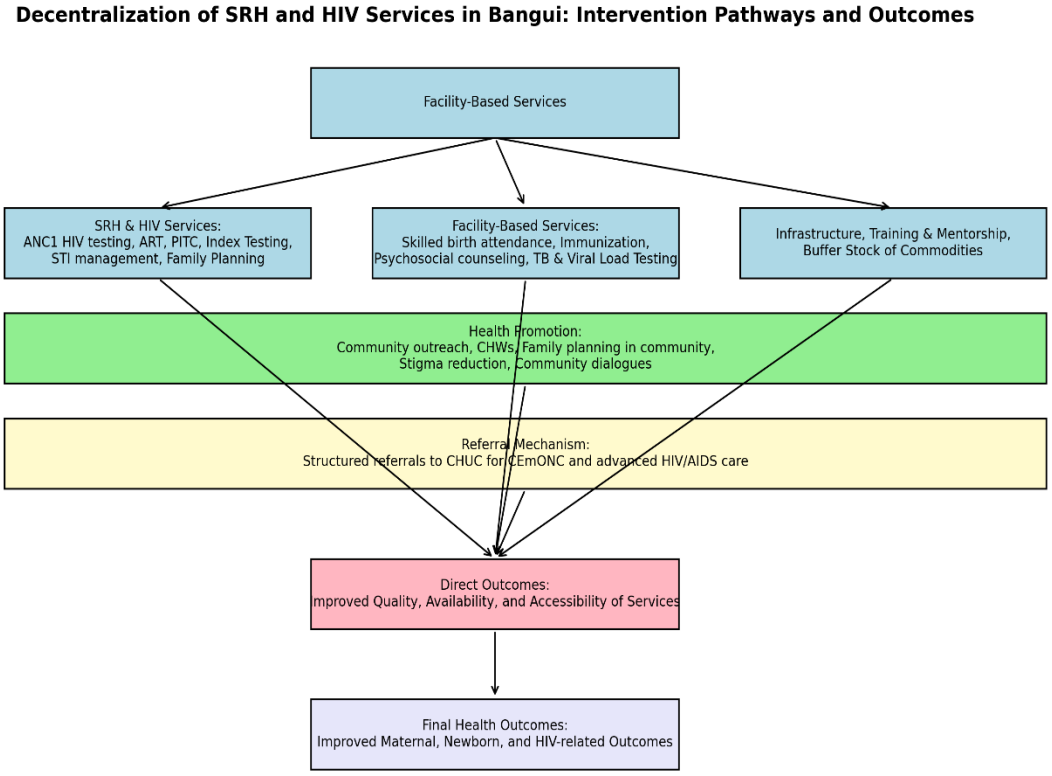


Figure 3: Decentralization of SRH and HIV services in Bangui: Intervention pathways and outcomes

RELEVANCE OF THE DECENTRALIZATION INITIATIVE

*This criterion assesses the relevance of the decentralization initiative to the medical needs of the target population in Bangui. It seeks to determine whether there are unmet SRH or HIV needs within this population, and if so, identifies which specific needs remain unaddressed. (**Evaluation question 1, as outlined in the Terms of Reference**).*

The CAR continues to face serious challenges in the areas of SRH and HIV/AIDS. Maternal and infant mortality rates remain alarmingly high, access to family planning is limited, and the country bears the highest HIV prevalence in West and Central Africa—particularly concentrated in the capital, Bangui. Structural barriers, including under-resourced health infrastructure, persistent shortages of trained healthcare personnel, frequent stockouts of essential supplies, and weak referral systems, significantly impede the delivery of quality care (WHO, 2022; UNAIDS, 2023). At the community level, stigma, limited health literacy, entrenched traditional beliefs, and restricted access in rural, remote, or conflict-affected areas further limit the uptake of essential SRH and HIV/AIDS services. Women, adolescents, and children are disproportionately affected, highlighting persistent inequities in access and health outcomes.

The government's commitment to international health targets remains uneven, including the SDGs, the UNAIDS 95-95-95 targets, and Universal Health Coverage (UHC) principles. While national policies aimed at improving maternal and neonatal health, the HIV/AIDS response, and access to family planning exist, performance on key indicators such as ART coverage, viral load suppression, FP demand satisfied with

modern contraceptive methods, and maternal and neonatal mortality remains suboptimal. This suggests ongoing gaps between policy commitments and their impact on service delivery and population health outcomes.

Considering these ongoing gaps, the decentralization initiative has proven both contextually relevant and appropriate to the SRH and HIV/AIDS-related medical needs of the target population in Bangui. The initiative directly addresses critical challenges in service delivery by strengthening the capacity of primary-level health facilities to provide quality and critical maternal and child health services, as well as HIV care and support, free of charge to target populations in Bangui. The initiative also enhances the responsiveness and access to care of the healthcare system by combining facility-based interventions with community outreach, thereby mitigating systemic, social, and individual-level barriers to care. A local healthcare provider underscored the relevance and importance of this initiative:

> *"…., MSF provides monthly incentives to staff and supplies. If there's a problem, we call colleagues at CHUC [the designated referral hospital in Bangui], and they assist. We ask MSF to continue helping us because we don't know what would happen to the women without them. MSF's financial, medical, and equipment support has been invaluable."* [MOH respondent]

Another key informant underscored the relevance of the decentralization initiative by saying:

> *"(...) This project is what we need right now. The HIV epidemic in Bangui is worsening, and too many people are not accessing treatment (...) This initiative has the potential to change lives."* [MOH respondent]

While another commented in the same vein as follows:

> *"There are also many other things, including certain tests that were not accessible to patients, such as CD4 counts. MSF has provided PIMA devices to perform CD4 tests on-site at the health centre [supported by the decentralization initiative in Bangui]."* [MSF respondent]

These testimonies highlight the critical role of the decentralization initiative in enabling access to timely, quality maternity care and HIV/AIDS healthcare services for target populations in Bangui. Furthermore, by establishing a robust referral system, the decentralization initiative provides essential transport services, connects patients to specialized services, and ultimately enhances prompt access to emergency care for those in need.

> *"Regarding the referral and counter-referral aspect, many health centres [in Bangui] initially did not have ambulances. Patients were transported to the hospital via motorcycles or public transportation. [Now], the health centres can call, and the ambulance will come to pick up the patient and transport them [to the CHUC] under ideal conditions."* [MOH respondent]

Despite the overall positive opinion expressed by the majority of respondents regarding the relevance of the decentralization initiative, some key informants questioned the relevance of its geographical focus. **They pointed out that while the initiative strengthens the availability and accessibility of quality HIV, maternal, and child healthcare services in urban health districts within Bangui, it leaves underserved remote and peripheral areas, where gaps in service delivery and health needs are often more critical**.

As one key informant noted:

> *"The project is too concentrated in central Bangui. But the real gaps are in the peripheral zones, such as Bimbo, some of those areas still have no functional maternity or HIV testing services."* [MOH respondent]

> *"Another difficulty we are having is the distance between the health centres and certain villages where there are no services"* [Client respondent]

This highlights a perceived disconnect between where support is directed and where the most acute service delivery challenges persist. Additionally, several respondents expressed concerns about the initiative's limited responsiveness to the needs of the most vulnerable groups, particularly adolescents, HIV-positive pregnant women, and their HIV-exposed infants. One key informant highlighted persistent gaps in the availability and continuity of services for HIV-positive pregnant women and their children, noting:

> *"The project aims to strengthen HIV services, but we still see critical challenges for pregnant women and their newborns. Many HIV-positive mothers struggle to access consistent and comprehensive prenatal care, and the project does not follow up exposed infants until 18 months, which increases the risk of transmission from mothers to their children."*

Other key informants emphasized the lack of adolescent-friendly services, pointing out that this group faces distinct challenges in accessing SRH services and HIV/AIDS care and support, including stigma, discrimination, limited confidentiality, and the absence of tailored communication strategies. They further highlighted that many adolescents, particularly girls and young women, encounter social and cultural barriers that discourage them from seeking family planning services, such as fear of judgment from health providers or community members. In addition, service delivery hours and locations are often not adapted to the needs of young people, making it even more difficult for them to access consistent care and follow-up. Thus, their needs are not adequately addressed, as one respondent stated:

> *"Adolescents are not just younger adults. They need privacy, counselling, and services that speak to them. Right now, the system is not built for that. Most avoid testing or care because they feel judged or misunderstood."*

Also, they reported persistent negative attitudes of the healthcare providers and stigmatization of PLVIH within the assessed health centres.

> *"Services are available and free, but access is problematic. Real discrimination within services and stigmatization of infected people."* [HIV-infected client]

These insights underscore the need for a more inclusive and adolescent-friendly approach in the decentralization initiative. By doing so, the initiative can ensure that quality health services are not only accessible but also tailored to meet the specific needs of adolescents. This involves designing interventions that are deliberately age-appropriate, culturally sensitive, and engaging for young people. Such an approach will help address adolescents' unique challenges, ultimately leading to greater satisfaction with the services provided and improved access.

Furthermore, these insights highlight the need to enhance the geographical responsiveness of the decentralization initiative. While the decentralization initiative aims to bring quality SRH and HIV services closer to the target population, its current concentration in central Bangui leaves peripheral and

underserved areas with limited access. This spatial imbalance undermines the initiative's core objective of equitable service delivery and risks excluding vulnerable populations, particularly adolescents living in peripheral neighbourhoods, who may face intersecting barriers such as transportation costs, poor SRH-related decision-making power, and social stigma. Addressing this gap requires a deliberate expansion of services/support into peripheral zones, ensuring that decentralization truly translates into proximity, equity, and inclusivity for all segments of the population.

COHERENCE OF THE DECENTRALIZATION INITIATIVE

This criterion assesses the alignment and consistency of the decentralization initiative with existing national SRH and HIV-related policies, strategies, and global goals ***(Evaluation question 2,*** *as outlined in the Terms of Reference).*

The decentralization initiative has shown **mixed coherence** with the national public health framework and evolving priorities to address HIV and pressing SRH challenges including maternal and child health in Bangui. On the one hand, it demonstrates intentional strategic alignment with national and international health goals, particularly in its support for maternal and neonatal health, as well as its contributions to the HIV response. However, the initiative's operational choices—partially integrating services and relying on fragmented delivery mechanisms—significantly limit its overall coherence. These implementation gaps hinder alignment with key strategic frameworks, including the Elimination of Mother-to-Child Transmission (EMTCT) of HIV, syphilis, and hepatitis B, and reveal a disconnect between the initiative's design and the broader national vision for comprehensive and integrated healthcare services.

Findings from the desk review and interviews confirm that the initiative's **implementation scope** aligns well with national efforts to reduce maternal and infant mortality, particularly in light of global commitments, such as SDG 3.1, and the national plan for enhancing maternal, child, and adolescent health. Interviewed stakeholders appreciated the initiative's life-saving impact, calling it well-suited to Bangui's urgent maternal and child health needs.

> *"It [the decentralization initiative] is particularly coherent in our context where maternal and neonatal mortality rates remain alarmingly high due to inadequate healthcare infrastructure, shortages of trained providers, and financial barriers."* [Excerpt from an interview with a key informant]

Another healthcare provider emphasized its coherence with the country's response to the HIV epidemic:

> *"This initiative has been instrumental in enhancing our ability to provide comprehensive HIV services, ensuring that even the most vulnerable populations receive the care they need."*

Yet, despite these strengths, many respondents flagged **some misalignments**. The initiative's **limited scope of interventions**—covering only some aspects of antenatal and childbirth services—was widely cited as weakening its coherence with national visions for comprehensive maternal and child healthcare. Respondents emphasized that fragmented service delivery undermines not only the quality of care but also the efficiency of broader health system reforms. As one key informant from the MoH put it:

> *"Maternal health cannot be tackled in parts. Women need complete, continuous care—from ANC to delivery to postnatal follow-up. Anything less is incomplete."*

> *"This fragmented approach undermines the impact of interventions (…) Without addressing this, the initiative risks reinforcing structural inefficiencies that national health strategies are working to overcome,"* an MOH key informant emphasized.

MSF respondents emphasized that the decision to support a targeted package of interventions was not arbitrary but rooted in strategic alignment with both operational realities and epidemiological priorities. They underscored that, given resource constraints and the need to maximize impact, the initiative prioritized high-yield interventions with the strongest evidence for reducing maternal, child, and HIV-related mortality. This focused approach, they argued, reflects a pragmatic balance between ambition and feasibility—ensuring that limited resources are directed toward interventions with the greatest potential for saving lives.

One key informant from MSF commented as follows:

> *"It's a choice … supporting the entire package of care from pregnancy until delivery is good, however, we [MSF] risked having a very large volume of activities more than our resources. We [MSF] also wanted the health facilities to be autonomous and manage some aspects and only support them if needed. This is an operational choice given the resource constraints and the need to create an impact."*

Compounding this, the initiative's **operational model contributes to structural misalignment**. As highlighted by health district officials and providers, MSF's use of Health Promotion Agents (HPAs) recruited and managed independently of the local health system further exacerbates the disconnect. While addressing key service gaps, these actors operate **parallel** to existing health zone structures, limiting coordination, supervision, and ownership of the community component of the decentralization initiative.

> *"At the community, their activities [MSF's activities] we [the district] don't know about them, which is a problem. We [the district] are supposed to be aware of them. They [MSF] cannot go to the community like that without informing the district of their activities. We [the district] have health promotion agents in the community from the Ministry; they [MSF] cannot recruit other agents for the same purpose. If there is any community activity in the district, it has to be done by the district's health promotion agents."* [MOH key informant]

Another significant gap pointed out by some key informants is the lack of alignment of the decentralization initiative with the country's commitment to EMTCT of HIV, syphilis, and HBV. They noted that the initiative does not include intentional strategies to address this triple elimination roadmap, which is currently a major national and global health priority, undermining the overall coherence of the initiative. As a key informant from the MoH noted:

> *"If we're aiming for triple elimination, we can't afford to treat HIV in isolation. The same mothers and babies are at risk for all three infections—it's inefficient and ineffective not to address them together."*

> *"… women continue to pay for Hepatitis B and syphilis testing even though we talk about free treatment, which strains the country's attainment of triple elimination. If MSF could also subsidise these services [Hepatitis B and syphilis testing] or provide testing kits that will be great"*

Conversely, respondents highlighted a misalignment between MSF's clinical guidelines and national protocols in the implementation of key HIV testing and prevention strategies. Specifically, they noted that clients from MSF-supported facilities where MSF does not support HIV care initiate prophylaxis for HIV-exposed infants late after childbirth, whereas national protocols and the availability of medications do not support this late initiation. A key informant from MOH put it as such:

> *"… We [Ministry of Health] observe a problem with early infant diagnosis of HIV-exposed infants, despite the high prevalence of vertical HIV transmission at 4% in CAR MSF's support does not respect the timing and duration of prophylaxis [ARV] for these exposed infants …*
>
> *… We [MOH] observe a delay in initial PCR testing and start of ARV prophylaxis from women who deliver in MSF-supported sites [that do not incorporate HIV care] because these women have to be referred to another health facility and this creates delays and missed opportunities and does not help our fight to eliminate vertical HIV transmission."* [MOH respondent]

Respondents noted that MSF introduced its own set of tailored indicators and reporting systems to monitor program performance. While these indicators and systems enhance internal monitoring and allow for project-specific reporting, our respondents pointed out that they are not fully aligned with the Ministry of Health's National Health Information System (DHIS2). As a result, they expressed concerns about challenges in harmonizing MSF health information with national systems. Despite using the same primary data sources—such as health registers—differences in indicators and reporting platforms often result in discrepancies. This misalignment not only limits the integration and utility of MSF-generated information in national health planning and decision-making but also risks reinforcing parallel reporting systems. As two respondents explained:

> *"A big challenge we are experiencing is that we often have difficulties harmonizing our [MSF]data with that of the MOH. The data we [MSF] collect is from the same registers as the MOH data, which means technically it should be the same data, but this is not the case. This is because certain indicators can be paired, but others cannot be paired between our software."* [MSF respondent]

> *"For the maternity component, MSF recruited a midwife, who is a midwife-supervisor. She collaborates with the maternity major, an agent of the Ministry of Health, to collect data together. They also share this with MSF. But for the HIV component, it is different. MSF has a database called 'Tiernet' and MSF also recruited data clerks to update the data in this database regularly, and that's where there's a bit of a problem, because the data we have is sometimes not corresponding with what MSF has"* [MOH respondent]

Overall, the decentralization initiative reflects a well-intentioned effort to align with national and global health priorities, particularly in addressing maternal and neonatal mortality and enhancing HIV services. Its contributions have been recognized by stakeholders as life-saving and contextually appropriate, especially in a setting with significant service availability and quality gaps.

However, the initiative's operational model reveals significant limitations in achieving complete coherence with the national public health system. Partial service integration, parallel staffing structures,

misalignment with national clinical protocols, and data system incompatibilities have weakened the initiative's ability to support a truly integrated and sustainable model of care. These gaps not only hinder coordination between MSF and public health actors but also risk fragmenting service delivery, particularly for maternal, neonatal, and HIV-related services that require continuity and integration across the care cascade.

Critically, the lack of alignment with the EMTCT roadmap, fragmented implementation of HIV testing strategies, and limited interoperability with the national health information system (DHIS2) suggest that while the initiative is responsive in intent, it falls short in harmonizing with broader structural reforms. Without stronger integration mechanisms—particularly at the community level and within routine health system functions—the decentralization initiative may inadvertently reinforce vertical approaches, reducing its long-term contribution to strengthening the national health system.

EFFECTIVENESS OF DECENTRALIZATION INITIATIVE

*The effectiveness criterion assesses whether the decentralization initiative effectively reduces mortality and morbidity among the target populations. It also examines whether any elements of care, strategies, or groups within the target population have been excluded from the decentralization initiative and whether these exclusions have significantly impacted reducing morbidity and mortality among those excluded groups. (**Evaluation question 5**).*

To assess the effectiveness of the decentralization initiative, we analysed secondary data from both the broader Bangui Project and the specific decentralization component to examine changes in service delivery, access, and patient health outcomes over time. This analysis drew on HIV program monitoring data (Tier.net export) and SRH datasets, focusing on key indicators related to the uptake of HIV services, maternal and newborn health, contraceptive use, and clinical outcomes for patients.

We also triangulated routine program data with findings from the exit survey to gain additional insights into the availability, accessibility, and quality of services, as well as the client's satisfaction and experience of care.

DEMOGRAPHICS OF THE SURVEY PARTICIPANTS

Table 3: Demographics of the survey participants (N=134)

Characteristic	Categories	Frequency (n)	Percentage (%)
Sex	Female	132	98.5
	Male	2	1.5
Age	15-19	16	11.9
	20-24	42	31.3
	25-29	29	21.6
	30-34	21	15.7
	35+	26	19.4
Education Level	Secondary or Higher	101	75.3
	Primary	26	19.4
	No formal education	7	5.2
Occupation	Employed (Temporary/Occasional Work, Self-employed, Salaried Employee)	71	52.6
	Not Employed	42	31.1
	Students, Other/Professional Training	22	16.3
Marital Status	Married/common law union	121	90.3
	Single/Never married	8	5.9
	Divorced/Separated	2	1.5
	Widowed	3	2.2
Religion	Protestant	53	39.3
	Catholic	36	26.7
	Other Christian (Apostolic, Elim, Frère, Ufeb, Aneb, etc.)	46	34.0

A total of 134 participants responded to the survey. Out of these, **98.5% were female** and **1.5% were male**. The participants ranged from 17 to 54 years, with an average age of 27.6 years. The majority (75.3%) had completed secondary education or higher, while 19.4% had completed primary education, and 5.2% had no formal education. For marital status, 90.3% of participants were married or in a common-law union, 5.9% were never married or in a common-law union, 2.2% were widowed, and 1.5% were divorced or separated. Regarding occupation, among the 134 participants, 52.6% were engaged in paid jobs, 30.4% were non-employed, and 16.3% were students pursuing professional training activities.

AVAILABILITY OF SRH AND HIV/AIDS SERVICES IN SUPPORTED HEALTH FACILITIES

To assess the availability of SRH and HIV/AIDS services at the case study sites, we applied the WHO Service Availability and Readiness Assessment (SARA) framework (WHO, 2025). The assessment focused on two main components: **(a) service availability**, including the range of services offered as well as their operating days and hours; and **(b) implementation factors**, such as human resources (midwives, nurses, and

community health workers), supplies and logistics (e.g. physical environment, essential medicines, and clean delivery kits), and key insights for the referral systems.

Availability of SRH and HIV services

To determine whether a health service is considered *available*, we assessed if the following criteria were met for essential SRH and HIV-related services across the assessed health facilities (WHO, 2017; UNFPA, 2019; Ministry of Health, 2021):

i. **Service is provided on-site and functional** during regular hours.
ii. **Staff are trained** to deliver the service.
iii. **Essential supplies, medications, and equipment** are in place.
iv. **At least one service point offers the intervention consistently during operating days and hours**.
v. **The referral system is functional** (for services that are not fully available at the point of care).

Table 4 below presents the availability of 18 key SRH and HIV-related services across the assessed health facilities, providing a comprehensive overview of service accessibility and identifying critical gaps in the current service package. The 18 selected SRH and HIV services were defined through a structured review of global, regional, and national guidance for essential SRH and HIV services in primary care (WHO 2017, WHO, 2021, WHO, UNFPA, UNHRC & UNAIDS, 2017) and the CAR's national service delivery package, which outlines a minimum set of interventions tailored to primary health centres (Ministère de la Santé et de la Population, 2021). This selection was further informed by systematic reviews identifying high-impact interventions as effective in improving maternal and child health outcomes in low-resource contexts (Chersich et al., 2016; Singh et al., 2018; Lindegren et al., 2012).

Table 4: Availability of critical SRH and HIV/AIDS-related healthcare services at the two assessed health centres (N=18)

Service (N=18)	Available	
	Boy Rabe Health Centre	Bédè Combattant Health Centre
Counselling on all modern contraceptive methods (short-acting, long-acting, emergency)	Inconsistent	Inconsistent
Family Planning provision of methods (at least three modern options)	Inconsistent	Inconsistent
Functional referral pathway for long-acting/permanent methods (IUDs, sterilization)	No	No
Antenatal Care (ANC): at least four visits, screening for anemia, syphilis, HIV, malaria prevention (IPTp), tetanus vaccination	Yes	Yes
Skilled Birth Attendance: midwife or trained provider managing normal deliveries	Yes	Yes

Emergency obstetric first aid (stabilization, referral readiness)	Yes	Yes
Newborn care: thermal protection, cord care, breastfeeding support	Yes	Yes
Functional pathway for obstetric and neonatal complications	Yes	Yes
Postnatal Care (PNC): maternal and newborn checkups within 48 hours and up to 6 weeks	Yes	Yes
Immunization: Tetanus for mother, BCG and OPV for newborns	Yes	Yes
HIV Testing Services (HTS): routine offer during ANC, TB, and STI consultations	Yes	Yes
Prevention of Mother-to-Child Transmission (PMTCT): HIV testing, ARV prophylaxis, infant feeding counselling	Yes	Yes
ART initiation and follow-up	Yes	Yes
Syndromic management of STIs	Inconsistent	Inconsistent
TB screening (especially for PLHIV)	Yes	Yes
Clinical management of rape survivors (Emergency contraception, STI prophylaxis, PEP (post-exposure prophylaxis for HIV), Wound care, pregnancy testing, Psychological first aid, and confidential referral for psychosocial and legal assistance)	No	No
Cervical Cancer Screening	No	No
Functional referral pathway for complicated HIV/TB cases	Yes	Yes

Based on WHO and UNFPA standards (WHO, 2017; UNFPA, 2019), a service was considered available "Yes" if it was provided on-site with trained personnel, supplies, and consistent functionality. **The overall level of accessibility is 72.2%, indicating that about 7 out of every 10 key SRH/HIV services were consistently available in both assessed health centres, with notable gaps in areas such as comprehensive family planning, GBV response, STI management, and cancer screening.**

Among the available services, the decentralization initiative plays a critical role in strengthening the delivery of targeted interventions at the assessed health centres. At both case study sites, the initiative supports key SRH services such as maternity care, family planning, and referral systems for obstetric and neonatal complications. Notably, at the Bédè Combattant Health Centre, it also facilitates the delivery of comprehensive HIV/TB services, including index testing and PITC, ART initiation and follow-up, HIV/TB laboratory monitoring and treatment, and referral for advanced HIV disease. While it supports routine HIV testing during the first antenatal care (ANC) visit at the Boy Rabe Health Centre.

By strategically focusing on these targeted areas, the initiative aims to strengthen service delivery in domains directly linked to the leading causes of maternal and newborn mortality around the time of birth and HIV/AIDS-related deaths in Bangui. A key informant from MSF put this forward:

> *"The choice of services offered [by MSF] is a strategic operational choice not to be lost in the activities. For example, going to support the ANC is true that it is a good thing, but we risk having a very large volume of activities to manage. We also wanted to leave some activities for the health facilities [MOH] to manage, and during sessions of coordination, we [MSF] see how to help them improve."*

The decentralization initiative also includes community health outreach activities to educate the population on HIV, family planning, and maternal health. These efforts are designed to improve awareness and increase the availability and uptake of family planning services at the community level, particularly in underserved areas. By engaging community health workers and promoting informed decision-making, the initiative seeks to address access barriers and strengthen demand for reproductive health services outside the facility settings.

> *"At the community, our job [MSF health promotion agents] involves training traditional birth attendants and providing them with the resources/materials they need to provide contraception at the community clinics, educating the women who attend the community clinics on HIV-prevention and contraception. We also work together with local stakeholders who help us to identify ideal spots to construct the local clinics, and MSF provides the logistics……The activities we carry out in the community are very much accepted and appreciated by the communities."*

Staff presence and qualifications, and technical support

The assessment revealed adequate staffing levels and trained personnel at both assessed health facilities to provide quality care. Each facility had at minimum one physician, one trained midwife, one nurse, and one HIV counsellor on-site—meeting WHO and national standards for essential HIV and maternal health service delivery, which recommend the presence of these key cadres to ensure integrated, person-cantered care.

In addition, the assessment revealed that staff received regular technical support, including in-service training and on-site mentorship. This support, provided by MSF teams, aimed to strengthen their clinical skills, reinforce adherence to protocols and clinical guidelines in place, and improve the overall quality of maternal and HIV-related service delivery

Further, key clinical guidelines and protocols were also in place and prominently displayed to ensure standardized care and procedures. These included, among others, HIV testing protocol procedures for the triage, pregnancy danger signs, an algorithm for the management of patients with high viral load, and criteria for transferral of patients to the CHUC.

However, we observed a lack of standardized procedures and clear guidelines for some key interventions within the decentralization initiative. Most notably, there was an absence of SOPs for the systematic tracking of HIV positive clients who interrupt treatment or are lost to follow-up. This was compounded by the lack of a dedicated logbook or digital tool to document follow-up actions and outcomes, making it difficult to ensure accountability and continuity of care. These gaps were particularly evident for the

tracking of HIV positive adolescents, male and exposed infants, a group that faces unique barriers to remaining engaged in HIV care.

Another significant gap identified during the assessment is the lack of clinical guidelines specifically tailored to the SRH needs of adolescents. While general SRH protocols are in place, they often overlook the unique developmental, emotional, and social factors that influence adolescent health-seeking behaviour and care needs. This absence of age-appropriate clinical guidance limits the capacity of healthcare providers to deliver safe, confidential, and responsive services to adolescents, particularly in areas such as contraception counselling, STI management, and menstrual health.

Equally concerning is the lack of adolescent-friendly communication tools. Health workers reported the absence of visual aids such as infographics, illustrated counselling materials, and simplified decision-making charts that could help engage young clients more effectively. In low-literacy settings or where health education is limited as this is the case in Bangui, such tools are essential for improving comprehension, building trust, and encouraging service uptake.

> *"We don't have any visual materials or tools to help explain things to adolescents—no infographics, no illustrated guides. It's hard to keep them engaged, especially when they're shy or don't understand the medical terms. We really need tools that speak their language."* [Healthcare provider]

Physical environment

To assess the physical environment of the health facility, we applied a structured evaluation framework focused on key aspects essential for quality care delivery. Specifically, participants were asked to rate their satisfaction with three core infrastructure elements—availability of clean toilets, clean water, and electricity—as well as their experience of confidentiality and privacy during service delivery.

Findings indicate that the assessed health facility provides an appropriate and supportive physical environment, with adequate access to water, sanitation, and energy. Respondents noted that these conditions contributed to maintaining confidentiality and privacy during consultations, which in turn fostered greater trust between patients and healthcare providers and encouraged service uptake.

Among the 130 participants who responded, a large majority (87.7%) reported being very satisfied with the facility's physical environment, while 9.2% were somewhat satisfied, and only 3.1% expressed dissatisfaction. Regarding confidentiality and privacy, 91.7% of participants reported being very satisfied, 6.1% were somewhat satisfied, and 2.3% indicated they were not. These results highlight the positive impact of a well-maintained and private clinical setting on client experience and service utilization.

Similar findings were obtained from the in-depth interviews, where participants expressed their satisfaction with the health facility environment, health personnel's respect for confidentiality, and humanity. However, some participants nuanced that not all attending personnel respected the privacy of clients as such.

> *"For me, the return is really satisfying. Because they [health personnel] speak to us normally, they respect us, give us privacy, and treat us like we matter."* [HIV service user]

"There are some [health personnel] who welcome us well, and respect our privacy, but others talk to us rudely, for example, when we ask for something" [ANC service user]

Figure 4 below depicts the clients 'overall satisfaction with the physical environment across the assessed health facility.

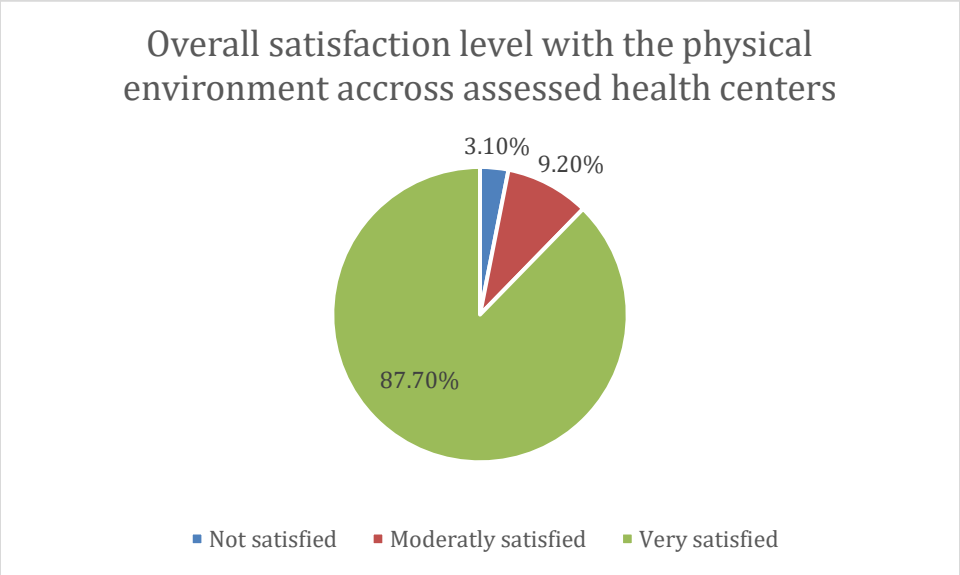


Figure 4: Overall satisfaction with the physical environment of the health facility (N=130)

Equipment and supplies

Besides, both assessed facilities had functional equipment such as delivery beds, hemoglobin photometer (to measure blood hemoglobin levels), and glucometer and creatinine analyser (to analyse blood sugar and creatinine levels). While the PIMA machine for CD4 testing and was available at Boy Rabe and fetal cardiac ultrasound machines were available at Bede Combattant where the decentralization initiative supports a comprehensive package of SRH and HIV/AIDS services. In addition, a transportation system was put in place to transport samples for viral load testing to the Institut Louis Pasteur in Bangui.

Key medicines such as oxytocin for preventing and treating postpartum hemorrhage, magnesium sulfate for managing pre-eclampsia and eclampsia, and iron-folic acid supplements for preventing anemia during pregnancy were considered for maternal health. Other essential maternal health medicines included **sulfadoxine-pyrimethamine** for malaria prevention during pregnancy, **misoprostol** for the management of incomplete abortions and hemorrhage, and antibiotics such as **ampicillin** and **gentamicin** for treating infections. For HIV services, the assessment looked at the availability of first-line antiretroviral drugs such as **tenofovir**, **lamivudine**, and **dolutegravir**, as well as pediatric formulations, **nevirapine** or **zidovudine (AZT)** for the PMTCT, and **cotrimoxazole** for the prevention of opportunistic infections. **Isoniazid** was also included as a key medicine for tuberculosis prevention in PLVIH.

These tracer medicines for HIV were essentially in stock across the assessed facilities, with minimal reports of stock-outs during the last month preceding the assessment. Where stock-outs did occur, they were short in duration—typically lasting less than seven days—indicating relatively stable supply chain

performance during the reporting period. Those HIV tracer medicines were dispensed at no cost at both assessed health facilities.

In contrast, significant and more persistent gaps were observed in the availability of key SRH tracer medicines. Notably, there were recurrent shortages of sulfadoxine-pyrimethamine, used for malaria prevention in pregnancy; iron-folic acid supplements, essential for preventing maternal anemia; antibiotics for the syndromic management of STIs; and post-rape kits, which are critical for providing timely care to survivors of sexual violence. These stock-outs were not only more frequent but also tended to last longer—often exceeding one to two weeks—disrupting the continuity of essential SRH services. The prolonged unavailability of these commodities compromises the quality and availability of antenatal care, STI treatment, and gender-based violence response, within the two assessed health centres.

Referral and counter-referral systems for emergency

The decentralization initiative ensures that every woman, newborn, and HIV/AIDS patient with condition(s) that cannot be dealt with effectively with the available resources at the assessed health centres is appropriately referred.

We observed that a functional referral system was in place 24 hours a day, 7 days a week, as part of the decentralization initiative. This referral system follows a pre-established plan that can be implemented without delay, ensuring the transfer of emergencies to the CHUC for specialized care and the management of obstetrical complications.

> *"MSF has put in place a referral system for cases of complications during delivery to be referred to CHUC [referral hospital]. They [MSF] trained the staff on the criteria for referral and pasted the SOP [standard operating procedure] on the wall of the delivery room, and all the midwives adhere to this."* [MOH respondent]

Programmatic data from the decentralization initiative reinforce these findings, demonstrating the consistent functionality and reliability of referral mechanisms across the supported health facilities. This is illustrated in Figure 5 below, which depicts the operational reach and responsiveness of the referral system.

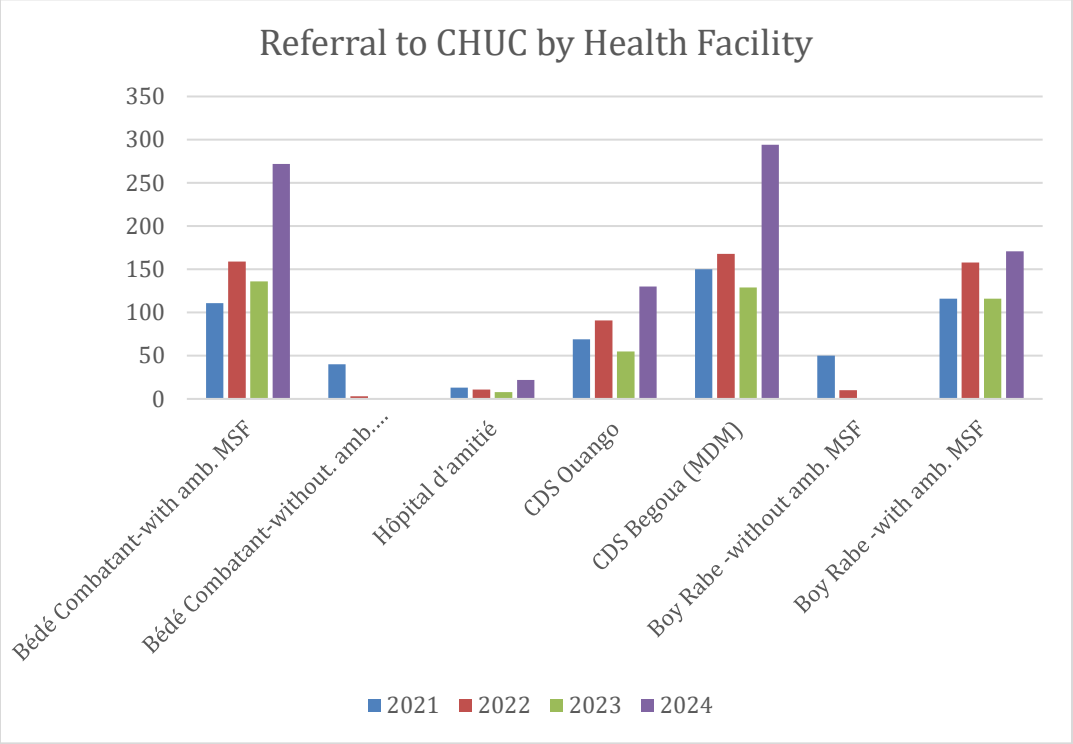


Figure 5: Annual referrals to CHUC by Health Facility

Figure 5 above shows a gradual increase in the annual trend from 2021 to 2024 of the number of complicated cases referred to CHUC per health facility. The results also show that only a small proportion of the referrals are made without the use of MSF's ambulance, and the trend is decreasing from 2021 to 2024.

Among the indications for referral to CHUC, obstetric complications were among the leading causes for referral across all three years. For example, in 2024, prolonged labour contributed up to 35% of referrals, and obstructed labour accounted for about 10% of referrals. This was closely followed by abortion treatment, which also made up about 10% of total referrals in 2024 (Fig. 6).

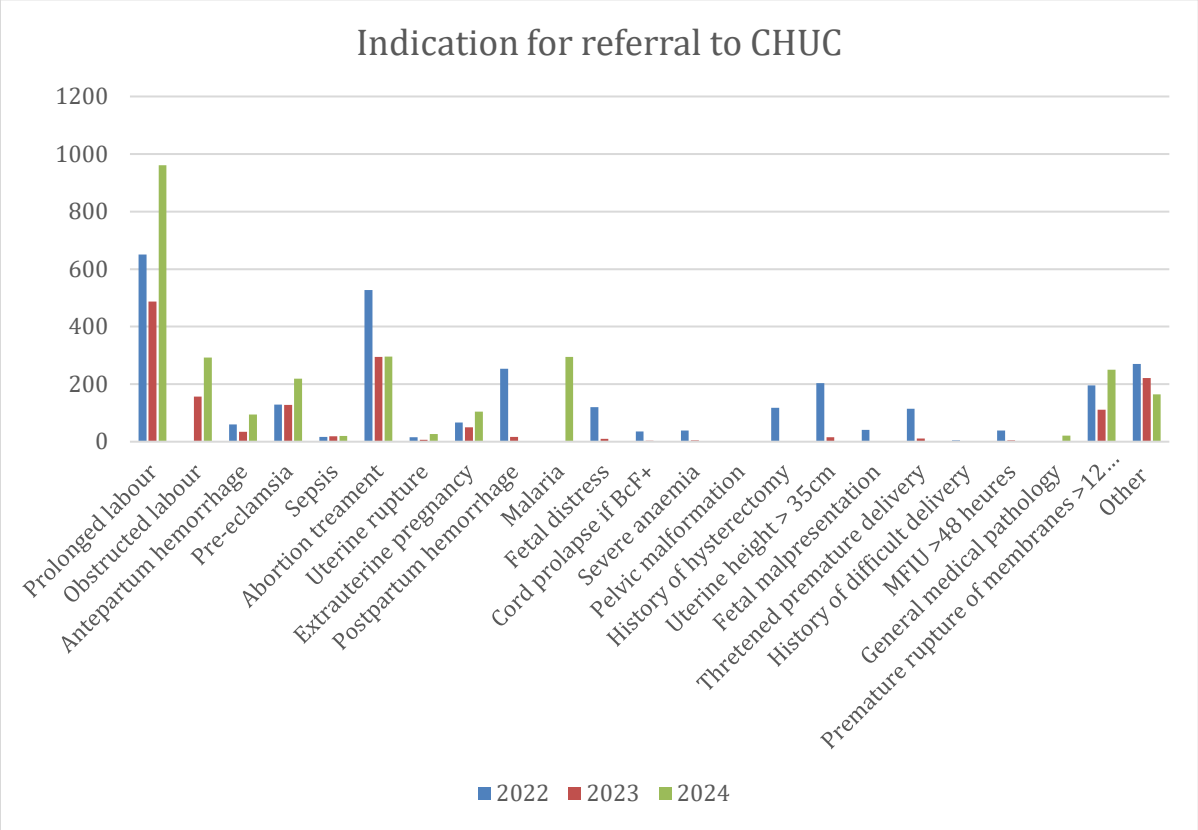


Figure 6: Indicators for referral to CHUC

However, there is limited evidence of a functioning counter-referral system between the assessed health facility and the designated referral (the CHUC). In most cases, there was no evidence of a formalized mechanism for information exchange or feedback from the CHUC to the originating facilities. As a result, frontline healthcare staff often remain unaware of the outcomes of the patients they refer, hindering continuity of care, follow-up, and shared clinical decision-making.

> *"MSF trained us on the criteria for referral, and it [the SOP] is pasted in the delivery room for every midwife to see, but no document is sent to us after referral. Usually, we will call the next day to find out. For example, I was told this morning by phone that the parturient we referred yesterday died on arrival"* [MOH respondent-midwife]

This lack of cross-communication mechanism can lead to fragmented care, repeated diagnostics, delayed interventions, and missed opportunities to strengthen trust and collaboration across different health system levels, particularly for PLVIH, who require continuous follow-up.

Overall, these findings indicate that the foundational elements necessary for effective SRH and HIV service delivery were largely in place, enabling the assessed health facilities to respond to the needs of their target populations. The decentralization initiative played a pivotal role, not only in supporting the direct provision of key SRH and HIV/AIDS services, but also in establishing a supportive physical environment and reinforcing essential service delivery systems. Nevertheless, significant gaps persist in areas such as comprehensive family planning, GBV response, STI management, and cancer screening. Furthermore, there is a need to strengthen the supply chain mechanism, communication across referral systems at

different levels of the healthcare system in Bangui, as well as to improve the tracking of clients lost to follow-up to ensure continuity and quality of care.

ACCESSIBILITY OF SRH AND HIV SERVICES

To assess the accessibility of SRH and HIV services at assessed health centres, the evaluation considered multiple factors influencing whether individuals could obtain the care they needed in a timely and acceptable manner. This included (1) the physical proximity of health facilities to the communities they served, and (2) the delivery of care without prolonged waiting times. Additionally, the assessment reviewed (3) whether services were offered free of charge or if costs represented a financial barrier to access. Consideration was also given to (4) the cultural and provider-related factors influencing comfort and acceptability of care (e.g. Provider gender, respectful treatment), (5) awareness of available services and sources of health information, and (6) the utilization and uptake of services, including the extent to which counselling led to decisions. These criteria reflect how health services are organized and delivered and how clients understand and engage with the services.

Physical proximity of health facilities to the communities served

Travel time, mode of transport, and proximity to residence were used to examine the physical accessibility of the two assessed health centres. Slightly more than half of the participants (54.9%) reported that the facility where they received services was the closest to their residence, while 45.1% indicated they bypassed nearer facilities. Among the 133 respondents, 47.4% reported reaching the health facility in under 30 minutes, and 41.4% reported reaching the health facility in 30 minutes to 1 hour. Only 11.3% reported travel times exceeding one hour. Regarding transportation, 57.5% accessed care on foot, suggesting that **many clients lived within walking distance of the two assessed health centres.**

These findings generally align with global norms, including WHO guidance (WHO, 2017), which considers health services reasonably accessible if they are located within 30 minutes' walking distance or less than 5 kilometres.

However, the fact that nearly half of the respondents did not use their nearest facility, and that 42.5% relied on paid transportations, suggests the consistent preference of clients for MSF-supported facilities, even when these are not the closest options. As shown in Table 5, despite living nearer to other health facilities, participants (n=60) chose MSF-supported sites due to factors such as better quality of care, availability of medicines, shorter wait times, and more respectful treatment, highlighting a higher acceptability and perceived reliability of care in the assessed health centres.

Table 5: Factors influencing clients to bypass nearby facilities in favour of MSF-supported sites (N=60 participants)

Reason	Frequency	Percentage
Preferred the providers at this health facility	27	45%
This facility is more comfortable (e.g., spacious waiting area, better temperature)	13	22%
Less crowded / shorter waiting times	11	18%

Reason	Frequency	Percentage
Closer to work/school	7	12%
Farther but easier to access (transport, road conditions, etc.)	7	12%
Referred to this facility by another provider	3	5%
More likely to have needed medicines	5	8%
Offers all necessary services in one place	3	5%
It is less likely for the family to know about the visit	1	2%
More likely to have needed equipment (e.g., imaging, testing)	1	2%

Similarly, clients expressed satisfaction with the attitude and care provided by healthcare providers in MSF-supported health facilities. Some clients said:

> *"I like coming here [Bede Combatant] because the staff are very welcoming and respect the ethics of their work"* [Client 1]

> *"I like it each time I come here [Boy Rabe] because the midwives are very welcoming and have a mastery of their work*" [Client 4]

MOH staff also affirmed that they receive clients who prefer to bypass nearby health facilities to come to MSF-supported health facilities.

> *"Some pregnant women we receive leave from their health area to come here [Boy Rabe]. For example, I received a woman who was 35km away who came here [Boy Rabe], and when I asked them, they said they are used to being here and feel welcomed here. Even though there is the Begoua hospital that is closer to them, they abandon it to come here because of the quality of care."* [MOH respondent]

Service Utilization Patterns and Perceived Accessibility

To understand service utilization patterns, participants were asked to report the number of services they accessed during their visit to the health facility. The majority (83.6%) reported accessing only one service, while smaller proportions accessed two (11.9%), three (2.2%), or four services (1.5%). Notably, only one participant (0.7%) reported receiving as many as ten services. These findings suggest that service use was predominantly limited to single-service visits, indicating targeted, issue-specific care-seeking behaviour or a lack of integration in service delivery at the assessed facilities.

Table 6: Number of services accessed per client during most recent health facility visit (N=134)

Service	Frequency	Percentage
Antenatal care	107	79.9%
Postnatal care	9	6.7%
Delivery services	12	9.0%
HIV counselling/testing	13	9.7%
HIV treatment/care	12	9.0%
STI services	6	4.5%
Family planning	6	4.5%
GBV services	2	1.5%
PMTCT for children	1	0.7%
Pharmacy only	1	0.7%
Laboratory only	2	1.5%

According to healthcare providers at the assessed facilities, the integration of HIV services—particularly testing, ART, and PMTCT—into routine maternal health care remains limited. While essential services such as ANC, PNC, and HIV testing are consistently available at both sites, providers reported that the delivery of comprehensive, integrated care is hindered by the separate organization of services, a shortage of cross-trained staff, and inconsistent availability of commodities. They noted that this fragmentation undermines continuity of care for pregnant women and poses a barrier to achieving key outcomes, including effective PMTCT and improved access to family planning.

> *"Another challenge we are facing now is in terms of human resources. You know, initially, the HIV and SRH projects were separate projects that were brought together. In doing so, the number of health facilities and interventions for SRH and IPC (Infection Prevention and Control) increased. Still, paradoxically, the number of healthcare providers of MSF has reduced, and now you find one person fitting in all the domains, undermining the quality of services. For example, some aspects of care, like the IPC, are completely dormant in some health facilities, and one will question if they exist."* [MSF respondent]

> *"In MSF, we have had periods of medication stock out, which extended to the health facilities and negatively impacted the service availability. It was among one of our major challenges, but it is a little better now"* [MSF respondent]

Satisfaction with waiting time today and stigma

Participants were asked to rate their satisfaction with the waiting time before receiving services. The vast majority (90.2%) reported being very satisfied, 9.1% were somewhat satisfied, and only 0.8% expressed dissatisfaction. Data from the client observation flow showed that on average, clients waited approximately one hour before receiving services. However, for first-time visits—particularly initial

antenatal care appointments and HIV treatment initiation—the waiting time could extend up to three hours, due to the additional time required for comprehensive assessments and counseling. Despite these longer wait times for initial visits, overall satisfaction with service delivery remained high.

In our qualitative analysis, some participants mentioned the perceived lower nurse-to-patient ratio as a probable reason for the long wait times.

> *"...sometimes we arrive and there are many patients, and the nurses are just two of them, so we have to wait"* [ANC attending client].

While healthcare providers pointed to the limited integration of HIV testing into ANC as a possible bottleneck, further discussions revealed that the current service model requires pregnant women attending their first ANC visit to undergo HIV testing in a separate ward. This testing is conducted by psychosocial support agents ("agents de soutien psychosocial") who are specifically trained and remunerated by MSF. One provider explained:

> "We cannot do the HIV test directly in the ANC consultation. The women are sent to the psychosocial agent who is trained to provide pre- and post-test counselling. They also referred to ART initiation where relevant. This takes time, and sometimes women are reluctant to go to another room."

This separation of services, while ensuring dedicated counselling, was reported to contribute not only to delays but also to stigma. Clients identified and directed to a different location for HIV testing may feel singled out, which can create fear or embarrassment. In some cases, this perceived lack of confidentiality and increased visibility within the facility discouraged women from completing the testing process or returning for follow-up. Healthcare workers noted instances of **discontinuation of care**, especially among women newly diagnosed with HIV, who felt their status might be exposed. As one provider noted, *"Some women do not come back after their first visit—they feel like they've been marked."* This underlines the need to strengthen integration and discretion within ANC services to improve uptake of and retention to HIV care.

Comfort with a provider of the opposite sex

Regarding participants' comfort with receiving care from a provider of the opposite sex, most (97.0%) of the 134 respondents reported feeling comfortable, while only 3.0% expressed discomfort. Similar findings were obtained from the interviews with service users where they reported satisfaction with the services provided by the healthcare professionals no matter their sex. One pregnant woman expressed this as such:

> *"The personnel of this health facility [Bede Combatant] are very welcoming and provide us with quality care reason why I am comfortable coming here. Sometimes it is a man providing services and sometimes it is a woman they all master their work"*

Types of expenses incurred during the health facility visit and their perceived affordability

To assess the financial burden of accessing care, participants were asked to report any expenses incurred during their visit to the health facility. The most frequently reported cost was for consultation services (64.7%), followed by diagnostic tests (60.9%), medications (32.3%), transportation (18.8%), and miscellaneous items (16.5%). In the assessed health centres, the median total cost of accessing care was estimated at approximately 10,000 CFA francs (about 15.24 euros). In contrast, notably, 13.5% of participants indicated they did not incur any costs.

Among those who selected "Other" expenses, the most commonly mentioned items were urine test and patient record book, each typically costing 500 FCFA (≈ 0.76 EUR). A few participants also reported higher-cost items such as echography (ultrasound) at 4,000–4,500 FCFA (≈ 6.10–6.86 EUR). Additional consultation fees were reported, including a "pregnancy confirmatory test" charged at 500 FCFA, along with medication costs ranging from 5,000 to 8,000 FCFA (≈ 7.62–12.20 EUR).

To assess the affordability of incurred health service costs, participants were asked whether the costs were manageable. Out of the 116 participants who responded, 89.7% stated that the costs were affordable, 6.9% felt they were only somewhat affordable, and 3.4% said they were not.

This financial burden, even if reported as "affordable" by most respondents who utilized SRH and HIV/AIDS services on the interview day, can still create barriers to access, particularly for low-income individuals, and may deter continued or timely use of essential health services.

Awareness of services offered at the health centre

To assess community awareness of the services provided at the health facility, participants (n = 134) were asked to indicate whether they were aware of 14 specific services. Each response was recorded as a binary variable (1 = aware, 0 = unaware), and each service's total count and percentage were calculated accordingly.

Findings reveal a generally high level of awareness for core maternal and HIV-related services, with antenatal care (82.1%) being the most recognized, followed by delivery care (73.9%) and HIV care and treatment (72.4%). A moderate level of awareness (between 62% and 64%) was observed for postnatal care, STI screening and treatment, family planning, and tuberculosis services.

In contrast, awareness of more specialized services, particularly those focused on GBV (8.2%), PMTCT for children (6.0%), and services for children under five, such as nutrition, vaccination, growth monitoring, and developmental milestones (all 0.0%), was very low or non-existent. These gaps suggest a need for stronger communication efforts and outreach targeting services beyond routine maternal and HIV care.

Sources of information about health services

Participants were also asked how they became aware of the services offered at the health facility. The most commonly cited source was community health personnel, reported by more than half of respondents (54.5%). This was followed by health facility-based communication (19.4%), community sensitization activities (15.7%), and community meetings (9.7%).

Only a small proportion of participants either did not know (2.2%) or listed other sources (1.5%), which included self-discovery and word of mouth. Notably, no participants identified social media as a source of information, suggesting limited digital health communication engagement in the Bangui context.

Table 7: Reported sources of health service information among respondents (N=134)

Source of Information	Frequency	Percentage (%)
Community health personnel	73	54.5%
Health facility (e.g. health discussions)	26	19.4%
Community sensitization	21	15.7%
Community meetings	13	9.7%
Does not know	3	2.2%
Other (please specify)	2	1.5%
Social media	0	0%
Total	**134**	**100%**

These findings indicate that while awareness of core maternal and HIV services is relatively strong, significant gaps exist in community knowledge of services addressing GBV and child health. The reliance on community health personnel underscores their critical role in health communication, while the limited use of facility-led and digital communication points to missed opportunities for outreach and education. While the initiative currently conducts community outreach, there is a clear need to strengthen and better target these communication efforts to ensure more equitable access to information, particularly for underrepresented service areas such as GBV response, child health, and PMTCT for children.

Accessing accurate information on SRH and HIV services

Contraception services

Clients reported limited access to accurate and timely information on SRH and HIV services. While some clients received information during their facility visits (41.1%), primarily through brief counselling or health talks in waiting areas, a larger proportion indicated they did not (58.9%).

Further, according to the respondents, these interactions were often inconsistent and dependent on staff availability. So, amongst the participants who reported discussing modern contraceptive methods during their visit, they were asked to clarify who initiated the conversation. Among the 54 participants who answered this question, 83.3% stated that the provider initiated the discussion about family planning, while 16.7% said they brought it up themselves.

Decision to use a contraceptive method after counselling (n=53)

Among the 53 participants who discussed family planning with a provider and were asked if they decided to start using a contraceptive method after the counselling, 49.1% indicated they had already begun using one, while 45.3% planned to start later. Only 5.7% had not made the decision to initiate a method.

Table 8: Impact of counselling on the decision to initiate family planning

Response	Frequency	Percentage
(0) No, I did not start	3	6%
(1) Yes, I started today	26	49%
(2) Yes, but I will start later	24	45%

Service uptake following the contraceptive counselling

Among the 25 participants who had decided to start using contraception after counselling, 84.0% reported that the same provider who counselled them also provided the method. Meanwhile, 12.0% were referred to another provider within the same clinic, and 4.0% were referred to a provider at a different clinic.

Table 9: Service provision following contraceptive counselling (n=25)

Response	Frequency	Percentage
(1) Provided you with a method of contraception	21	84%
(2) Directed you to another provider at this health centre	3	12%
(3) referred you to another health facility	1	4%

HIV counselling and services (n=132)

To assess if HIV-related topics were discussed during facility visits, participants were asked whether they had addressed issues related to HIV counselling and services. Analysis shows that 93.2% of participants reported having this discussion, while 6.8% did not.

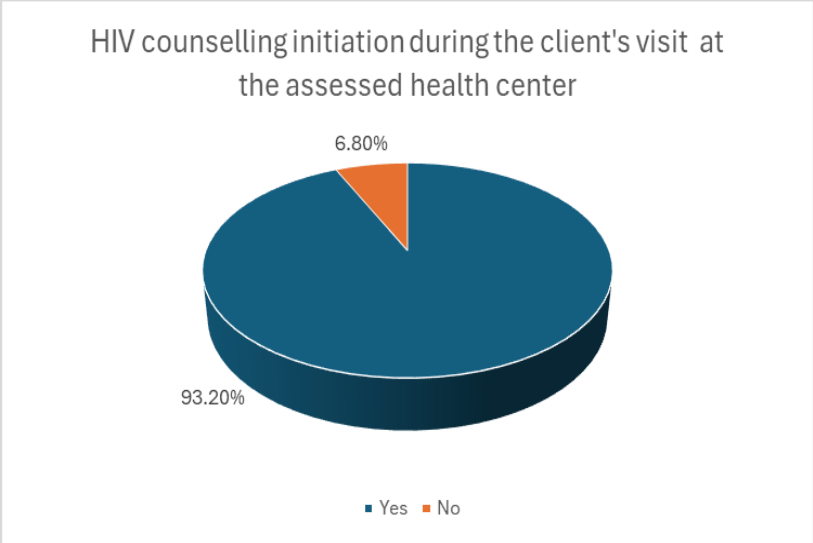


Figure 7: HIV counselling during the client's visit

Initiation of HIV counselling and testing discussion (n=122)

Among participants who reported discussing HIV during their visit, 90.2% indicated that the provider initiated the conversation on HIV counselling and testing. Meanwhile, 9.8% of participants reported initiating the discussion themselves.

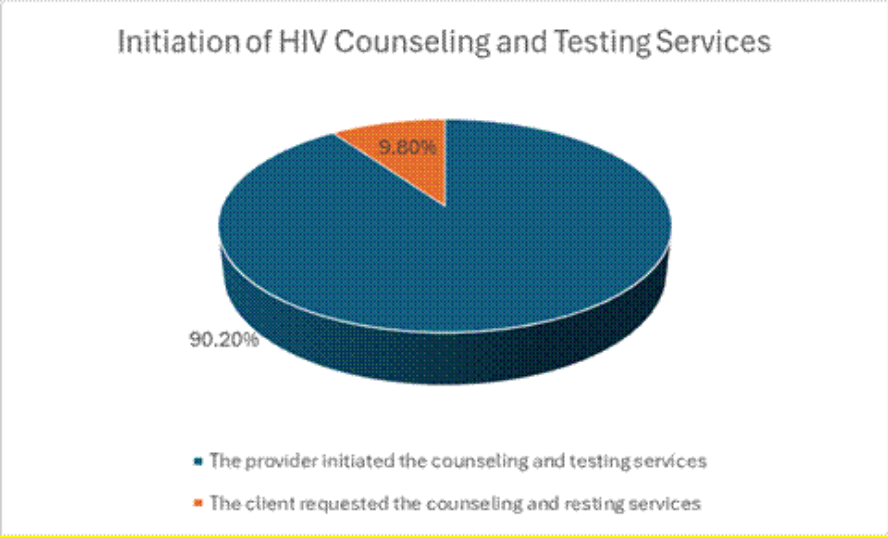


Figure 8: Initiation of HIV counselling discussions during health centre visits

Decision to undergo HIV testing after counselling (n=123)

Following HIV counselling, 37.4% of participants reported that they had taken an HIV test the same day, and 18.7% planned to take the test later. A small proportion (2.4%) decided against testing. Notably, 41.5% indicated that they had already done it.

Table 10: Decision to undergo HIV testing after counselling (n=123)

Response	Frequency	Percentage
(1) Yes, I took the test today	46	37.4%
(2) Yes, I will take it later	23	18.7%
(0) No	3	2.4%
(88) Already done the text	51	41.5%
Total	**123**	**100.0%**

Accessibility of community outreach and impact on services uptake

To assess community awareness about HIV testing through the community outreach activities, participants were asked whether they had heard messages about the importance of knowing one's HIV status or getting tested before coming to the health facility. Among the 133 participants, 67.7% reported having heard such messages in their community, while 32.3% had not.

Among participants who had heard about HIV services in their community, the majority (58.9%) reported being informed by other community health workers, followed by 17.8% through community health workers linked to the Bangui project, and 15.6% via radio. Only a small portion cited MSF staff (4.4%), TV (2.2%), or other unspecified sources (1.1%) as their primary information source.

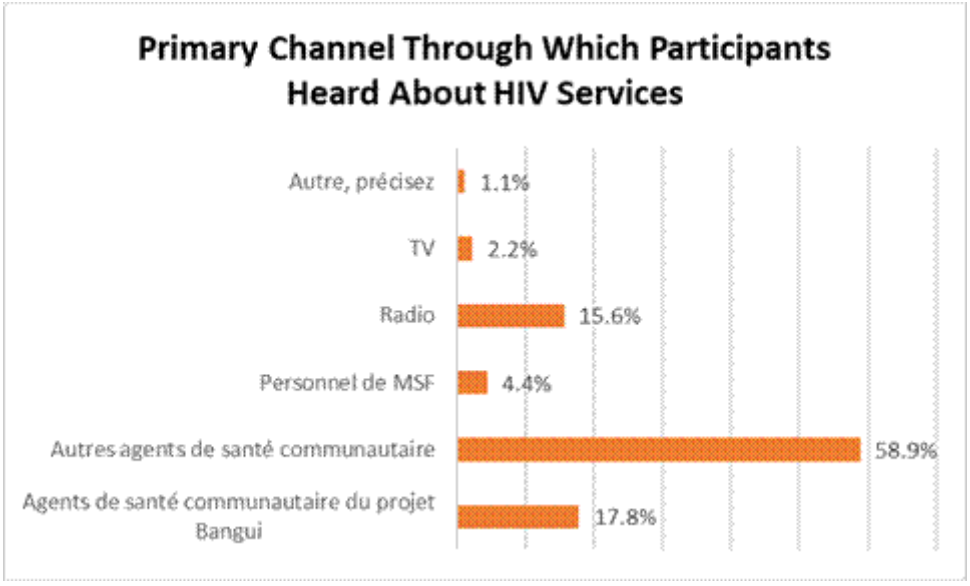


Figure 9: Primary channel through which participants heard about HIV services

Conversely, respondents noted gaps in the availability of printed materials, visual aids, and adolescent-friendly communication tools. Providers acknowledged that misinformation, stigma, and a lack of sustained education efforts contributed to poor awareness, especially among adolescents and underserved populations. A health promotion staff put it as such:

> *"We [MSF health promotion staff] also carryout community sensitization activities for family planning and HIV prevention, however, there is still a lot of stigma around HIV and people prefer to rely on information they here from the community and shy away from hospital-related programs."*

Reported influence of community outreach messages on contraceptive intentions and the uptake of HIV/AIDs services

Participants who reported hearing messages in their community about the importance of knowing one's HIV status (n=90) were asked whether these messages influenced their decision to seek HIV-related services. A majority (73.3%) said the messages increased their willingness to obtain such services, while 26.7% reported that they discouraged them.

Similarly, among participants who had heard community messages about contraception, 64.3% reported that these messages increased their willingness to begin using a method, while 35.7% said the messages reduced their willingness.

EVALUATING EFFECTIVENESS: ANALYSING KEY SRH AND HIV INDICATORS AND OUTCOMES

Maternal and child health outcomes

To estimate maternal and child health outcomes at the decentralisation health facilities, outcomes of referrals from the decentralisation health facilities received at CHUC were analysed. This provides a proxy of the effectiveness of the activities carried out at the decentralization health facilities, including referrals and counter-referrals.

Maternal and neonatal mortality trends from 2022 to December 2024 within the Project Bangui-supported Health Centres

The outcomes of women with obstetric emergencies referred to CHUC were analysed and presented annually and per MSF and non-MSF supporting health facility. The data analysed was obtained from the BDD_Obstetricals_SONUC_V2 for 2022, BDD_Obstetricals_SONUC_V2.1 for 2023, and 2024 from the BBD_Obstetricale_CHUC databases. Figures 10 and Table 11 provide details of outcomes on maternal mortality trends from all health facilities (MSF versus non-MSF supported), while table 12 and figure 11 provide details on neonatal mortality trends. Details of the health facilities supported by MSF are in Appendix 2.

Table 11: Maternal mortality trends at the CHUC (2022–2024)

Year	Health facility	Number of women referred to CHUC	Number of deaths among women referred to CHUC		Total deaths	% deaths (total deaths/number of women received)
			<24 hours	>24 hours		
2022	MSF supported	633	2	0	2	0.32
	Non-MSF supported	1764	11	1	12	0.68
	Spontaneous referrals, other, and blanks	7044	13	7	20	0.28
2023	MSF supported	424	1	0	1	0.24
	Non-MSF supported	1284	7	3	10	0.78
	Spontaneous referrals, other, and blanks	2185	8	9	17	0.78
2024	MSF supported	636	5	3	8	1.26
	Non-MSF supported	2668	10	7	17	0.64

	Spontaneous referrals, other, and blanks	3934	6	8	14	0.36
Total		**20,572**	**63**	**34**	**101**	

The data on maternal deaths have increased significantly over the years, with total deaths (within and after 24 hours of admission) rising from 2 in 2022 to 8 in 2024, among MSF-supported health facilities.

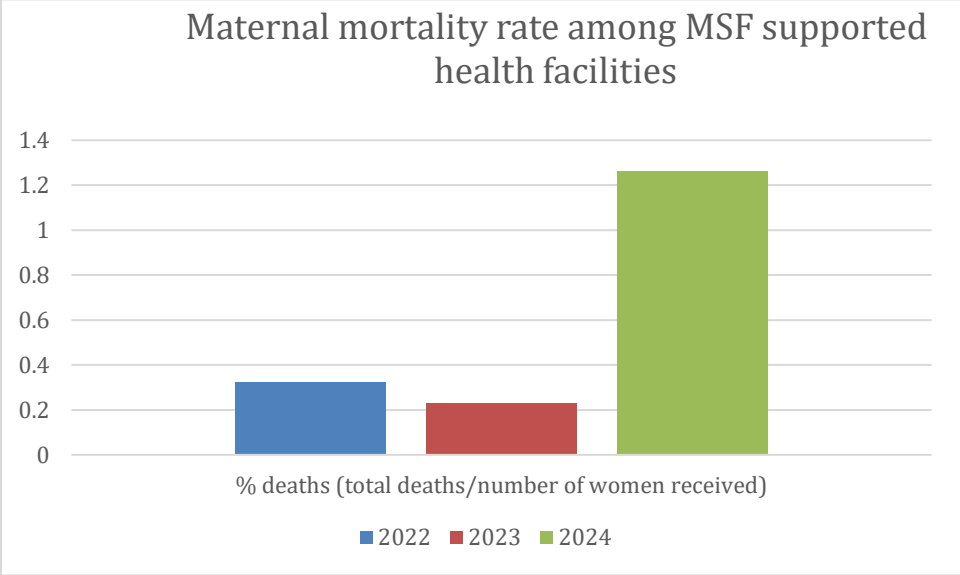


Figure 10: Maternal mortality rate among MSF-supported health facilities

The trend in the maternal mortality rate among MSF-supported health facilities from 2022 to 2024 indicate a worrying deterioration in outcomes, particularly in 2024. After a modest decline in the mortality rate in 2023 (from 0.32% in 2022 to 0.23% in 2023), 2024 saw a sharp increase to 1.26%, marking the highest mortality rate over the three years. A significant portion of these deaths occurred within the first 24 hours of admission, which strongly suggests delays in women accessing care, possible late referrals, or insufficient emergency obstetric response capacity at the facility level. This pattern may also reflect increased case severity at admission, highlighting systemic weaknesses in community-level health-seeking behaviour and primary-level detection and referral.

Table 12: Neonatal mortality trends from 2022 to 2024 among the MSF supported health facilities

	2022	2023	2024
Marcerated fetal death	5	7	7
Fetal death (fetal heart rate present at admission)	9	5	11
Fetal death (fetal heart rate absent at admission)	25	19	27
Death between 12 and 24hours after delivery	0	1	2
Death <12hours after delivery	3	0	2
Death 24 hours and 7 days after delivery	1	0	0
Total deaths	**43**	**32**	**49**
Number of births	633	424	636
Neonatal death rate % (total deaths/births)*100	6.80%	7.5	7.7

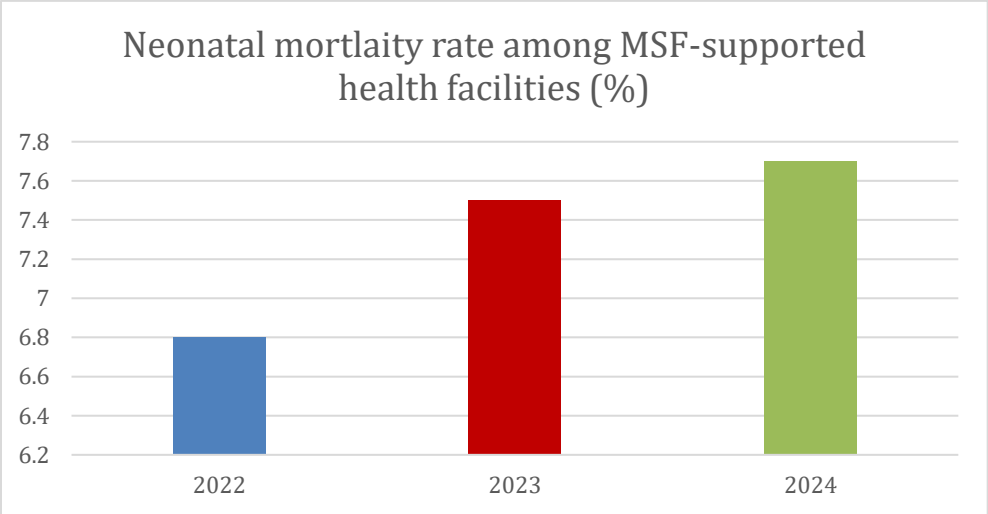


Figure 11: Neonatal mortality rate among MSF-supported health facilities

Similarly, Table 12 and Figure 11 show concerns in the rising rate of neonatal deaths among children born from mothers referred to CHUC from the decentralisation health facilities from 6.8% in 2022, to 7.5% in 2023 to 7.7% in 2024. Moreover, majority of the deaths were from women who presented with already absent foetal heart rates on admission at CHUC. These trends raise concerns about the functionality of the referral system and portray possible critical gaps in emergency triage, timely referrals, and management of obstetric emergencies among MSF-supported decentralisation health facilities.

Together, the maternal and neonatal mortality trends suggest that despite the initiative's effort in reducing maternal and neonatal mortality, critical gaps remain in emergency obstetric care, timely triage, and system-wide coordination, all of which are essential to reversing the rise in maternal and neonatal mortality.

Newborn vaccination, including BCG, Polio, and Hepatitis B

Like the maternal and neonatal mortality, data on newborn vaccination was obtained from the BDD data captured at CHUC. To obtain a proxy of the vaccination coverage among the decentralisation health facilities, the vaccination rate of babies of mothers referred to CHUC was analysed and presented in figure 12 below.

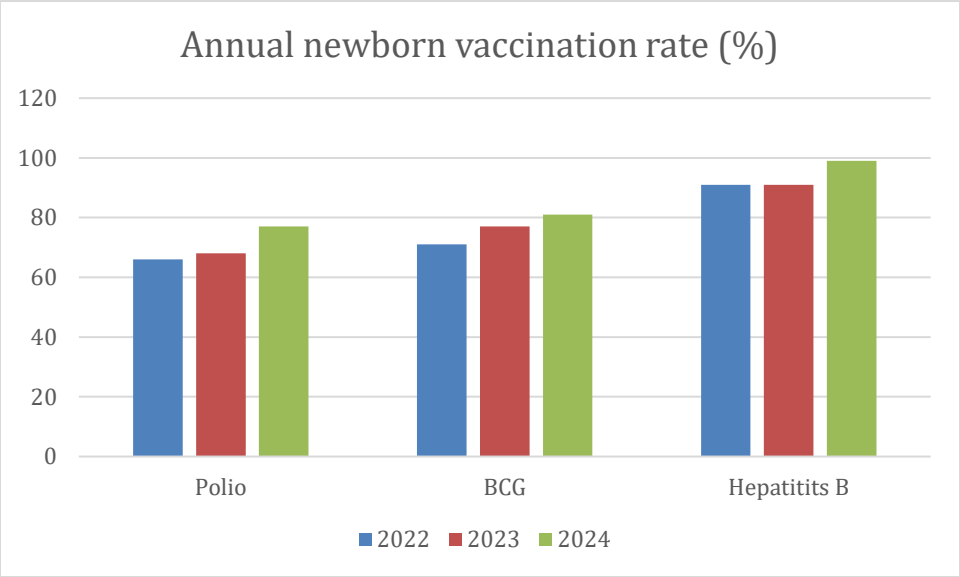


Figure 12: Newborn vaccination coverage

The newborn vaccination rate from 2022 to 2024 though not optimal shows a slight increase in coverage for all 3 vaccines (Polio, BCG, and Hepatitis B vaccines) from 2022 to 2024. Hepatitis B vaccine had the highest vaccination coverage for all 3 years (91% in 2022 and 2023, and 99% in 2024), followed by BCG (71% in 2022, 77% in 2023 and 81% in 2024) and then Polio (66% in 2022, 68% in 2023 and 77% in 2024). Though this trend shows slight increase in vaccination coverage, significant gaps persist especially for Polio and BCG vaccines, pointing to immunity gaps among newborns, increasing the risk of vaccine-preventable diseases and emphasizing the need for catch-up immunization efforts, strengthened service delivery, and improved integration of newborn care within the broader maternal and child health system.

HIV/AIDS care and support

TX_CURR: This indicator represents the proportion of individuals who are currently receiving ART (TX_CURR) at the health facilities supported by the decentralization initiative.

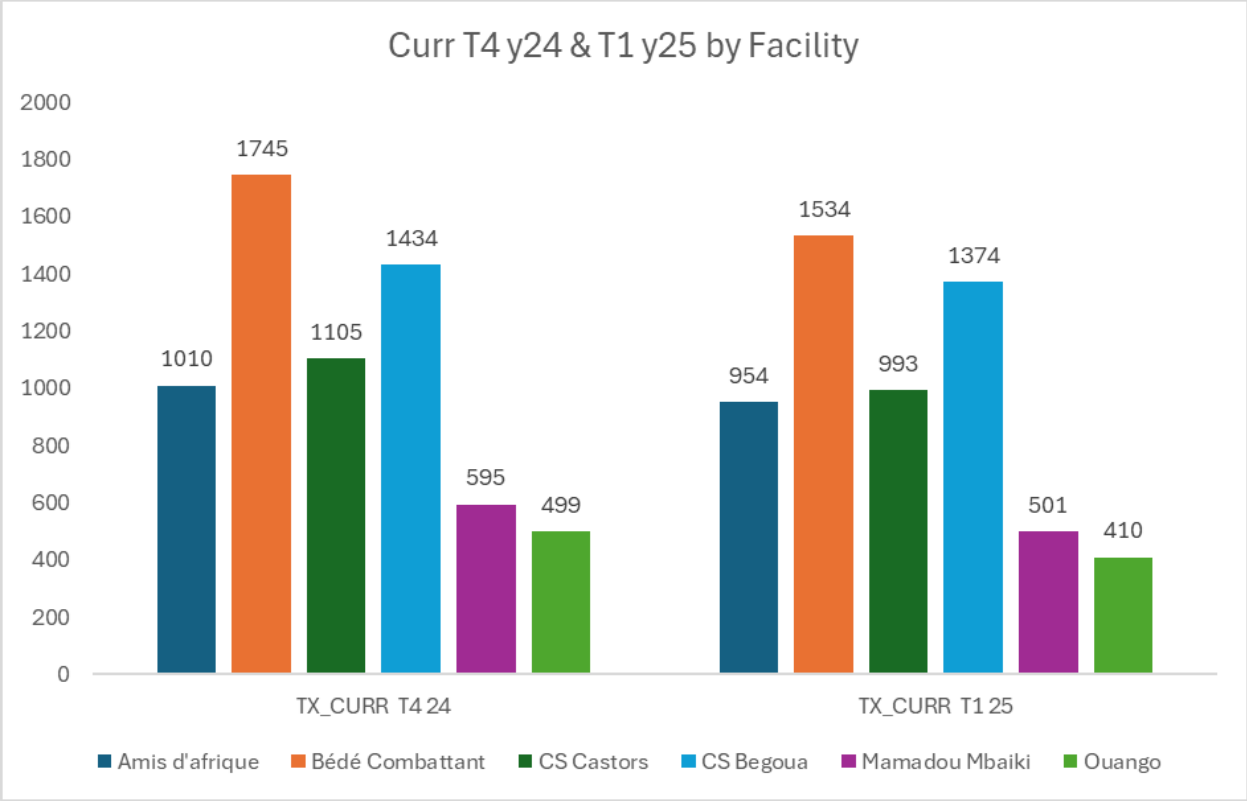


Figure 13: Number of individuals currently on antiretroviral therapy (ART), disaggregated by facility across various reporting periods from 2023 (T1–T4), 2024 (T1–T4), and into the first quarter of 2025 (T1)

Across all facilities, there is a consistent decline in TX_CURR values from T4 24 to T1 25, indicating a net loss of patients actively receiving ART. Bédé Combattant, the largest facility by volume, experienced a notable drop from 1,745 to 1,534 patients, while CS Begoua decreased slightly from 1,434 to 1,374. Amis d'Afrique and CS Castors also recorded declines, with reductions of 56 and 112 patients respectively. Mamadou Mbaiki dropped from 595 to 501, and Ouango saw the most significant relative decrease, falling from 499 to 410—a nearly 18% loss.

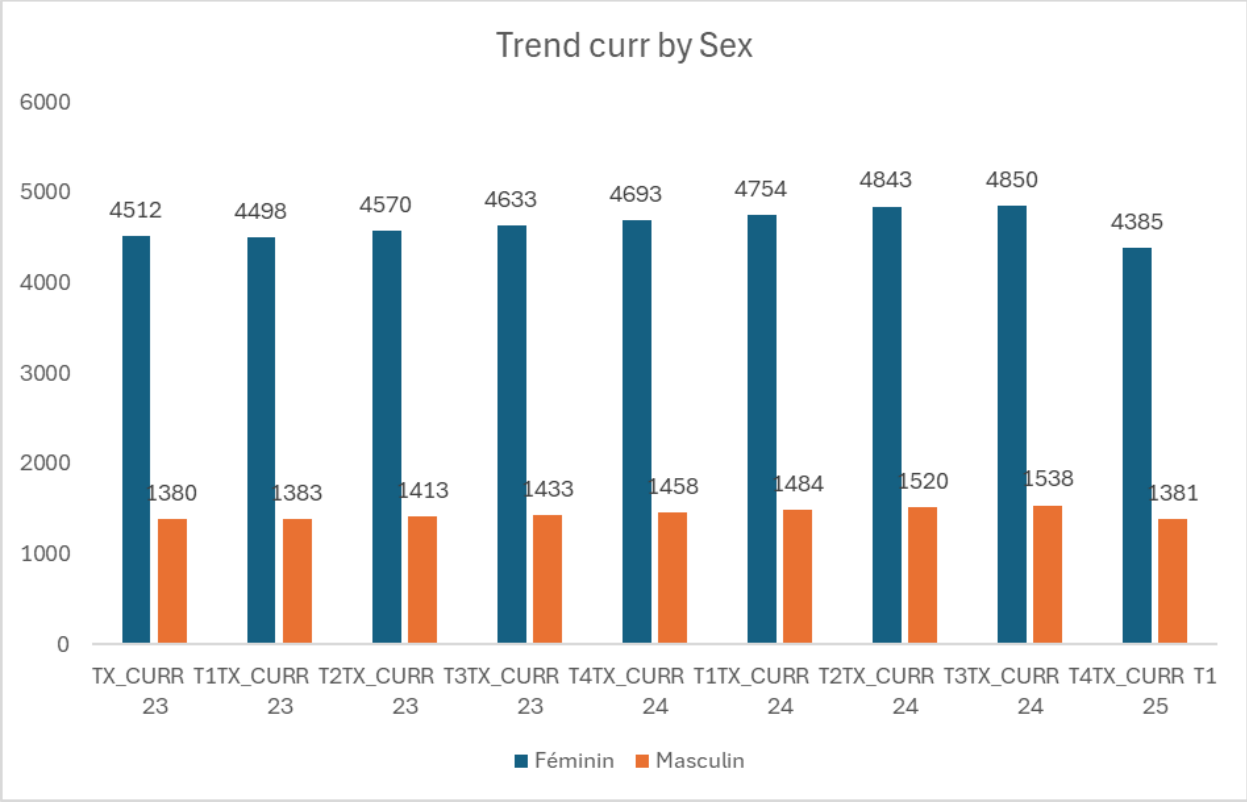
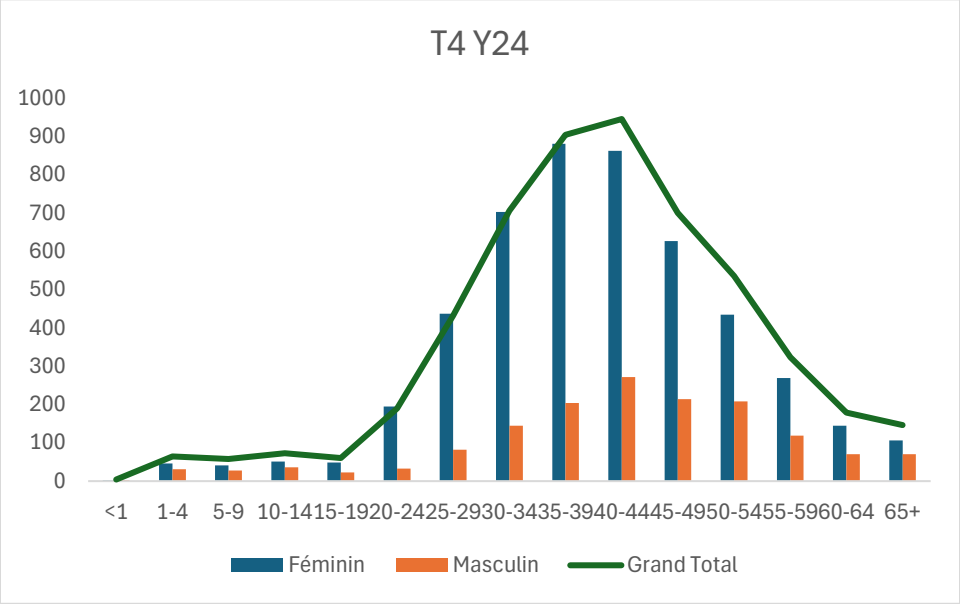


Figure 14: Number of individuals currently on antiretroviral therapy (ART), disaggregated by gender, across various reporting periods from 2023 (T1–T4), 2024 (T1–T4), and into the first quarter of 2025 (T1)

The data on ART enrolment trends by sex from 2023 to early 2025 reveals a consistent pattern of higher female participation than male. Across all quarters, women represent the majority of individuals currently on treatment, likely due to their more frequent interaction with health services through antenatal and reproductive health programs. From early 2023 to late 2024, there is a steady increase in ART enrolment for both sexes, with female clients rising from 4,512 to a peak of 4,850 and male clients increasing more modestly from 1,380 to 1,538. However, both groups decline in the first quarter of 2025, with female numbers dropping to 4,385 and male to 1,381. This disparity is likely driven by stronger linkage to care through maternal and reproductive health services and greater health-seeking behaviour among women. Male enrolment remains relatively flat, indicating ongoing barriers such as stigma, late diagnosis, and reduced service engagement.



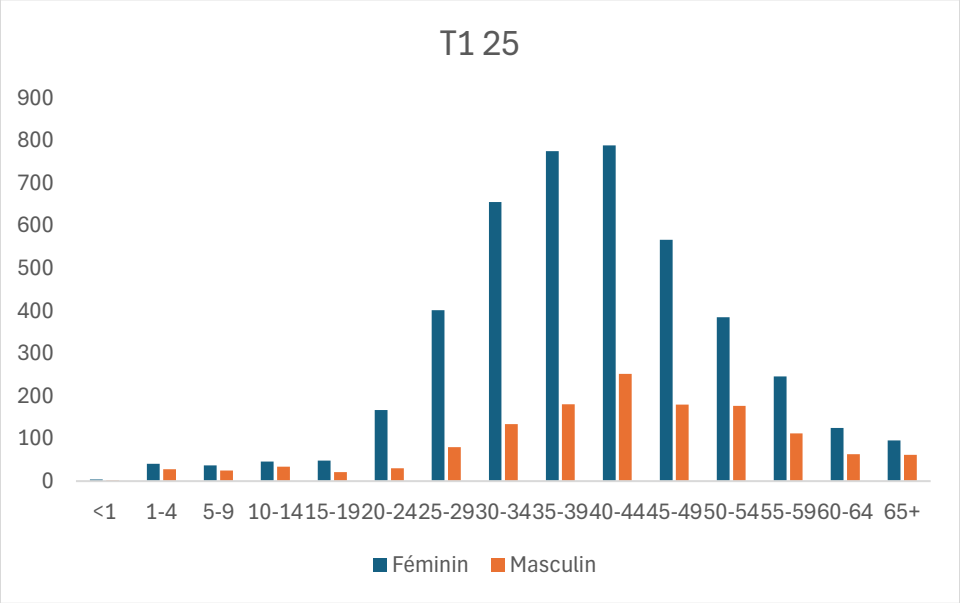


Figure 15: Number of individuals currently on antiretroviral therapy (ART), disaggregated by age, across various reporting periods from 2024 (T1–T4), and into the first quarter of 2025 (T1)

Age-disaggregated data further reveal that the majority of ART clients fall within the 25–49 age group, reflecting the demographic most affected by HIV and actively engaged in care. However, adolescent and young adult enrolment remains comparatively low, raising concerns about delayed diagnosis, insufficient youth-friendly services, or poor retention in this age cohort. Additionally, within the same age categories, male enrolment in ART remains lower than that of females. These findings underscore the need for age- and gender-sensitive interventions to enhance ART access and retention, particularly among men and younger populations.

TX_ML (Treatment mortality and loss)

This indicator measures the number of people previously on ART who are no longer actively receiving ART at the reporting site at the end of the reporting period, disaggregated by the reason for interruption. Analysis of the data revealed lower retention rates among specific sub-populations, notably among male and adolescent HIV-positive clients. These trends were further supported by insights from healthcare providers and clients themselves, who highlighted a range of barriers affecting continuity of care.

Male clients were often described as less engaged with routine health services, with one provider noting,

> *"Men only come when they are very sick. They don't like to wait or be seen at the clinic." Similarly, adolescents faced unique psychosocial challenges, including fear of disclosure, stigma from peers, and lack of tailored support. One adolescent client shared, "I stopped coming because I didn't want anyone at school to know. I didn't feel comfortable here."*

Healthcare workers also emphasized the absence of youth-friendly and male-focused services as contributing factors. *"We don't have a specific day or space for young people. They mix with adults and feel judged,"* explained a counsellor. These insights suggest that beyond clinical follow-up, sociocultural and structural issues play a significant role in ART interruption for these groups. Addressing these barriers through differentiated service delivery such as fast-track, peer support, and more confidential, inclusive environments is key to improving retention outcomes.

HIV/AIDS care and support outcomes

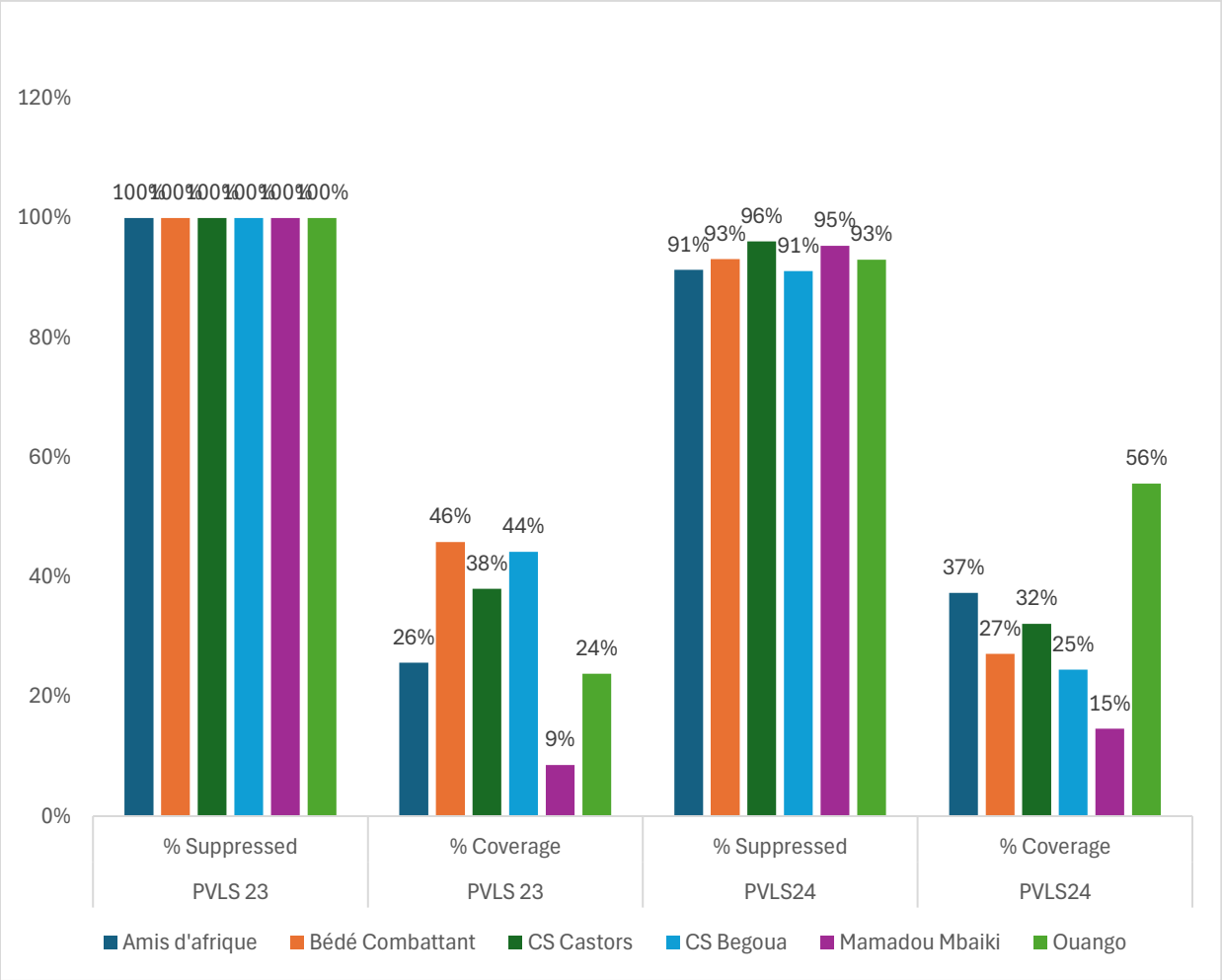


Figure 16: Number of patients experiencing interruption when in treatment for less than 6 months, disaggregated by gender and health facility, in 2023 and 2024, and T12025

Viral load coverage and suppression rates by facility from 2023 to 2024

Figure 17 reveals a significant disparity between viral load suppression and testing coverage across all health facilities. While the viral load suppression rate is impressively high, above 90%, this only reflects the outcomes among the small proportion of tested patients. With viral load testing coverage below 50%, most patients on antiretroviral therapy are not being monitored as recommended by national and international guidelines (WHO, 2021; Ministry of Health (CAR), 2023). This gap raises concerns about the representativeness of the suppression data and suggests that potential cases of treatment failure or poor adherence may go undetected. The findings highlight an urgent need to scale up viral load testing coverage to ensure equitable access to monitoring, improve treatment outcomes, and support timely clinical decision-making.

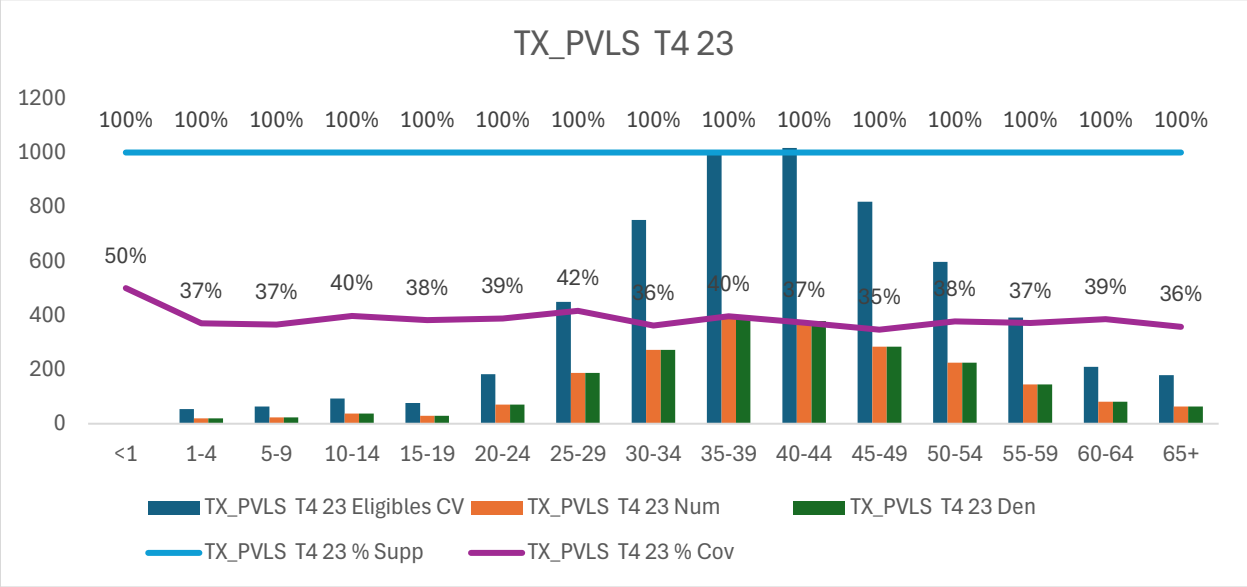


Figure 17: Viral load coverage and suppression rates by age in 2023 (T4)

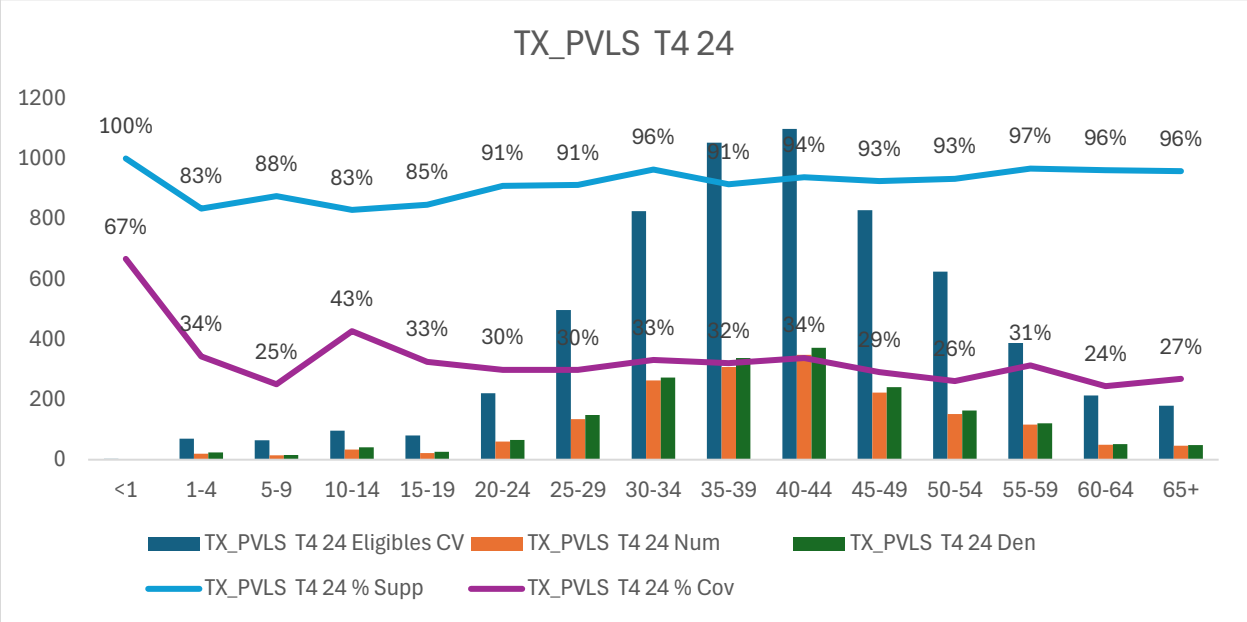


Figure 18: Viral load coverage and suppression rates by age in 2024 (T4)

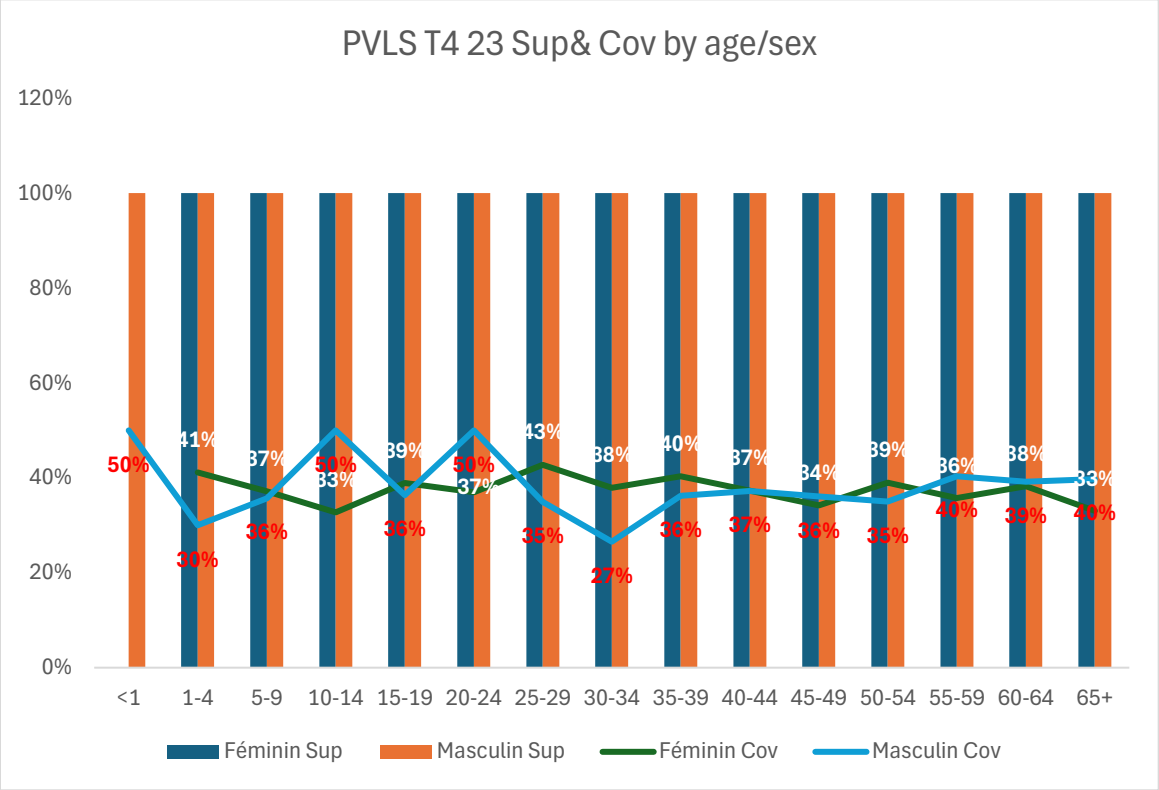


Figure 19: Viral load coverage and suppression rates by age and gender in T4 2023

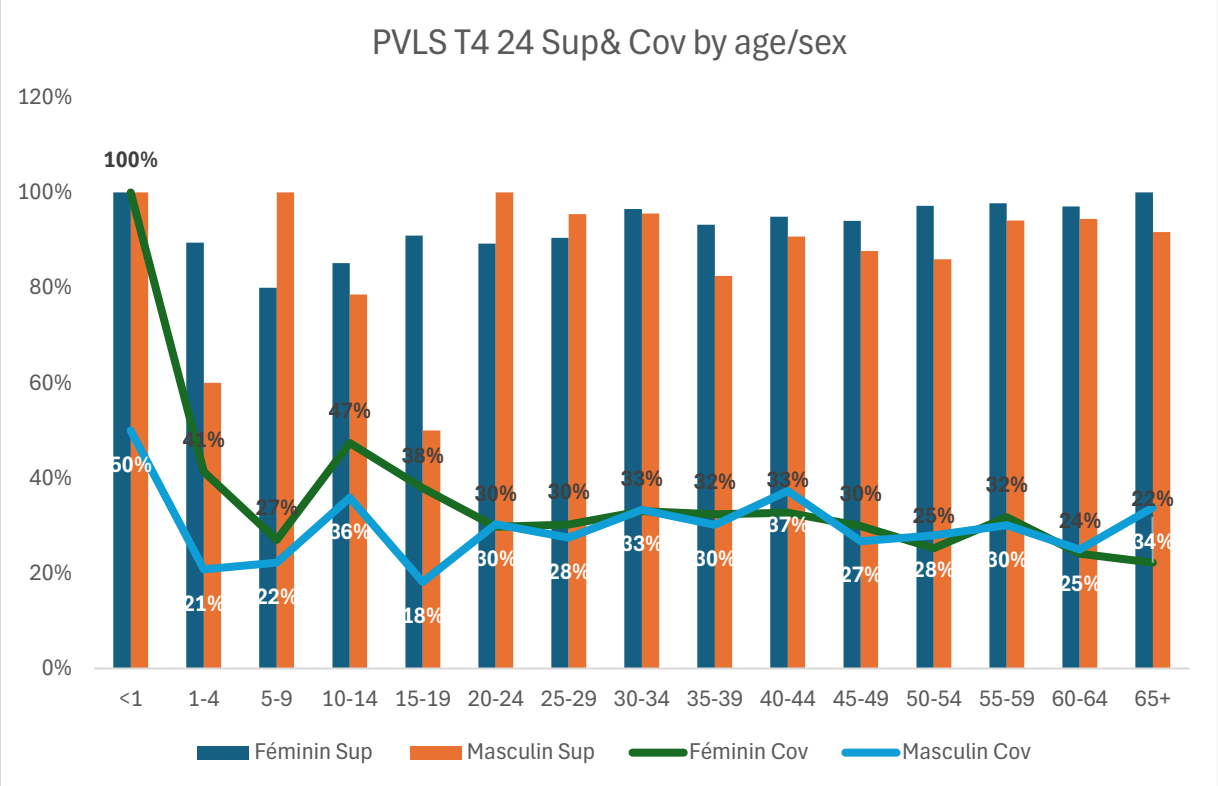


Figure 20: Viral load coverage and suppression rates by age and gender in T4 2024

HIV/AIDS and TB treatment outcomes

Effectiveness of TB screening and IPT in preventing TB-HIV co-infection

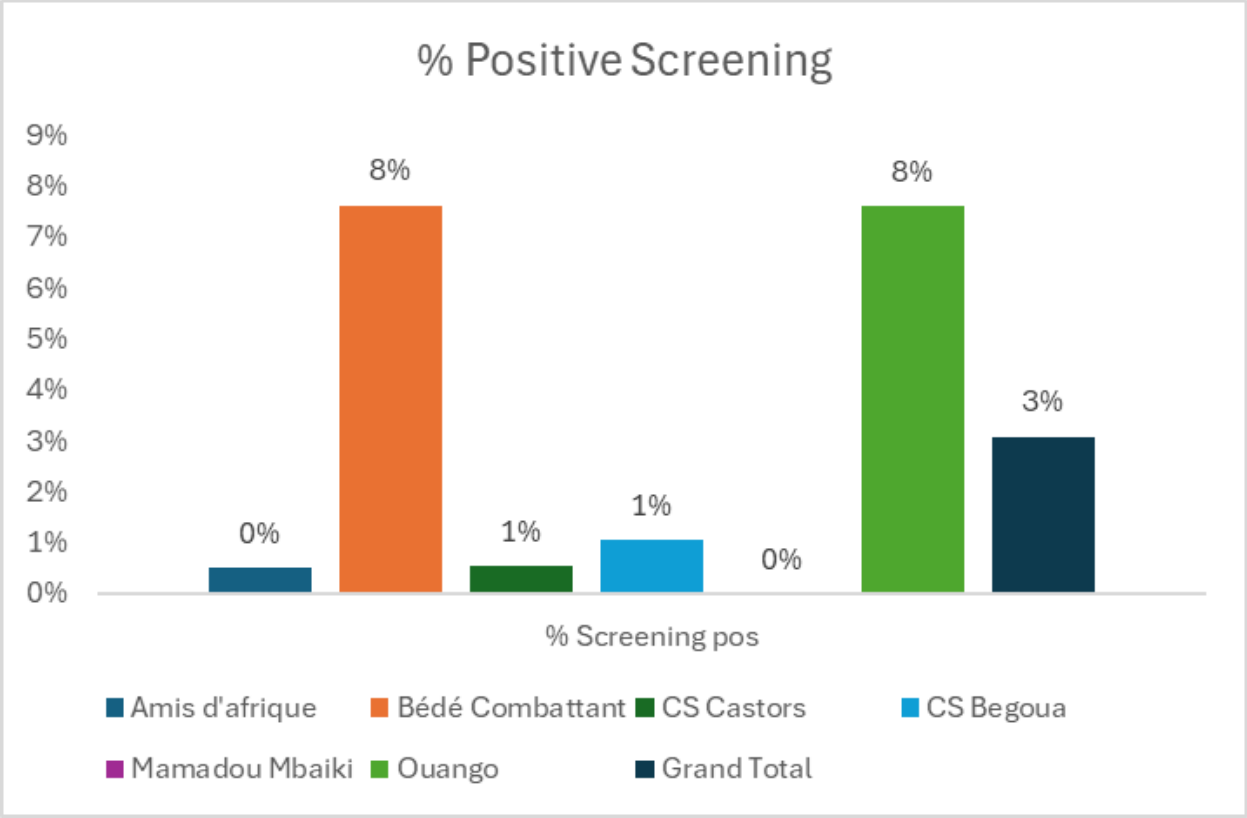


Figure 21: Viral load coverage and suppression rates by age and gender in T4 2024

These findings suggest that in 2024, the proportion of HIV-positive patients who were screened positive for TB remained below the threshold of 15%. This indicates a relatively low co-infection rate, suggesting that the majority of HIV-positive individuals do not have TB, or even a reporting issue. This outcome reflects the effectiveness of measures in controlling TB, such as the IPT, among this vulnerable population.

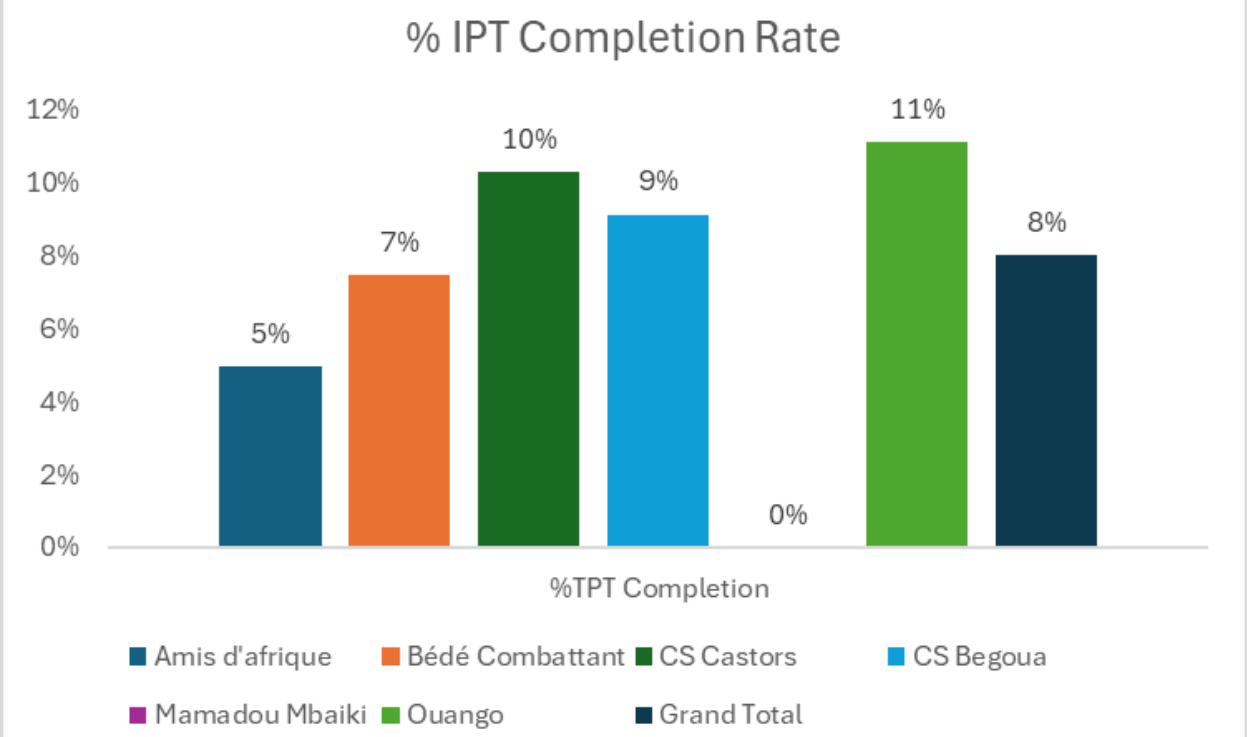


Figure 22: Completion rate for IPT (Isoniazid Preventive Therapy) among HIV-positive patients in 2024

The completion rate for IPT among HIV-positive patients was well below 100%, indicating that a substantial number of patients did not complete their TB preventive treatment. This could be due to various factors such as side effects, pill burden, lack of adherence support, or other barriers to completing the therapy, or even reporting issues.

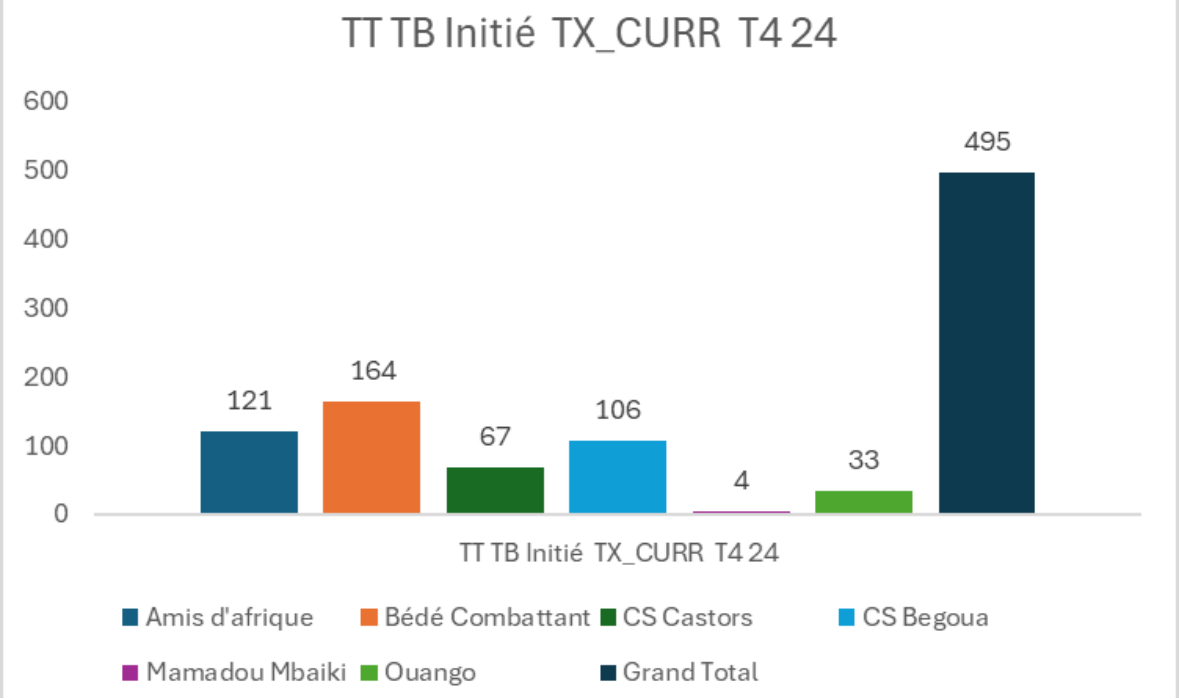


Figure 23: Number of HIV-positive clients enrolled in TB treatment in 2024

Figure 24 below describes the proportion of HIV-positive patients infected with tuberculosis who have completed TB treatment or have been confirmed cured from TB. To achieve these findings, only patients who started TB treatment before quarter 4 of 2024 were considered in the analysis, as they were assumed to have completed treatment on or before the end of quarter 1 of 2025 when the data was shared. The numerator comprised patients who had completed TB treatment or were marked as cured, and the denominator was all patients on TB treatment for that health facility during the period specified.

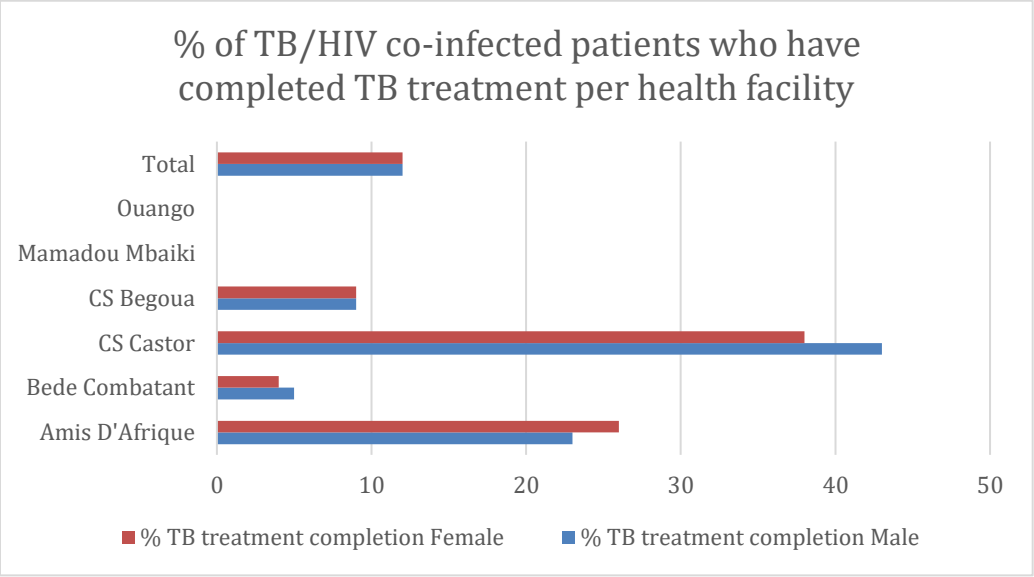


Figure 24: % of HIV/TB co-infected patients who have completed TB treatment or are cured from TB per health facility

Generally, for all the decentralised health facilities combined, the TB treatment completion rate among HIV/TB co-infected patients was well below 100% (12% for both males and females). Data disaggregated per health facility demonstrated higher treatment completion rates at CS Castor (43% in males and 38% in females) compared to Amis D'Afrique (23% in males and 26% in females), (Begoua (9% in both males and females), Bede Combattant (5% in males and 4% in females), and Ouango and Mamadou Mbaiki where there was no treatment completion recorded. This trend, like the IPT completion rate, could be due to several factors, including side effects from medications, pill burden, inadequate adherence support, or data capture issues.

EFFICIENCY

The evaluation team reframed this criterion to more accurately assess the efficiency of the decentralization initiative in service delivery rather than focusing solely on the efficiency of streamlining the two components of the Bangui Project, as initially outlined in ***Evaluation Question 7 of the ToR****. This reframing was informed by early interviews with the consultation group and preliminary insights from data collection. The revised criterion allows a more meaningful assessment of how effectively resources, systems, and partnerships have been leveraged to deliver essential SRH and HIV services at the decentralized level.*

AVAILABILITY OF ESSENTIAL MATERNAL AND NEWBORN HEALTH COMMODITIES

One key measure of service delivery efficiency is the availability of essential maternal and newborn health and HIV commodities, including oxytocin, magnesium sulfate, and clean delivery kits, as well as HIV testing kits and ART drugs. Data from supported facilities suggest improvements in commodity availability through strengthened procurement systems and buffer stock mechanisms; however, intermittent shortages were still reported, particularly during periods of high demand or logistical delays.

> *"MSF provides us with many medicines, including essential ones for our work. For example, ampicillin, if there's a case of water loss lasting more than 72 hours, oxytocin, gloves, etc. And I have a discharge book. But what we've noticed is that recently, there have been shortages. We've experienced shortages of certain medicines."*

REFERRAL SYSTEM FOR EMERGENCY SRH AND HIV CARE AND IMPROVED ACCESS TO LIFE-SAVING INTERVENTIONS

Another critical dimension of the efficiency of the decentralization initiative is the performance of the referral system between MSF-supported health centres and the CHUC. This system has reduced delays in emergency transfers, allowing for more timely access to life-saving interventions, particularly for obstetric complications such as hemorrhage and obstructed labour. Further, it has improved coordination and communication between primary care facilities and the referral hospital, supported by clearer protocols, designated focal points, and follow-up procedures.

> *"Another significant support from MSF is the referral of complicated obstetric cases. So, MSF has ambulances stationed at the community hospital. If we need to refer a woman in labour who has dystocia, we call the community hospital, and very quickly, they send us an ambulance to come and collect the patient. And that goes very well, and it helps a lot."* [MOH respondent]

EFFICIENCY OF SAMPLE TRANSPORTATION IN HEALTHCARE DELIVERY

Sample transportation is a key feature of the decentralization initiative to improve healthcare delivery. This system ensures that biological samples for viral load testing are efficiently transported from remote or decentralized health facilities to central laboratories (the Louis Pasteur Institute) for analysis. The rationale behind this system is to provide timely and accurate diagnostic services, which are crucial for effective patient management and treatment. According to the respondents, by reducing the time it takes for samples to reach laboratories, be processed, and returned, the initiative helps in quicker diagnosis and initiation of appropriate treatments, thereby improving patient outcomes.

> *"Another essential change we can talk about is the patient sample transport to and back to the Pasteur Institute, as well as retrieving the results to take them to the patients. MSF pays for the transportation, and the retrieving system is shortening the turnaround time of results."* [MSF Respondent]

Additionally, the system operates through a network of reliable transport services that follow optimized routes and schedules, ensuring cost efficiency and minimizing delays. This structured approach enhances healthcare delivery efficiency and supports the decentralization initiative's broader goals by making high-quality diagnostic services more accessible to underserved populations.

> *"MSF has put in place a system of transportation of viral load samples to the Institute Pasteur weekly from the other sites, and they [MSF] facilitate the transportation and, when needed, provide technical support to the laboratory team, like training and providing them with SOPs [Standards for Operational Procedures]".* [MOH Respondent]

According to our respondents, the transport system has shown increased reliability, with fewer delays and disruptions reported, ensuring that biological samples reach the laboratory promptly for analysis. Additionally, they underscored that efforts to optimize transport routes and consolidate trips have led to significant cost savings, reducing operational expenses while maintaining high service quality. Overall, these positive trends in sample transportation efficiency may have contributed to more effective healthcare delivery.

EFFICIENCY OF THE DECENTRALIZATION INITIATIVE IN PREVENTING TB AND HIV CO-INFECTION

According to respondents, the integration of the Pima machine for CD4 testing and TB-Lam for early TB diagnosis into service delivery at Bede Combattant has significantly improved TB case detection among people living with HIV. It has streamlined diagnostic processes and enabled clinicians to make timely, evidence-based decisions, contributing to more effective HIV and TB management and improved patient outcomes in this high-risk group.

> *"MSF has improved the care given to HIV patients by making available some machines that were not previously available, for example, the installation of Pima machines for CD4 testing at the health facilities"* [MSF respondent]

> *"MSF has made available reagents for TB LAM testing and tuberculosis screening, which has greatly reduced the turnaround time for TB diagnosis."*

Despite the positive portrayal and trends observed, several barriers hinder effective care delivery under the decentralization initiative. Firstly, the poor integration of HIV and SRH services, particularly in ANC, has led to increased client waiting times. Additionally, parallel reporting, supervision, and supply systems further complicate efficient and integrated care delivery.

LIMITED INTEGRATION OF SRH AND HIV/AIDS SERVICES: A BARRIER TO OPTIMAL SERVICE DELIVERY

Data from the client flow and interviews with healthcare providers from the case study sites have revealed that the poor integration of SRH and HIV/AIDS services presents a significant constraint to achieving optimal service delivery. This lack of integration was particularly evident in ANC, where the separation of services leads to increased waiting times for clients and fragmented care experiences. Our respondents

reported that pregnant women tested for HIV at the ANC ward often face multiple referrals from one provider to another and repeated visits, which delay the initiation of treatment and reduce the overall efficiency of healthcare delivery.

> *"We are happy for the good work MSF is doing, but we are having a problem with the care for pregnant women because we don't do HIV medications here; there's only the HIV testing kit. If a pregnant woman needs HIV medications, she will need to go to the treatment centre to see a doctor there or be referred to the other community centre if she needs HIV hospitalisation services"* [MOH respondent]

PRESENCE OF PARALLEL SYSTEMS FOR REPORTING, SUPERVISION, AND SUPPLY

One of the key efficiency challenges identified during the evaluation is the presence of parallel systems operated by different actors, most notably, MSF and the MoH. These parallel structures exist across several domains, including reporting, supervision, and supply chain management, and have led to operational inefficiencies at the facility level.

A particularly prominent example is in data collection and reporting for SRH and HIV services, pointed out by healthcare providers we interviewed. Healthcare providers at MSF-supported facilities stated they must collect and enter service delivery data into separate reporting systems—one for MSF and another for the MoH. These systems often use different indicators, formats, and reporting timelines, resulting in duplication of work and a significant administrative burden for frontline staff.

> *"MSF uses 'Tiernet' [the database] while the health facility [MOH] uses DHIS [the database] for reporting, which sometimes have different indicators. As a result, we [the health facility staff] have to fill out separate reporting sheets, and this creates supplementary work"* [MOH respondent]

They further highlighted that this duplication diverts time and attention away from patient care and contributes to reporting fatigue while also increasing the risk of inconsistencies or errors in the data. Sometimes, they must manually transfer the same information into two separate registers or digital platforms, with limited interoperability between the two systems. This fragmentation undermines overall data quality, completeness, and timeliness and can weaken the ability of both MSF and MoH to make informed, timely decisions based on harmonized service data.

> *"...MSF has also given us supplementary reporting sheets and registers that we have to fill out alongside the patient's file, and this increases our workload and the risk of errors. Sometimes we do not have enough time to properly counsel our clients."* [Psychosocial support staff]

Beyond reporting, key informants from the MOH argued that parallel supervision structures, where MSF and MoH conduct independent supervisory visits using different tools and approaches, can lead to mixed messaging, redundant oversight, and reduced clarity around accountability for the quality of care.

> *"...to conduct site supervisions, MSF goes out without our [MOH] knowledge. Sometimes we go to the facility and notice tools that we don't know about. Normally, this should be a joint activity so that the report is shared between parties [MOH and MSF] so that everyone is on the same page. ...However, since recently, they started inviting us for quarterly supervisions"* [MOH key informant]

EFFICIENCY OF CHWS AND PSYCHOSOCIAL AGENTS IN RE-ENGAGING LOST-TO-FOLLOW-UP (LTFU) CLIENTS

This assesses how effectively psychosocial support agents and CHWs reach and successfully return disengaged patients to care. To evaluate this, we analysed the average proportion of clients contacted (Figure 26) and the average proportion of those who returned to care monthly (Figure 27) between January 2024 and Q1 of 2025 per health facility. However, it should be noted that the proportion of clients who returned to care might not necessarily reflect a subset of those who were contacted during the period, as some might have returned to care on their own, or some patients who were contacted from previous periods might have returned to care during the period of analysis.

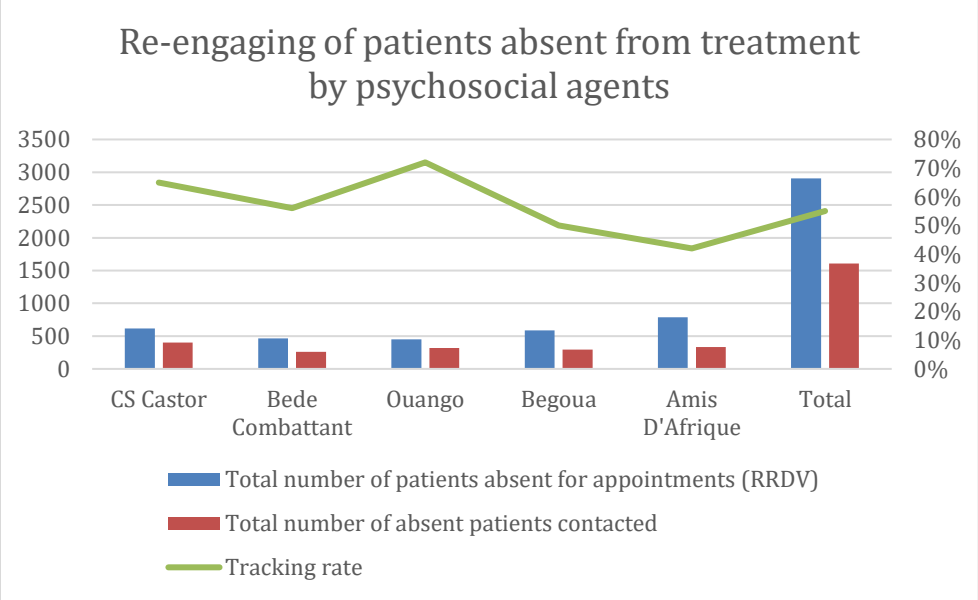


Figure 25: Re-engagement of patients absent from treatment by psychosocial support staff

Figure 25 above shows the average monthly rate of re-engagement of patients absent from treatment by psychosocial support staff per health facility between January 2024 to Q1 of 2025. In general, for all health facilities, about 55% of patients absent were contacted monthly. Analysis per health facility showed a similar trend, with the highest rate observed at Ouango (72%) and the lowest rate in Amis D'Afrique (42%). This rate of tracking is sub-optimal for successfully bringing back patients absent from treatment monthly and demonstrates a weakness in the initiative's efficiency in retaining patients in care.

Interviews with psychosocial support staff shed some light on why the re-engagement rate is not optimal, including the fact that they (the psychosocial support staff) only come to work few times a week, hence, those who show up to work are usually overworked and are not able to contact patients as often as they should. Moreover, they can only contact patients who are absent by phone, as MSF only provides a phone and airtime without any means to go out to the community to find those who are unreachable by phone. Furthermore, they also pointed out that upon calling the phone numbers that exist in patients' files, some phone numbers are usually not available, do not belong to the patients, or are simply phone numbers that do not exist (made-up numbers). One support staff put it as such:

"…To track absent patients, MSF has only provided us [psychosocial support staff] a phone to call from the health facility; however, our contract with the ministry [MOH] demands that we conduct home visits as part of the activities to bring back patients who do not respect their appointment. … Since January 2025, they have not renewed our contracts with the ministry [MOH], hence, we have not received a salary, but for the little support we receive from MSF reason we cannot come to work every day. For example, my colleague who is in charge of enrolling new patients did not come today, and so I am the one to enrol all the new patients and also do all the other activities, including calling absent patients." [Psychosocial support staff].

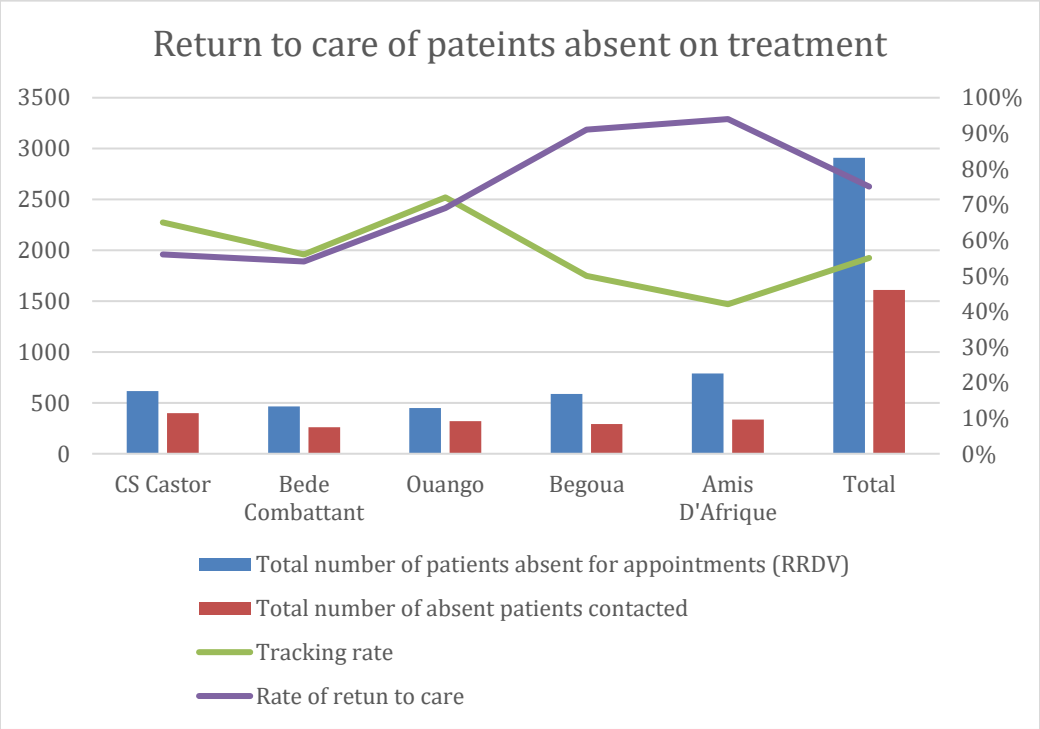


Figure 26: Average monthly return to care rate of patients absent from treatment

STAKEHOLDER ENGAGEMENT AND OWNERSHIP

*As framed in **evaluation question 3**, this criterion assesses the extent to which local authorities and key partners—including the MOH and community stakeholders—were meaningfully involved in the decentralization initiative's design and implementation. It also examines whether these actors developed a sense of ownership and accountability toward the program's objectives and outcomes.*

Findings indicate limited engagement and weak ownership among key stakeholders, including MOH and health district officials. This was primarily due to their lack of involvement at the initiative's early stages of development, resulting in missed opportunities for joint planning and alignment of priorities.

> *"MSF starts off well, but often without us [MOH]. And then, they want it to be taken over by the national side because they have to withdraw, or the project is over. Normally, involvement must be at the beginning and during so that the people from the national side can have a hand. And then, when they withdraw, it's just continuity. But often, that's not the case."* [MOH respondent]

> *"Back then, [at the initiation of the decentralization initiative], we were dealing with the Minister and then with the district and hospitals. When we realized that we were skipping the region, it was actually very difficult to open that conversation again."* [MSF respondent]

Furthermore, the initiative lacked a structured mechanism for partner engagement, which hindered ongoing consultation and coordination during implementation. The absence of a formal joint coordination mechanism limited transparency and information sharing and contributed to a fragmented implementation approach. As a result, local actors felt disconnected from the decision-making process, weakening their sense of ownership and long-term commitment.

> *"The gap we [MSF] saw was that there was no coordination between us [MSF and the MOH]. It was as if we were operating on our own, without involving, for example, the districts or the region in our activities. We deal directly with the health centres, which is not how it should be. So, we decided to organize coordination meetings regularly, quarterly, and to conduct joint supervisions with the ministries, which was not the case*." [MSF respondent]

In addition, while the treatment protocols used by MSF adhered to international standards and evidence-based practices, they were not fully aligned with national guidelines, creating operational friction with local health systems. This lack of alignment reduced opportunities for integration into the national framework and posed challenges for ownership among regional actors, constraining their ability to support and sustain the initiative beyond MSF's operational presence.

> *"We [MOH] work a lot with MSF, they help us a lot. They are the ones we see in most of the sectors. It is true that in the beginning it was not easy, also because they used other protocols that were not in the national guidelines, and this caused some friction at the site"* [MOH respondent]

These findings on stakeholder engagement and ownership reveal limited implications for the sustainability and effectiveness of the decentralization initiative. The limited involvement of key stakeholders, particularly the MOH and district health authorities, during the design and early implementation stages led to weak alignment with national priorities and missed opportunities for joint planning. As a result, local actors felt excluded from decision-making processes, undermining their sense of accountability and reducing their readiness to assume ownership once MSF scales down or exits. The absence of structured

coordination mechanisms and inconsistent communication further fragmented implementation and limited trust and transparency between MSF and local health authorities. Additionally, the use of treatment protocols not fully aligned with national guidelines created operational friction and hindered seamless integration into existing health systems. These gaps in engagement and alignment weakened the initiative's institutionalization and undermined its long-term sustainability. Without stronger and earlier collaboration with national and subnational stakeholders, the initiative risks being perceived as externally driven and isolated, rather than embedded within the national health system—a dynamic that could limit scale-up, policy adoption, and continuity of services post-MSF.

IMPACT ON MORBIDITY AND MORTALITY REDUCTION

This criterion assesses whether the decentralization initiative has contributed to strengthening the capacity of MSF partners—including public health management teams (PHMs), individual health facilities, and community actors—to advance progress toward the project's overarching goal of reducing morbidity and mortality related to maternal, newborn, and HIV-related conditions.

MATERNAL AND NEONATAL HEALTH OUTCOMES

MOH respondents acknowledged MSF's efforts to improve maternal and neonatal health outcomes and cited efforts such as support for the referral of obstetric complications, training of health personnel on the identification and referral of obstetric complications, and the provision of emergency kits in delivery rooms as effective strategies to reduce maternal and neonatal deaths.

> *"Another significant support from MSF is also the referral of complicated obstetric cases. MSF has ambulances stationed at the community hospital, and if we need to refer a woman in labour who has dystocia, we call the community hospital, and very quickly, they send us the ambulance to come and collect the patient. And that goes very well, and it helps a lot. And all of this contributes considerably to the reduction on maternal and infant mortality."* [MOH respondent]

Despite improvements in various aspects of maternal healthcare, trends indicate a persistent rise in adverse maternal and neonatal deaths. Several key factors contribute to this ongoing challenge. While there have been notable advancements in facility readiness, provider training, and the availability of essential drugs and equipment, these improvements have led to increased rates of skilled birth attendance and enhanced newborn resuscitation practices, which are directly linked to reduced maternal and neonatal complications rates. However, the overall impact on maternal mortality remains insufficient, highlighting the need for further enhancements in quality care or maternal healthcare-seeking behaviour within the target populations.

Additionally, establishing functional and responsive referral systems for obstetric emergencies has facilitated faster access to life-saving interventions, as stated in the quote opening this section. Women with complications such as obstructed labour, hemorrhage, or hypertensive disorders are more frequently referred promptly to CHUC, capable of providing CEmONC in Bangui, improving survival outcomes for both mothers and newborns. Nevertheless, the steady increase in maternal deaths suggests that additional

measures are necessary to address underlying issues and ensure the overall impact of the decentralization initiative in reducing maternal mortality in Bangui.

HIV OUTCOMES

Progress has also been observed in HIV service delivery, aligned with the UNAIDS 95-95-95 targets.

Earlier HIV diagnosis: There is a notable shift in the timing of HIV diagnosis, with an increasing share of individuals being diagnosed during earlier stages of infection rather than at advanced disease stages. This shift may reflect the effectiveness of provider-initiated testing and counselling (PITC), index testing, and community outreach strategies to increase early detection, particularly among pregnant women and key populations.

> *"We [MSF facility staff] see that the decentralisation has helped to reduce the burden on the reference hospital [CHUC] as the number of patients presenting with advanced HIV disease and complications has decreased significantly. Most often, the ambulatory treatment for HIV opportunistic infections is sufficient".* Excerpt of an interview with a key informant from MSF.

Improved linkage to treatment (Second 95): The decentralization of HIV services has contributed to stronger continuity of care. A greater proportion of individuals diagnosed with HIV are now being linked to ART at the primary care level. Decentralized ART initiation and follow-up reduce barriers such as travel and waiting time associated with centralized care at MSF-run health centres, notably the Castors health centre.

> *"What encourages me to come here is the proximity of the health centre, community mobilizations, the healthcare personnel who are very welcoming, and we have free HIV care and support"* [Attending client]

Limited retention in care, particularly among male and younger patients, remains a significant challenge to achieving better health outcomes among these sub-groups of HIV patients.

Improved adherence support, follow-up mechanisms, and viral load monitoring may have contributed to a growing number of clients on ART achieving viral suppression. This is a critical outcome in reducing both HIV-related morbidity and the risk of onward transmission. However, overall viral load testing coverage remains below 50%, highlighting the urgent need to scale up access to viral load monitoring to fully realize the benefits of treatment and the impact of the decentralization initiative on HIV patients' outcomes.

These results suggest that the decentralization and integration efforts have enhanced immediate access to care and strengthened the health system's capacity to provide timely, effective, and sustained responses to HIV-related challenges. Although long-term impact data are still evolving, current trends indicate a positive trajectory in reducing morbidity and mortality across the targeted catchment areas.

CAPACITY STRENGTHENING AND SUSTAINABILITY

This criterion examines whether the decentralized support model implemented by MSF for SRH and HIV services has built sufficient capacity and structures to allow for replication and long-term sustainability. Specifically, it assesses whether the MOH can feasibly adopt and scale up the approach—either independently or in partnership with other actors. The focus is on evaluating the transferability of tools, systems, and practices introduced by MSF and the extent to which local health authorities are prepared and equipped to sustain service delivery beyond MSF's involvement.

The decentralization initiative was implemented within public healthcare facilities, leveraging available infrastructure, personnel, and systems. This integration into the national health service delivery platform enhances the potential for sustainability as it builds on institutional assets already embedded within the Bangui healthcare system. For example, the procurement and supply of SRH and HIV-related drugs and medical commodities followed national protocols. They were channelled through MoH systems, contributing to a high level of compatibility and long-term viability.

Respondents highlighted several components of the initiative facing significant sustainability challenges, ranging from service delivery capacities to operational support. Notably, the community-based outreach activities—critical for improving service uptake—were delivered by a dedicated network of community health workers (CHWs) directly recruited and supported by MSF. These CHWs are not integrated into the formal district health workforce, raising concerns among respondents about the continuity of outreach services once MSF withdraws. Without formal recognition, financing, or supervision mechanisms within the national system, respondents expressed that this model may not be sustained unless proactively integrated into the national CHW framework. As one key informant put it

> *"At the community level, we [the district] do not know the activities they carry out, that's not normal. We [the district] really need to be involved in that. But right now, we [MSF and MOH] haven't agreed with each other about what activities to carry out at the community level."* [MOH participant]

Respondents similarly highlighted the network of psychosocial support workers responsible for actively tracking interrupted treatments and lost-to-follow-up clients operating outside the MoH structure. While these agents played a crucial role in improving adherence and retention in HIV care through phone calls, follow-ups, and psychosocial support, respondents expressed concerns about their continued operation without MSF's financial and technical backing. The lack of institutional pathways to absorb these agents into the public sector workforce limits the sustainability of this component, despite its demonstrated value in improving treatment continuity and outcomes.

> *"We [the APS-psychosocial support workers] have been working with the little means that MSF provides us every month. MSF gives us 20,000frs every month and from there we have to pay transport to work, feed ourselves and sometimes use some to pay for airtime to call absent clients. We do not have permanent contracts with the government, and for more than three months, we have not received any payment from the government"* [Psychosocial support worker].

Some respondents noted that the initiative significantly strengthened coordination between primary care facilities and referral hospitals, particularly for obstetric emergencies and advanced HIV/AIDS cases. However, they expressed concerns that this system remains highly dependent on MSF-supported logistics,

such as transport and communication. Respondents indicated that the referral system may not function at the same efficiency level once MSF phases out without sustained funding, training, and operational support from the government or donor mechanisms.

> *"The government funds healthcare, for example, the government pays the salaries of healthcare providers. However, without the support of partners, the government doesn't have all the possibilities or the capacity to take charge of healthcare. We're emerging from crises. So, the government is still making efforts to stabilize. As a result, there are still some gaps in terms of funding."* [MOH respondent]

> *"Regarding continuity of care, I think the government will do its best. For example, in case MSF decides they no longer have the capacity to continue referral services, the state will need to look for other partners to continue supporting this maternity service."* [MOH respondent]

Further, they reported that the diagnostic services also face mixed prospects for sustainability. They underscored that providing on-site PIMA machines for CD4 testing is highly valuable. Still, they argued that it presents a low likelihood of continuation due to high costs for cartridges, machine maintenance, and the technical capacity required to manage the platform.

> *"…we [MOH] are grateful to MSF for providing us with the gene expert platform, however, we still need MSF to support the transportation of samples, training personnel on the use of the machines, and providing cartridges."* [MOH key informant]

On the other hand, some respondents added that the referral system for transporting samples to the Pasteur Institute in Bangui for viral load and confirmatory testing shows moderate sustainability potential. They clarified that the MOH will leverage existing infrastructure and available funds from the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), which has a budget for supporting the sample transport systems.

> *"Normally, each district in Bangui was supposed to have a micro-plan for sample [viral load] transport funded by the Global Fund. Unfortunately, this plan is still the subject of much discussion because, since we're under zero cash, the districts don't know how to get the funds to trigger and implement this plan. It will imply the government's financial contribution, which the zero cash framework doesn't indicate. So far, MSF has been supporting this cycle, but if MSF has to withdraw, we need to reconsider this option. What is sure is that there will be missed opportunities, because with this system, it's one day a week, and that means that if other patients arrive on other days, they will not get tested. However, we can try to make available a freezer at the laboratories, for example, to collect and store samples to avoid these missed opportunities."* [MOH respondent]

DISCUSSION OF KEY FINDINGS FOR EACH EVALUATION CRITERION

The evaluation findings underscore multiple and intersecting challenges affecting the delivery, uptake, and sustainability of SRH and HIV services in fragile health care system, such as the Bangui, in the CAR. The predominance of female participants in our exit survey reflects broader gendered dynamics of healthcare engagement commonly observed across Sub-Saharan Africa, including the CAR, where sociocultural norms, stigma, and prevailing norms of masculinity inhibit male engagement in SRH and HIV services (Peacock et al., 2009; Skovdal et al., 2011). Similar patterns have been documented in Uganda, Malawi, and Kenya, where men's disengagement persists despite targeted efforts to enhance their involvement (Doyle et al., 2014). This underrepresentation not only undermines individual health outcomes but also limits the collective impact of programs aimed at improving family planning, maternal health, and HIV service uptake and related health outcomes.

Financial accessibility also emerged as a complex and layered issue. While most respondents reported that healthcare costs were affordable, this finding must be interpreted with caution. Facility-based surveys inherently exclude those unable to access services in the first place, introducing a selection bias that obscures the experiences of the most economically vulnerable. Studies from Chad and the DRC have similarly shown that indirect costs—such as transportation, lost income, childcare, and the cost of repeated visits—remain significant deterrents to SRH and HIV care, even when direct fees are officially waived (Grepin et al., 2019; Kruk et al., 2010). In the CAR, including Bangui, where the majority of the population lives below the poverty line (World Bank, 2023), such barriers likely result in delayed care-seeking, treatment interruptions, and fragmented access to chronic care services, particularly for HIV and maternal health. Moreover, the evaluation revealed the presence of unjustified or informal costs within health facilities—such as fees for pregnancy confirmatory tests, patient record books, and certain medications—that contradict the principle of free care for essential services. These hidden charges not only erode trust in the health system but also disproportionately affect the poorest users, who may forgo care altogether or resort to harmful alternatives. To truly meet the goal of free provision of critical SRH and HIV services, it is essential to address both formal and informal financial barriers. This includes auditing and eliminating unjustified fees, expanding financial protection mechanisms such as transportation vouchers or community-based health insurance, and strengthening community outreach to reduce the need for costly travel. Integrating cost monitoring into routine supervision and engaging communities in service design and feedback processes are also crucial to ensure that affordability is defined not just by providers, but by those most affected. Without addressing these systemic and often hidden financial burdens, the promise of free SRH and HIV services will remain incomplete and inequitable, particularly for the most marginalized.

The geographic distribution of services revealed further inequities that challenge the fundamental goal of decentralization—to bring quality healthcare closer to underserved populations. Although the initiative has expanded access to SRH and HIV services within Bangui, it primarily operates through existing public health centres located in the central districts of the capital. As such, the decentralization effort has, in effect, reinforced the urban-centric structure of service provision. Peripheral and peri-urban areas, such

as Bimbo, where health needs remain high, continue to experience limited access to consistent, high-quality care. This design choice, though perhaps pragmatic in leveraging existing infrastructure, unintentionally mimics long-standing geographic disparities in the Bangui's health system, where human resources, logistics, and health investments are concentrated in administrative hubs.

This pattern is not unique to CAR or the decentralization initiative. Across Sub-Saharan Africa, decentralization reforms have often been implemented through better-equipped urban health facilities, leading to uneven coverage and exacerbating rural-urban health disparities (Bossert & Mitchell, 2011; Abimbola et al., 2019). In fragile contexts, such disparities are further deepened by structural challenges including poor road networks, insecurity, and the absence of effective referral systems. In Bangui, these constraints restrict the mobility of both patients and providers, making it difficult for populations in peripheral areas to benefit from centrally concentrated services, regardless of their technical quality. The current operational geography of the decentralization initiative thus risks perpetuating a dual system—one in which central health districts across Bangui benefit from enhanced service availability, while peripheral zones remain on the margins of the decentralization efforts

The evaluation also revealed a significant trend of patients bypassing their nearest health centres in favour of MSF-supported facilities. This phenomenon—commonly referred to as bypassing behaviour—has been widely documented in fragile and resource-constrained health systems, where patients are willing to travel further to access care perceived as higher quality, more respectful, or more reliable (Kruk et al., 2009; Leonard et al., 2002). In the context of this decentralization initiative, such behaviour indicates a persistent trust deficit in the broader public health system. Despite efforts to decentralize service delivery through the expansion of services to local health centres, the continued preference for MSF-supported sites—often concentrated in central areas—suggests that patients prioritize service quality and availability over geographic proximity. This undermines a core objective of decentralization, which is to increase equitable access by bringing essential services closer to communities.

Moreover, bypassing behaviour contributes to systemic inefficiencies. It results in overcrowding and increased workloads at select high-performing facilities, while nearby centres remain underutilized and under-resourced. This imbalance can distort planning; strain already limited human resources and widen perceptions of inequality between different areas or populations. In fragile contexts like CAR, where the health system already operates with limited resilience, such disparities risk reinforcing a two-tiered system—where well-supported facilities offer relatively comprehensive care, while public sector facilities struggle to deliver even the most basic services.

This trend also illustrates **the limitations of vertical, project-based models of service delivery, which tend to improve outcomes in isolated facilities without addressing the structural weaknesses of the overall system.** While targeted interventions by NGOs like MSF can provide critical support in the short term, they may inadvertently draw patients away from the formal public sector if parallel systems are created without capacity transfer. In contrast, a broader health systems strengthening approach—focusing on quality improvement, supply chain management, workforce development, and governance across all levels of care—could mitigate these disparities by building confidence in the public health system as a whole. For example, studies from Rwanda and Ethiopia have shown that integrated system-wide quality improvement

efforts, when supported by national leadership and adequate financing, lead to more consistent service delivery and reduced disparities in care-seeking behaviour (Binagwaho et al., 2014; O'Connell et al., 2019).

By aligning decentralization efforts with national health planning frameworks and prioritizing uniform quality standards across facilities—regardless of external support—health systems can reduce the incentive for bypassing. This would not only support more rational use of health resources but also reinforce the legitimacy and capacity of the national health system to deliver equitable, trusted care. In fragile states like CAR, where decades of conflict have weakened institutional trust, investing in system-wide quality, rather than pockets of excellence, may be essential to restoring confidence in local health services and achieving the full promise of decentralization.

The evaluation revealed a striking contrast in the HIV care cascade under the decentralization initiative: while viral suppression rates among those tested were high—indicating strong treatment efficacy—the overall coverage of VL testing remained limited. This gap reflects ongoing systemic barriers common in fragile health systems, including constrained diagnostic capacity, centralized laboratory services, and frequent stockouts of testing supplies. In CAR, these challenges restrict routine VL monitoring, preventing timely identification of treatment failure and limiting both clinical management and programmatic oversight. In parallel, the evaluation found persistent gaps in retention, particularly among men and adolescents, who exhibited higher rates of missed appointments, treatment interruptions, and loss to follow-up. These findings echo regional evidence from Malawi, Mozambique, and Zambia, where stigma, gender norms, and mobility reduce engagement in HIV care among these groups. Within the CAR context, the absence of adolescent- and male-friendly services, coupled with limited psychosocial support and rigid clinic structures, appears to hinder long-term retention despite improved physical access through decentralization. This highlights the need for a more differentiated and inclusive model of care, supported by broader health system investments in diagnostics, community outreach, and tailored service delivery, to ensure that the gains of decentralization reach all segments of the population.

Maternal and neonatal mortality trends present a deeply complex and concerning picture. Despite the presence of emergency readiness measures—such as 24/7 triage, established referral pathways, and adequate stocks of obstetric supplies—most maternal deaths continue to occur within the first 24 hours of hospital admission and most neonatal deaths occurring before the mothers' arrival at the referral hospital. This critical window highlights systemic failures not in infrastructure per se, but in the *application* of clinical guidelines and *quality* of care. The persistence of high mortality rates in the presence of seemingly robust systems suggests that the problem lies in the *timeliness*, *appropriateness*, and *effectiveness* of clinical interventions.

This pattern reflects findings from post-crisis and resource-constrained settings like Sierra Leone and Sudan, where maternal health outcomes remained poor despite substantial investments in health infrastructure. These cases illustrate the "three delays" model proposed by Thaddeus and Maine (1994): delays in seeking care, reaching care, and receiving adequate care. In this context, the third delay—receiving appropriate and timely care at the facility—appears to be the most persistent and deadly. To address these systemic gaps, a multi-pronged approach is essential. First, strengthening clinical decision-making is critical. This can be achieved through regular, simulation-based training for obstetric emergencies, which enhances the ability of clinical teams to respond swiftly and appropriately under

pressure. Second, improving the timeliness of care requires the implementation of real-time monitoring systems, such as maternal early warning scores, to flag high-risk patients immediately upon admission. These tools enable faster triage and prioritization of critical cases.

Third, enhancing quality assurance mechanisms is vital. Establishing maternal death surveillance and response (MDSR) committees that review every maternal death within 72 hours can help identify root causes and foster a culture of accountability and continuous improvement. Fourth, investing in human resources—particularly by increasing the availability of skilled birth attendants and obstetricians during peak hours and night shifts—ensures that expertise is accessible when most needed, especially during the high-risk first 24 hours.

Fifth, fostering a culture of team-based care through structured communication protocols, such as SBAR (Situation, Background, Assessment, Recommendation), can improve coordination and reduce errors due to miscommunication. Finally, leveraging digital health tools to track maternal outcomes and identify patterns in delays or adverse events allows for data-driven insights that can inform targeted interventions and policy adjustments.

Further, while the decentralization initiative has introduced critical improvements in access to care and emergency responsiveness, its long-term impact on maternal and neonatal mortality remains uncertain—and potentially limited—if current trends continue unaddressed. The initiative has undoubtedly enhanced the operational capacity of peripheral health facilities. Training programs, emergency obstetric kits, and functional referral systems have improved the readiness of frontline providers and increased the number of women delivering in facilities with skilled birth attendants. These are foundational achievements. However, the persistent rise in maternal deaths—despite these advancements—signals a troubling disconnect between access to care and quality of care. If this trend is not reversed, the decentralization initiative risks becoming a well-intentioned but ultimately insufficient intervention. The continued occurrence of maternal deaths within 24 hours of admission suggests that systemic issues such as delayed clinical decision-making, inadequate emergency response, and inconsistent adherence to clinical protocols remain unresolved. If these gaps are not addressed, the initiative may inadvertently reinforce a false sense of progress. Infrastructure and access improvements may mask deeper quality deficits, leading to a plateau—or even regression—in maternal health outcomes. In such a scenario, the decentralization model could fail to deliver on its core promise: reducing preventable maternal and neonatal deaths.

Finally, the sustainability of the decentralization initiative remains precarious. While MSF's investment has strengthened public infrastructure and service delivery in targeted areas, core components—such as community outreach, psychosocial care, and referral logistics—remain heavily reliant on external support. Similar vulnerabilities have been identified in Chad and Afghanistan, where vertical programs failed to transition to government ownership, resulting in service contraction after donor exit (Pavignani & Colombo, 2009; WHO, 2017). In CAR, where health governance and public financing mechanisms are weak, the absence of structured transition planning risks reversing current gains.

Taken together, the evaluation findings reflect a dual reality: meaningful improvements in service availability and quality have been achieved in the decentralization initiative-supported health centres, yet persistent systemic weaknesses threaten the overall impact and sustainability of the decentralization initiative. These results echo broader evidence from fragile and post conflict-affected settings, suggesting

that external donor efforts alone are insufficient to deliver equitable, accessible, and resilient health systems. Instead, these efforts must be embedded within a comprehensive health systems strengthening strategy—one that includes workforce development, governance reforms, financing integration, and institutional accountability—to ensure lasting improvements in SRH and HIV outcomes.

KEY TAKEAWAYS AND RECOMMENDATIONS

→ **Recommendation 1: Strengthen the geographic and programmatic responsiveness of the decentralization initiative to improve its relevance**

BACKGROUND

Despite the initiative's achievements, the evaluation identified important gaps in its relevance to the needs of underserved populations in Bangui. The intervention remains overly concentrated in the city centre, with limited reach in peripheral zones such as Bimbo, where reproductive and HIV-related health needs are also acute. In addition, the initiative currently lacks dedicated strategies for certain high-risk and underserved groups, including HIV-positive pregnant women and their exposed infants, adolescents, and HIV+ individuals facing stigma within health services.

PROPOSED ACTIONS

1. Expand geographic reach to underserved areas

- Conduct a **rapid needs assessment** in peripheral zones to map gaps in sexual and reproductive health (SRH) and HIV services.
- Pilot **satellite services or mobile units** in areas lacking basic maternal and HIV care.
- Use **geospatial data** and facility readiness indicators to prioritize expansion based on equity and need.
- Work in partnership with **district health teams and the Ministry of Health** to co-plan localized service packages aligned with district priorities.

2. Strengthen the continuum of care for HIV-positive mothers and exposed infants

- Extend MSF follow-up protocols for **HIV-exposed infants** up to at least 18 months, including routine EID testing and early ART initiation when indicated.
- Improve **integration of HIV services** within antenatal, delivery, and postnatal care platforms.
- Introduce **case management systems** to track and retain mother-infant pairs in care.
- Build provider capacity on **integrated maternal-infant HIV care**, including adherence counselling, infant feeding guidance, and psychosocial support.

3. Develop youth-friendly SRH and HIV services

- Establish **youth-dedicated spaces or adolescent service hours** in supported health centres.
- Train providers in **non-judgmental, adolescent-responsive care**, including issues of confidentiality and consent.

- Involve adolescents in the **co-design of services** using participatory approaches to ensure responsiveness and acceptability.
- Enhance **peer-led outreach and education** through schools, community-based initiatives, and social media campaigns.

4. Address stigma and discrimination in health facilities

- Conduct **regular stigma-reduction trainings** for all healthcare staff, with emphasis on confidentiality, ethics, and respectful care.
- Establish **client feedback mechanisms** (e.g., suggestion boxes, satisfaction surveys) to monitor experiences of discrimination.
- Promote and enforce **patient rights charters** within service delivery points.
- Support the presence of **peer navigators and support groups** to reduce isolation and improve psychosocial wellbeing of HIV+ clients.

5. Expand access to comprehensive family planning, especially for adolescents

- Ensure **confidential access** to a full range of contraceptive options, including long-acting and emergency methods.
- Train providers in **youth-appropriate counselling** and consent protocols for family planning.
- Advocate for the Integration **family planning education** into school and community-based outreach targeting both adolescents and their caregivers.
- Implement the **community champion model** to challenge gender norms and cultural barriers to adolescent contraceptive use.

→ Recommendation 2: Strengthen retention and monitoring systems to improve HIV care effectiveness within the supported health centres

BACKGROUND

Findings from the evaluation indicate significant gaps in retention in care, particularly among male and adolescent HIV patients. Furthermore, despite high viral suppression rates among those tested, the coverage of viral load testing remains suboptimal.

PROPOSED ACTIONS

1. Establish standard operating procedures for patient follow-up

- Develop and institutionalize **context-specific SOPs** across all health facilities supported by the decentralization initiative to track patients lost to follow-up (LTFU).
- Ensure SOPs are aligned with national HIV program guidelines and **integrated into daily workflows**.
- Train clinical and community health staff on these SOPs, emphasizing timely identification, documentation, and active follow-up of missed appointments.

2. Strengthen retention strategies for men and adolescents

- Introduce **male- and adolescent-friendly service delivery models**, including extended hours, fast-track services, and youth-cantered counselling.
- Engage or reinforce the ability of peer **educators and community-based navigators** to provide psychosocial support, health literacy, and appointment reminders.
- Sensitize healthcare providers to reduce bias and create an inclusive, non-judgmental environment to improve service uptake and retention.

3. Expand coverage and quality of viral load testing

- Strengthen logistical and laboratory systems to ensure consistent **availability of viral load testing** at decentralized sites.
- Develop **data-driven protocols** for prioritizing patients due for viral load monitoring and those with suspected treatment failure.
- Use suppression data to reinforce adherence counselling and address the low **testing coverage (<50%)** to ensure the suppression rate reflects population-level outcomes.

4. Enhance data systems for program monitoring

- Improve **interoperability between MSF's monitoring systems and national platforms (e.g., DHIS2)** to facilitate real-time data sharing and decision-making.
- Conduct regular data reviews, disaggregated by age and gender, to **identify trends in LTFU, treatment gaps, and missed testing opportunities**.
- Integrate **quality improvement cycles** at facility level, using data to inform adaptive strategies.
- Expand data collection cascades to include primary indicators around persons eligible for HIV services (e.g. eligibility for index-case testing (ICT), early infant diagnosis (EID), PITC)

→ Recommendation 3: Enhance quality and timeliness of emergency obstetric care to reduce early maternal and neonatal deaths

BACKGROUND

Despite the presence of 24/7 triage systems, functional referral pathways, and availability of essential obstetric commodities in MSF-supported facilities, evaluation findings show that a **majority of maternal deaths still occur within 24 hours of admission and majority of fetal deaths are those who present with already absent fetal heart rates at the referral hospital**. This indicates persistent challenges related to **timeliness, coordination, and clinical quality of emergency response** once women arrive at health centres.

PROPOSED ACTIONS

1. Strengthen clinical decision-making and emergency readiness

- Conduct regular **clinical drills and emergency simulations** (e.g., for postpartum hemorrhage, eclampsia, sepsis) to enhance rapid response capacity.

- Integrate **case-based learning and bedside coaching** into daily clinical routines to reinforce accurate and timely clinical decision-making.

2. Implement real-time case review mechanisms

- Establish **near-miss and early mortality review systems** (deaths within 24 hours) to identify preventable clinical and systemic failures.
- Use findings from reviews to improve protocols, identify training needs, and inform continuous professional development.

3. Improve multidisciplinary team coordination during emergencies

- Reinforce emergency response protocols that define **clear team roles, escalation procedures, and communication lines** during obstetric emergencies.
- Monitor the actual implementation of triage protocols to ensure timely management of critical cases.

4. Deploy targeted quality improvement interventions

- Use service delivery data to identify recurring **bottlenecks in the first two hours of care**, and apply structured quality improvement cycles (e.g., Plan-Do-Study-Act).
- Incorporate community feedback mechanisms to address potential mismatches between perceived and actual readiness at facility level.

5. Ensure coordination with the Ministry of Health

- Collaborate closely with the **Ministry of Health and district health teams** to align emergency obstetric care standards and training protocols.
- Support the **institutionalization of maternal death reviews and quality improvement practices** within national systems for sustainability and scale-up.

→ Recommendation 4: Institutionalize key components of the decentralization initiative to ensure sustainability and enable replication

BACKGROUND

The decentralization initiative has successfully leveraged existing public health infrastructure, personnel, and systems, reinforcing its potential for long-term impact. However, several critical components — such as community outreach, free childbirth services, psychosocial support, sample transport, and referral logistics — remain heavily reliant on MSF support. Without formal integration into national structures, funding mechanisms, and supervisory frameworks, these components are at risk of being discontinued once external support is withdrawn.

PROPOSED ACTIONS

1. Integrate core components into Ministry of Health structures

- Work in close coordination with the **Ministry of Health** to identify which MSF-supported components are essential for continuity of care (e.g., sample transport, psychosocial services).

- Support the development or updating of **national protocols and operational guidelines** to reflect and institutionalize these components.
- Collaborate with district-level managers to ensure inclusion of decentralized services in **routine planning and budgeting cycles**.

2. Gradually transfer ownership and build capacity

- Develop a **transition plan** for each component, with clear timelines and roles for gradual handover to MoH structures.
- Provide targeted **capacity building** for local staff and managers to sustain quality service delivery after MSF withdrawal.
- Reinforce supply chain management and referral coordination at facility and district levels to ensure continuity of essential logistics.

3. Mobilize and align domestic and donor financing

- Advocate with government stakeholders and health financing partners for **earmarked resources** to sustain and scale key decentralization activities.
- Integrate decentralization priorities into **national health strategy documents and investment frameworks**, including Global Fund or GAVI proposals where appropriate.
- Support the costing and financial modelling of specific components (e.g., community outreach, sample transport) to guide domestic resource mobilization.

4. Document and disseminate the decentralization model for replication

- Produce and share detailed **implementation packages** (including tools, training materials, monitoring frameworks) to support replication in other urban and peri-urban zones.
- Organize **cross-district learning exchanges** to facilitate peer learning and adaptation of the model in similar settings.

LIMITATIONS AND CHALLENGES

Despite the efforts to ensure a comprehensive and robust evaluation, several limitations and challenges may affect the interpretation and generalizability of the findings:

LACK OF OPERATIONAL DATA FOR COST-EFFECTIVENESS ANALYSIS

The absence of structured operational data, particularly regarding sample transportation systems, turnaround time for viral load testing, time-to-arrival at facilities after referrals, and time to treatment initiation, has constrained the evaluation team's ability to conduct a cost-effectiveness analysis of these critical components of the decentralization initiative. Understanding the economic and operational efficiency of these features is essential to inform potential scale-up, guide resource allocation, and support decision-making at the national level.

LACK OF OPERATIONAL DATA TO COMPUTE THE EFFECTIVENESS OF PMTCT AND HIV TESTING SERVICES

The evaluation team was unable to compute the effectiveness of PMTCT and HIV testing services due to the absence of key indicators in the PMTCT and HIV testing cascade notably:

- Number of pregnant women received per health facility at ANC 1
- Number of contacts of HIV-positive patients eligible for index-case testing
- Number of persons referred by providers for provider-initiated HIV testing (PITC)
- Number of exposed infants born to HIV-positive mothers
- Number of HIV exposed infants who were given prophylaxis
- Number of HIV-exposed infants tested for HIV through PCR (Early infant diagnosis-EID).

Understanding the effectiveness of PMTCT service uptake and HIV testing services is critical in informing the progress towards early HIV identification and the elimination of mother-to-child transmission of HIV which are key aspects in the reduction of HIV-related deaths.

POTENTIAL BIAS IN STAKEHOLDER RESPONSES

Qualitative findings, particularly those derived from interviews and focus group discussions, may be subject to social desirability or confirmation bias. Some respondents, particularly service providers and MSF, may have emphasized successes or downplayed operational challenges due to their affiliation with the program or their expectations from the evaluation. Similarly, beneficiaries may have adjusted their feedback based on perceived expectations or bias.

LIMITED SCOPE AND GENERALIZABILITY OF CASE STUDIES

The evaluation included two in-depth case studies of MSF-supported health facilities, notably Boye Rabe and Bede Combatant health centres, to provide contextualized insights into the delivery of HIV and reproductive health services under the decentralization initiative. While these case studies offer valuable detail on the implementation process and user experience, they represent snapshot observations in specific settings. As such, they may not reflect the full range of practices, challenges, or innovations present across all MSF-supported facilities in Bangui. Variations in catchment populations, facility capacity, local leadership, and staff commitment may influence the replicability of findings elsewhere.

SELF-SELECTION BIAS

Self-selection bias presents a significant limitation when evaluating feedback from clients who accessed services at the two case study sites, particularly during exit interviews. The clients who participated are likely those who were able to access services without substantial barriers, such as transportation, mobility, language, or scheduling constraints, which may exclude individuals who faced greater challenges. As a result, the data may disproportionately reflect the experiences of clients for whom access was relatively straightforward, giving an inflated impression of overall service accessibility at these sites. Additionally, participants are more likely to be individuals for whom the cost of services was manageable, while those who struggled with affordability or discontinued service use due to financial pressures may be underrepresented. This creates a skewed picture that may underestimate the financial barriers faced by a broader segment of the target population.

Another critical observation is the limited participation of male clients in the exit surveys, which mirrors their generally low engagement in SRH and HIV services. This underrepresentation may result in a lack of

visibility of male-specific concerns, such as reluctance to seek care, long waiting times, or fear of stigma. As one provider noted, "Men often don't come back for follow-up—they're not used to being patients." Consequently, their voices are less likely to be reflected in qualitative perspectives, reinforcing the invisibility of gender-specific barriers.

Therefore, self-selection bias must be carefully considered when interpreting client feedback from the case study sites to ensure that conclusions about accessibility, affordability, and overall user experience are accurate and inclusive of those least likely to engage. Complementary methods—such as outreach interviews, male-specific focus groups, and triangulation with retention data—may be needed to capture a fuller picture of service equity and reach.

CONCLUSION

This evaluation assessed the SRH and HIV services implemented under the decentralised component of the Project Bangui initiative in the Central African Republic from mid-2021 to early 2025. The findings highlight the initiative's contextual relevance and appropriateness in directly addressing critical HIV/AIDS and SRH-related medical needs for the population of Bangui, with some doubts about the relevance of its geographical focus. This highlights a perceived disconnect between where support is directed and where the most acute service delivery challenges persist. The foundational elements necessary for effective SRH and HIV service delivery were largely in place; however, the initiative has shown mixed coherence with the national public health framework and evolving priorities to address critical HIV and SRH challenges, including maternal and child health in Bangui. Its implementation gaps and limited scope of interventions hinder alignment with key strategic frameworks, including the Elimination of Mother-to-Child Transmission (EMTCT) of HIV, syphilis, and hepatitis B, and reveal a disconnect between the initiative's design and the broader national vision for comprehensive and integrated healthcare services. These gaps not only hinder coordination between MSF and the ministry of health (MOH) actors but also risk fragmenting service delivery, particularly for maternal, neonatal, and HIV-related services that require continuity and integration across the care cascade.

The initiative plays a critical role in strengthening the delivery of targeted SRH and HIV interventions including facilitating the emergency management of obstetric and advanced disease HIV cases to CHUC. However, the rising rates of maternal and neonatal mortality highlights the persistence of critical gaps in emergency triage, timely referral, coordination and the management of obstetric emergencies which compromises the initiative's effectiveness in reducing maternal and neonatal deaths. To strengthen the relevance and impact of the decentralization initiative, we recommend strengthening its geographic and programmatic responsiveness, strengthening retention and monitoring systems to improve HIV care effectiveness, enhancing the quality and timeliness of emergency obstetric care to reduce maternal and neonatal deaths, and institutionalizing key components of the decentralization initiative to ensure sustainability and enable replication.

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APPENDICES

APPENDIX 1: LIST OF STAKEHOLDERS INTERVIEWED

List of participants interviewed

	Category	**number**
MSF participants	MSF project/decentralization staff (including Medical Doctors, health promotion staff, HIV/SSR supervisors)	8
	MSF above site personnel/coordinators (including program coordinators, human resource staff, supply, data, and international staff)	7
MOH participants	Central level staff/program coordinators	2
	District-level staff	1
	Health facility level (including medical doctors, nurses/midwives, psychosocial counsellors)	9
Service users/patients	SRH service users	10 (7 adults and 3 adolescents)
	HIV service users	2

APPENDIX 2: HEALTH FACILITIES SUPPORTED BY MSF UNDER THE DECENTRALIZATION INITIATIVE FROM 2022 TO 2025

Health Facilities supported by MSF under the decentralization initiative from 2022 to 2025

Year	Health Facilities supported	
	HIV	**SRH**
2022	Bede Combatant, Ami d'Afrique, Castors, Begoua, Ouango	Bede Combatant, Boy Rabe, Petevo, Gbaya Dombia,
2023	Bede Combatant, Ami d'Afrique, Castors, Begoua, Ouango	Bede Combatant, Boy Rabe,Gbaya Dombia
2024	Bede Combatant, Ami d'Afrique, Castors, Begoua, Ouango, Mamadou Mbaiki (From July 2024)	Bede Combatant, Boy Rabe, Castors (from September 2024), Ouango (from October 2024), Mamadou Mbaiki (from July 2024), Begoua (from October 2024)
2025	Bede Combatant, Ami d'Afrique, Castors, Begoua, Ouango, Mamadou Mbaiki	Bede Combatant, Boy Rabe, Castors, Begoua, Ouango, Mamadou Mbaiki

APPENDIX 3: DATA COLLECTION TOOLS (INTERVIEW GUIDES, SURVEY INSTRUMENTS)

3.1. Interview guide with key MSF staff involved with the Bangui Project

Date of Interview	__/__/____
Site ID	
Interviewer ID	

Introduction

Thank you again for agreeing to take part in this interview. As you know, we are evaluating the decentralization initiative, i.e. the support provided by MSF to health centres to improve the availability of SRH and HIV services closer to the target population in Bangui. For this evaluation, we are particularly interested in the design, the implementation process, the changes brought about by the decentralization initiative; and the lessons learned throughout the project cycle.

Let me briefly explain the process. The interview will last around 30 minutes, and I'd like to record it so that I can capture what you say. However, your name and other identifying information will not be shared with anyone except other members of the research team. Nor will we attribute quotes or other information to you in any reports or presentations resulting from this evaluation. You can ask us to turn off the recorder at any time.

Do you consent to participate in the interview?

Yes

No

Do you consent to recording the interview?

Yes

No

Section I: General information

1. Please begin by telling me a little bit about yourself.

   Probes: Professional role, educational experience, duration of work in the Bangui context specifically?

2. Please tell me (more) about your role at MSF and in the Bangui Project.

Section 1I: Bangui Project design process and relevance

Now I would like to ask you some about the design process of the decentralization initiative and the extent to which the initiative is relevant in its implementation context.

3. To begin, please tell me about the decentralization initiative.

   Probes: Aims and objectives, structure, duration

   Probes: Theory of change/Intervention logic

   In 2021, at the round table formalizing the decentralization and integration of SRH and HIV projects at the peripheral level of the Bangui healthcare system, were you actively involved in the design process of the decentralization initiative?

No (GO TO Q10)

Yes

4. Please describe the process that led to the conceptualization of the decentralization initiative.

   Probes: How was the need for this project identified?

   Probes: Who was involved in the initial conversations?

5. Now I'd like you to tell me (more) about the design of the decentralization initiative. How did the design of the initiative come about?

   Probes: Alignment with international, national, local, and MSF's SRH and HIV priorities and policies

   Probes: Engagement with potential beneficiaries, community, MSF personnel, Ministry of Health/SGBV Cluster, and other external stakeholders

6. Can you tell me about the main tools and mechanisms put in place to ensure the involvement of local health authorities in the design process of the decentralization initiative?

   Probe: co-design workshop, consensus-building process with the local health authorities, mutual procedure of reflection and conceptualization.

7. Do you think the available resources (finances, logistics, staffing, time) are sufficient to fully meet the expectations and needs of the beneficiaries?

Probes: Why/why not?

8. Tell me about any best practices and lessons learned from other projects that factored into the design of the decentralization initiative.

Probe: Best practices considered from MSF projects and external projects

Probe: Lesson learned considered from MSF projects and external projects

Section III: Project implementation process of the decentralization initiative

Now I'd like to talk with you about the implementation of the decentralization initiative.

9. Please tell me about the specific intervention strategy of the decentralization initiative. What was the rationale for the choice of this specific intervention? What was the rationale for choosing the performance framework?

   Probes: How do these strategies align with the project's objectives and expected results?

   Probes: If not, how can this strategy be made more relevant?

10. Tell us about the challenges you face in implementing this decentralization initiative in selected health districts/facilities. What needs to be done to improve the implementation strategies of this project?

11. Tell us about the factors that facilitated the implementation of the decentralization initiative in selected health districts/facilities.

12. What are some key changes that were needed at the health centre level to deliver quality SRH and HIV services closer to target populations?

    Probe: supervision of health centres, design/management of community strategies, in-service training of healthcare providers, logistics support for healthcare commodities and drugs, Budgeting/resources, data collection mechanism, data utilization for clinical decision making, referral process, etc.

13. Tell me about the nature and extent of cooperation between the Bangui Project team and the health district management team during the implementation phase of the decentralization initiative.

    Probes: Coordination meetings, monitoring visits, adoption of guidelines and protocols

    Probes: Any difficulties or challenges in coordination

14. Tell me about any mechanisms put in place to address challenges or problems arising throughout the implementation process.

    Probes: Advisory group, community engagement

15. Tell me about how data that are being collected as part of the decentralization initiative are being used for decision-making.

Probes: Internal uses, including project adjustment/improvement

Probes: External uses, including engagement with community, MOH

16. Tell me about any best practices and lessons learned from the implementation of the decentralization initiative that can inform its next phase.

Section IV: Improving the availability of and accessibility to SRH and HIV services

17. What factors prevent people in your target community from accessing timely SRH and HIV-related health services as needed for routine screening, preventive, diagnostic, and therapeutic care?

    Probe: community factors (stigma, taboo surrounding sexuality, cultural and religious beliefs)? Organizational factors (lack of essential drugs, unfriendly services, poor healthcare provider attitudes, out-of-pocket fees, etc.)? Interpersonal factors (support from one's social network, etc.)? Individual factors (health literacy, age, gender, disability status; etc.)?

18. What would it take to get more community members to seek SRH and HIV healthcare services at the MSF-supported community point of care or health centres?

    Probe: From community healthcare workers? From the health centre?

19. What are the SRH and HIV services that clients need but do not know that they are available at the health centre? If any services: how can the availability of these services be better communicated to the community?

20. What are the SRH and HIV services that clients need but are not being offered at the health centre? Why not? What challenges are faced in offering these services?

    Probes: staffing issues, patient volumes, laboratory infrastructure or transport, availability of drugs or commodities, restrictive SRH and HIV policies, etc.

Section V: Gender and human rights considerations

Studies have shown that certain sub-populations such as women and girls living with disabilities and gender and sexual minorities may experience increased barriers to accessing health services

21. In your experience, are there specific sub-populations that have more difficulty accessing SRH and HIV services in the Bangui context?

Probes: Specific populations, types of barriers

22. To what extent were the needs of these sub-populations taken into consideration in the design and implementation of the decentralization initiative?

    Probes: Specific populations, types of accommodations, types of awareness-raising activities, etc.

Section VI: Success, impact, and prospects for replicability of the decentralization initiative

Now I would like to ask some questions about the prospects for replicability of the decentralization initiative.

23. Tell us about the key positive changes that the decentralization initiative has brought about in the delivery of SRH and HIV services in MSF-supported health centres and community points of care within your health district.

    Probes: Quality of information/services? Convenience of services? treatment availability? service availability?Fee of charges services?Improved uptake of SRH and HIV services? Improved referral process for advanced HIV care and comprehensive emergency maternal and neonatal care?Improved patients's health outcomes?

24. Can you tell us what feature of the "packaging" of the decentralization initiative intervention is expected to be replicated by external stakeholders, including the Ministry of Health?

25. To what extent do you think local health authorities will be able to replicate some key features of the decentralization initiative, such as the free provision of maternity care?

Probes: Facilitators and barriers

Probes: Any suggestions on what could be done to enhance the prospects of replicability

Improvements

1. What, if anything, could be done to improve the design of similar projects in the future?
2. What, if anything, could be done to improve the implementation process of the Bangui project?
3. What, if anything, could be done to improve the prospects for success, impact, and replicability of the decentralization initiative?

Conclusion

Thank you very much! These are all questions I have.

- Is there anything else you would like to add?
- Is there anything you would have liked me to ask, but that I left out?
- Do you have any questions for me?

Thank you! This concludes our conversation today. Thank you for your participation. All the information you have given us today will be very useful to us. Again, we assure you that it will be kept confidential.

Field Notes: _____

_____

_____

_____

_____
_____
_____
_____

3.2. Client Exit Survey

Date de l'entretien	_ _ / _ _ / _ _ _ _
ID du site	
ID de l'enquêteur	

SECTION A : CARACTÉRISTIQUES DÉMOGRAPHIQUES

Q#	QUESTION	RÉPONSE
1.	Sélectionnez le point de service de du centre de santé où se déroule l'entretien ou le point de sortie du participant.	❒ (1) Santé maternelle et infantile ❒ (2) Soins ambulatoires ❒ (3) Clinique ART ❒ (4) Clinique de la tuberculose ❒ (5) Planification familiale ❒ (6) Clinique IST

		❒ (08) Urgences ❒ (88) Autre, précisez : _____
3.	Quel âge avez-vous *(en années)* ?	_____
4.	Quel est votre sexe ?	❒ (1) Homme ❒ (2) Femme ❒ (3) Autre identité : _____
5.	Quel est votre niveau d'études le plus élevé ?	❒ (1) Aucune ❒ (2) Primaire ❒ (3) Enseignement secondaire ou supérieur ❒ (4) Enseignement professionnel ❒ (5) Enseignement supérieur (diplôme, grade)
6.	Quelle est votre activité principale ?	❒ (1) Non employé ❒ (3) Travail/travail occasionnel ❒ (4) Indépendants ❒ (5) Fonctionnaire/salarié ❒ (6) Retraité ❒ (88) Autre, précisez : _____
7.	Quel est votre état civil actuel ?	❒ (1) Célibataire/jamais marié ❒ (2) Mariés

		❒ (3) Divorcé/séparé ❒ (4) Veuve ❒ (88) Autre, précisez _____
8.	Quelle est votre religion ?	❒ (1) Catholique ❒ (2) Protestants ❒ (3) Musulman ❒ (4) Religion traditionnelle africaine ❒ (88) Autre, précisez : _____

SECTION B : SERVICES DE SSR et de VIH REÇUS

Q#	QUESTION	RÉPONSE
9.	Quels sont les services de santé qui vous ont été fournis aujourd'hui ? ***Cochez toutes les cases qui s'appliquent.***	❒ (1) Soins prénatals ❒ (2) Soins postnatals ❒ (3) Soins en matière d'accouchement ❒ (4) Conseil et dépistage du VIH ❒ (5) Traitement et soins du VIH ❒ (6) Dépistage et traitement des IST ❒ (7) Planification familiale ❒ (8) Gestion des violences sexuelles ❒ (9) Services pour les enfants - PTME ❒ (10) Services pour les enfants de moins de 5 ans - Vaccination ❒ (11) Services pour les enfants de moins de 5 ans - nutrition

		❒ (12) Services pour les enfants de moins de 5 ans - suivi de la croissance ❒ (13) Services pour les enfants de moins de 5 ans - étapes clés ❒ (14) Services de lutte contre la tuberculose ❒ (15) Services de pharmacie uniquement ❒ (16) Services de laboratoire uniquement ❒ (88) Autre, précisez : _____
10.	Avez-vous reçu tous les services dont vous aviez besoin ?	❒ (0) Non ❒ (1) Oui **---- PASSER A Q15**
11.	Si non, quels sont les services dont vous n'avez pas bénéficié ? ***Cochez toutes les cases qui s'appliquent.***	❒ (1) Soins prénatals ❒ (2) Soins postnatals ❒ (3) Soins à l'accouchement ❒ (4) Conseil et dépistage du VIH ❒ (5) Traitement et soins du VIH ❒ (6) Dépistage et traitement des IST ❒ (7) Planification familiale ❒ (8) Gestion des violences sexuelles ❒ (9) Services pour les enfants - PTME ❒ (10) Services pour les enfants de moins de 5 ans - Vaccination ❒ (11) Services pour les enfants de moins de 5 ans - nutrition ❒ (12) Services pour les enfants de moins de 5 ans - suivi de la croissance

		❒ (13) Services pour les enfants de moins de 5 ans - étapes clés ❒ (14) Services de lutte contre la tuberculose ❒ (15) Services de pharmacie uniquement ❒ (16) Services de laboratoire uniquement ❒ (88) Autre, précisez : _____
12.	Si non, pourquoi n'avez-vous pas reçu tous les services dont vous aviez besoin aujourd'hui ? **---- Pour toutes les options autres que 4, PASSEZ à Q15**	❒ (1) Le personnel du centre de santé n'est pas disponible ou est trop occupé aujourd'hui ❒ (2) Matériel médical défectueux ou cassé ❒ (3) Rupture de stock ❒ (4) Médicament non disponible/en rupture de stock ❒ (87) Ne sait pas ❒ (88) Autre, précisez : _____
13.	Quels sont les médicaments qui n'étaient pas disponibles aujourd'hui ? *Peut indiquer le médicament spécifique ou l'affection (par exemple, le traitement de la tuberculose).*	❒ (1) Précisez : _____ ❒ (87) Ne sait pas
14.	Qu'est-ce que le prestataire a fait ou vous a dit de faire ?	❒ (1) retirer le médicament dans une clinique ou une pharmacie privée ❒ (2) Revenir à un autre moment pour récupérer le médicament ❒ (3) Fournir un traitement de substitution ❒ (88) Autre, précisez : _____

15.	Savez-vous que ce centre de de santé offre les services suivants ? ***Lisez les options, puis sélectionnez toutes celles qui s'appliquent.***	❒ (1) Soins prénatals ❒ (2) Soins postnatals ❒ (3) Soins à l'accouchement ❒ (4) Conseil et dépistage du VIH ❒ (5) Traitement et soins du VIH ❒ (6) Dépistage et traitement des IST ❒ (7) Planification familiale ❒ (8) Gestion des violences sexuelles ❒ (9) Services pour les enfants - PTME ❒ (10) Services pour les enfants de moins de 5 ans - Vaccination ❒ (11) Services pour les enfants de moins de 5 ans - nutrition ❒ (12) Services pour les enfants de moins de 5 ans - suivi de la croissance ❒ (13) Services pour les enfants de moins de 5 ans - étapes clés ❒ (14) Services de lutte contre la tuberculose
16.	Comment vous ou les membres de votre communauté sont-ils informés des services de santé offerts dans ce centre de santé ? ***Cochez toutes les cases qui s'appliquent.***	❒ (1) Réunion communautaire ❒ (2) Personnel de santé communautaire ❒ (3) Établissement de santé - par exemple, discussions sur la santé ❒ (4) Sensibilisation de la communauté ❒ (5) Les médias sociaux ❒ (87) Ne sait pas ❒ (88) Autre, précisez : _____

17.	Avez-vous été orienté vers un autre centre de santé ou un autre hôpital aujourd'hui ?	❒ (0) Non **---- PASSER A Q19** ❒ (1) Oui
18.	Si oui, vers qui êtes-vous orienté ?	❒ (1) Un autre centre de santé ❒ (2) Hôpital de district ❒ (3) Hôpital tertiaire ❒ (4) Laboratoire ❒ (88) Autre, précisez (par exemple, police, services sociaux) : _____
19.	Si oui, quels sont les services supplémentaires qui vous sont proposés ? ***Cochez toutes les cases qui s'appliquent.***	❒ (1) Tests de laboratoire ❒ (2) Imagerie diagnostique ❒ (3) Soins ou traitements spécialisés ❒ (88) Autre, précisez : _____

SECTION C : ACCÈS AUX SERVICES DE SSR ET DE SANTÉ RELATIFS AU VIH DANS LE CENTRE DE SANTÉ LE PLUS PROCHE et SATISFACTION À L'ÉGARD DES SERVICES REÇUS

Q#	QUESTION	RÉPONSE
20.	Cet établissement de santé (où vous avez reçu des services aujourd'hui) est-il le plus proche de votre lieu de résidence ?	❒ (0) Non ❒ (1) Oui ----- PASSER A Q24
21.	Si ce n'est pas le cas, pourquoi ne cherchez-vous pas à obtenir des services de santé dans le centre de santé le plus proche de chez vous ?	❒ (1) Ce centre de santé est plus proche du travail/de l'école

	Cochez toutes les cases qui s'appliquent.	❒ (2) Ce centre de santé est plus éloignée mais plus facile d'accès (par exemple, en raison de la disponibilité des transports, de routes emportées, etc.) ❒ (3) a été orienté vers ce centre de santé par un prestataire de soins ❒ (4) Il est moins probable que ma famille sache que j'ai visité ce centre de santé ❒ (5) Il est moins probable que mes amis et mes pairs sachent que j'ai visité ce centre de santé ❒ (6) Ce centre de santé a des temps d'attente plus courts/est moins fréquenté ❒ (7) Je préfère les prestataires de ce centre de santé ❒ (8) Ce centre de santé est plus confortable (par exemple, salle d'attente spacieuse, plus frais/plus chaud) ❒ (9) Le centre de santé le plus proche de chez moi était fermé au moment où je cherchais des services de santé ❒ (10) Ce centre de santé a plus de chances de disposer des médicaments dont j'ai besoin ❒ (11) Ce centre de santé a plus de chances de disposer de l'équipement nécessaire pour fournir les services dont j'ai besoin (par exemple, imagerie diagnostique, tests de laboratoire). ❒ (12) Ce centre de santé me permet de recevoir tous les services dont j'ai besoin en un seul endroit. ❒ (13) Pas de raison particulière ❒ (88) Autre, précisez : _____

22.	Si ce n'est pas le cas, quel est le centre de santé le plus proche de votre domicile ?	❒ (1) Nom : _____ ❒ (87) Ne sait pas
23.	Si ce n'est pas le cas, qu'est-ce qui devrait changer pour que vous puissiez recherchier des services de santé SSR et de VIH au centre de santé primaire proche de votre résidence/centre de santé primaire désigné? ***Cochez toutes les cases qui s'appliquent.***	❒ (1) Emplacement plus pratique, expliquer : _____ ❒ (2) Accès plus privé aux services/prestataires ❒ (3) Amélioration des flux des clients ou des temps d'attente ❒ (4) Meilleure attitude du personnel de santé ❒ (5) Plus confortable (par exemple, salle d'attente spacieuse, plus frais/plus chaud) ❒ (6) Des professionnels de la santé mieux informés/qualifiés ❒ (7) Davantage de médicaments/une disponibilité plus régulière des médicaments ❒ (8) Plus de services ou d'équipements disponibles ❒ (9) Plus de types de services fournis en une seule visite ❒ (99) N/A - a été référé ici ❒ (88) Autre, précisez : _____ ----- PASSER À Q25
24.	Si oui, pourquoi avez-vous décidé de vous faire soigner dans cet établissement aujourd'hui et pas ailleurs ?	❒ (1) Le centre de santé le plus proche de mon domicile

	Cochez toutes les cases qui s'appliquent.	❒ (2) N'a pas les moyens de payer le transport pour se rendre dans un centre de santé plus éloigné. ❒ (3) Ne peut pas payer les frais d'une clinique privée ❒ (4) Ont été satisfaits des soins reçus ici dans le passé ❒ (5) a été orienté vers ce centre de santé par un prestataire de soins de santé ❒ (6) a été orienté vers ce centre de santé par un agent de santé communautaire ❒ (88) Autre, précisez : _____
25.	Combien de temps avez-vous mis pour vous rendre de votre domicile à ce centre de santé ?	❒ (1) Moins de 30 minutes ❒ (2) 30 minutes - 1 heure ❒ (3) >1 - 2 heures ❒ (4) >2 - 3 heures ❒ (5) >3 - 4 heures ❒ (6) Plus de 4 heures
26.	Quel mode de transport avez-vous utilisé pour vous rendre dans ce centre de santé ?	❒ (1) À pied ❒ (2) Transport public (taxi/bus/moto) ❒ (3) Voiture particulière ❒ (88) Autre, précisez : _____
27.	L'itinéraire pour se rendre au centre de santé et en revenir est-il sûr ?	❒ (0) Non - généralement dangereux ❒ (1) Oui - généralement sans danger

		❒ (2) Cela dépend (heure de la journée, itinéraire, etc.) - problèmes de sécurité à certains moments. ❒ (3) Cela dépend (heure de la journée, itinéraire, etc.) - les conditions météorologiques sont parfois préoccupantes.
28.	Combien de temps avez-vous attendu avant d'être vu par un prestataire aujourd'hui ?	❒ (1) Moins de 30 minutes ❒ (2) 30 minutes - 1 heure ❒ (3) >1 - 2 heures ❒ (4) > 2 - 3 heures ❒ (5) >3 - 4 heures ❒ (6) Plus de 4 heures
29	Quel est votre degré de satisfaction concernant le temps d'attente aujourd'hui ?	(1) Non satisfait (2) Moyennement satisfait (3) Très satisfait
30.	Vous sentez-vous à l'aise lorsqu'un prestataire d'un sexe différent du vôtre s'occupe de vous dans la salle de consultation ?	❒ (0) Non ❒ (1) Oui
31.	L'établissement est-il ouvert à des heures qui vous conviennent ?	❒ (0) Non ❒ (1) Oui **----- PASSER A Q33**

32.	Si ce n'est pas le cas, en quoi ces horaires sont-ils gênants ? ***Cochez toutes les cases qui s'appliquent.***	❒ (1) Ouvre trop tard dans la journée ❒ (2) Ferme trop tôt dans l'après-midi/soirée ❒ (3) Fermé pendant le déjeuner ❒ (4) Pas d'ouverture le week-end/les jours fériés ❒ (88) Autre, précisez : _____
33.	Quels sont les frais que vous avez engagés aujourd'hui dans ce centre de santé ? ***Cochez toutes les cases qui s'appliquent.***	❒ (0) Aucun **----- PASSER A Q35** ❒ (1) Consultation ❒ (2) Médicaments ❒ (3) Tests ❒ (4) Tarif des transports ❒ (5) Nourriture/boissons pendant l'attente ❒ (88) Autre, précisez : _____
34.	Ces coûts sont-ils abordables pour vous ?	❒ (0) Non ❒ (1) Oui ❒ (2) Un peu
35	Y a-t-il des toilettes propres dans ce centre de santé ?	❒ (0) Non, non disponible ❒ (1) Oui, disponible mais pas propre ❒ (1) Oui ❒ (87) Ne sait pas

36	Y a-t-il de l'eau courante dans ce centre de santé ?	❒ (0) Non ❒ (1) Oui ❒ (87) Ne sait pas
37	Y a-t-il de l'électricité dans ce centre de santé ?	❒ (0) Non ❒ (1) Oui ❒ (87) Ne sait pas
38	Dans l'ensemble, quel est votre degré de satisfaction à l'égard de l'environnement physique de ce centre de santé ?	❒ (1) Non satisfait ❒ (2) Moyennement satisfait ❒ (3) Très satisfait
39	Dans quelle mesure avez-vous été satisfait de la confidentialité et du respect de la vie privée lors de votre visite aujourd'hui ?	❒ (1) Non satisfait ❒ (2) Moyennement satisfait ❒ (3) Très satisfait
40	Dans quelle mesure avez-vous été satisfait de l'attitude des prestataires de soins de santé lors de votre visite d'aujourd'hui ?	❒ (1) Non satisfait ❒ (2) Moyennement satisfait ❒ (3) Très satisfait
41	Dans quelle mesure avez-vous été satisfait des compétences des prestataires de soins de santé qui vous ont traité lors de votre visite d'aujourd'hui ?	❒ 1) Pas satisfait ❒ (2) Moyennement satisfait ❒ (3) Très satisfait
42	Dans l'ensemble, quel est votre degré de satisfaction à l'égard des services de santé que vous avez reçus aujourd'hui ?	❒ 1) Pas satisfait ❒ (2) Moyennement satisfait

		❒ (3) Très satisfait

SECTION D : L'ACCÈS AUX SERVICES DE SRH ET DE VIH

Q#	QUESTION	RÉPONSE
43.	J'aimerais maintenant vous parler de certains services offerts dans ce centre de santé. Au cours de votre visite, avez-vous discuté des méthodes de contraception modernes ?	❒ (0) Non **Passer à Q47** ❒ (1) Oui
44.	En pensant à cette discussion sur les méthodes modernes de contraception, diriez-vous que	❒ (1) Vous avez interrogé le prestataire sur la planification familiale, ❒ (2) Le prestataire a entamé une conversation avec vous sur la planification familiale, ❒ (98) Vous ne vous souvenez pas ❒ (99) Pas de réponse
45.	Avez-vous décidé de commencer à utiliser une méthode de contraception aujourd'hui à la suite des conseils que vous avez reçus ? ***---- Pour toutes les options autres que 2, PASSEZ à Q47***	❒ (0) Non ❒ (1) Oui, j'ai commencé aujourd'hui ❒ (2) Oui, mais je commencerai plus tard ❒ (88) Autre, précisez : _____
46	Diriez-vous que le même prestataire qui vous a conseillé...	❒ (1) vous a fourni une méthode de contraception , ❒ (2) vous a orienté vers un autre prestataire de cette clinique ,

		❒ (3) vous a orienté vers un prestataire d'une autre clinique, ❒ (4) Ne vous a pas indiqué comment obtenir cette méthode, ❒ (98) Vous ne vous souvenez pas ❒ (88) Autre, précisez : _____
47	Avant de venir au centre de santé aujourd'hui, avez-vous entendu des messages dans votre communauté sur l'importance de la contraception ? ***---- Pour toutes les options autres que 2, PASSER à Q50***	❒ (1) Non ❒ (2) Oui ❒ (98) Ne sait pas/ne se souvient pas ❒ (88) Autre, précisez : _____
48.	Diriez-vous que ces messages	❒ (1) ...Augmenté ou, ❒ (2) ...Diminué votre volonté de commencer une méthode de contraception aujourd'hui, ❒ (3) ...ou n'a pas affecté votre volonté de rechercher et d'adopter une méthode de contraception ? ❒ (88) Autre, précisez : _____
49.	Quel est le principal canal par lequel vous avez entendu parler de ce service de contraception ?	❒ (1) Agents de santé communautaire du projet Bangui ❒ (2) Autres agents de santé communautaire ❒ (3) Personnel de MSF ❒ (4) Ambassadeurs de l'école ❒ (5) Radio

		❒ (6) TV ❒ (88) Autre, précisez : _____
50.	Au cours de votre visite, avez-vous abordé la question des conseils et des services liés au VIH ?	❒ (0) Non **Passer à Q54** ❒ (1) Oui
51.	En pensant à cette discussion sur le conseil et le dépistage du VIH, diriez-vous que	❒ 1) Vous avez demandé au prestataire un conseil et un test VIH ❒ (2) Le prestataire a entamé une conversation avec vous sur le dépistage du VIH et le conseil, ❒ (98) Vous ne vous souvenez pas (99) Pas de réponse
52.	Avez-vous décidé de faire un test de dépistage du VIH aujourd'hui à la suite des conseils que vous avez reçus ? ***---- Pour toutes les options autres que 2, PASSEZ à Q54***	❒ (0) Non ❒ (1) Oui, je l'ai pris aujourd'hui ❒ (2) Oui, mais je le prendrai plus tard ❒ (88) Autre, précisez : _____
53.	Diriez-vous que le même prestataire qui vous a conseillé...	❒ (1) vous a fait passer un test de dépistage du VIH ❒ (2) vous a fourni l'ART ❒ (3) vous a orienté vers un autre prestataire de cette clinique , ❒ (4) vous a orienté vers un prestataire d'une autre clinique, ❒ (5) Ne vous a pas dit comment faire un test de dépistage du VIH, ❒ (98) Vous ne vous souvenez pas

		❒ (88) Autre, précisez : _____
54.	Avant de venir au centre de santé aujourd'hui, avez-vous entendu des messages dans votre communauté sur l'importance de connaître votre statut sérologique ou de faire un test de dépistage du VIH ? ***---- Pour toutes les options autres que 2, mettre fin à l'entretien.***	❒ (1) Non ❒ (2) Oui ❒ (98) Ne sait pas/ne se souvient pas ❒ (88) Autre, précisez : _____
55.	Diriez-vous que ces messages	❒ (1) ...Augmenté ou, ❒ (2) ...A diminué votre volonté d'obtenir des services de santé liés au VIH aujourd'hui, ❒ (3) ...Ou n'a pas affecté votre volonté d'obtenir des services de santé liés au VIH aujourd'hui, ❒ (88) Autre, précisez : _____
56.	Quel est le principal moyen par lequel vous avez entendu parler de ce service VIH ?	❒ (1) Agents de santé communautaire du projet Bangui ❒ (2) Autres agents de santé communautaire ❒ (3) Personnel de MSF ❒ (4) Ambassadeurs de l'école ❒ (5) Radio ❒ (6) TV ❒ (88) Autre, précisez : _____

Merci encore d'avoir pris le temps de participer à cette enquête. Nous apprécions votre participation. Nous vous souhaitons une bonne journée.

3.3. Client In-depth interview guide

Date de l'IDI	___ ___ / ___ ___ / ___ ___
ID de l'enquêteur	
ID du site	

Enregistrer l'heure de début de l'IDI : ___ hr ____ min

INTRODUCTION :
Nous vous remercions d'avoir accepté de participer à cet entretien approfondi à la sortie de votre visite. Nous aimerions vous interroger sur vos expériences et vos opinions concernant les soins de SSR et/ou de VIH que vous avez reçus aujourd'hui dans ce centre de santé, y compris les parcours d'utilisation des services de SSR et de santé VIH par votre communauté. En outre, nous vous demanderons votre avis sur les obstacles et les facteurs facilitant l'accès à ces services pour vous et les membres de votre communauté. Je vous poserai une série de questions ouvertes où vous pourrez parler librement de vos expériences pendant que je prendrai des notes.

INSTRUCTIONS : *Les questions suivantes ne sont qu'un guide. Il ne s'agit pas d'une ligne de questions obligatoires, mais plutôt de questions suggérées. L'enquêteur doit formuler ces questions de la manière qui convient le mieux au participant.*

Allumez maintenant l'enregistreur audio.

Nous souhaitons tout d'abord comprendre comment les membres de votre communauté ont tendance à accéder aux soins de santé sexuelle et reproductive et aux soins liés au VIH, tels que les soins prénatals, les soins de maternité, le planning familial et le dépistage du VIH, lorsqu'ils ont besoin de ces services.

A. <u>COMPORTEMENTS EN MATIÈRE DE RECHERCHE DE SOINS DE SANTE SEXUELLE ET REPRODUCTIVE ET LE VIH</u>

1. Quelle est la probabilité que les membres de la communauté se rendent au centre de santé lorsqu'ils sont malades ou ont besoin de services ?

    a. Quelles sont les principales raisons ou les principaux obstacles qui empêchent les personnes concernées de rechercher ou d'accéder aux services ?

***Sondez** : sensibilisation ? accès ? pression ? qualité de l'information/des services ? connaissance/manque de connaissance du processus ? La confiance ? Mauvais comportement en matière de recherche de santé ? Stigmatisation/discrimination ? Commodité ? disponibilité des traitements ? disponibilité des services ?*

b. Cela a-t-il tendance à se produire avec certains groupes de personnes (par exemple, les femmes, les hommes, les personnes âgées, les personnes vivant avec un handicap) ? Ou les personnes qui recherchent certains services **(par exemple, la violence liée au sexe, le VIH, les soins prénataux**) ? Quels groupes ou services ?

c. Quelles sont, selon vous, les principales raisons ou les principaux obstacles qui empêchent les membres de votre communauté de rechercher ou d'accéder aux services de VIH et de santé sexuelle et reproductive ?

***Sondez:** sensibilisation ? accès ? pression ? qualité de l'information/des services ? connaissance/manque de connaissance du processus ? La confiance ? Mauvais comportement en matière de recherche de santé ? Stigmatisation/discrimination ? Commodité ? disponibilité des traitements ? disponibilité des services ?*

2. Quels sont les facteurs qui motivent les membres de votre communauté ( ) à accéder en temps voulu aux services de santé sexuelle et reproductive et de lutte contre le VIH nécessaires au dépistage de routine, aux soins préventifs, diagnostiques et thérapeutiques ?

***Sondez :** facteurs communautaires ? facteurs liés à l'établissement ? famille/amis ? expériences individuelles ?*

3. Que faudrait-il faire pour que davantage de membres de la communauté recherchent des soins de santé sexuelle et reproductive et de lutte contre le VIH au niveau du centre de santé ?

d. De la communauté ?

e. Du centre de santé ?

4. Quels sont les services de SSR et de VIH dont les clients ont besoin mais dont ils ne savent pas qu'ils sont disponibles au centre de santé ? S'il s'agit de services, comment peut-on mieux informer la communauté de la disponibilité de ces services ?

5. Quels sont les services de SSR et de VIH dont les clients ont besoin mais qui ne sont pas proposés au centre de santé ? Pourquoi ? Quelles sont les difficultés rencontrées pour accéder à ces services ?

***Sondez :** problèmes de personnel, longs délais d'attente, infrastructure ou transport des laboratoires, disponibilité des médicaments ou des produits, stigmatisation/discrimination, etc.*

B. SATISFACTION À L'ÉGARD DES SERVICES REÇUS EN MATIÈRE DE SRH ET DE VIH

6. Dans quelle mesure êtes-vous satisfait des services de santé que vous avez reçus aujourd'hui ?
7. Quelle est la principale raison de votre satisfaction/insatisfaction ?
8. Comment vous ou les membres de votre communauté percevez-vous les prestataires de soins de santé/le personnel soignant de ce centre de santé/de ces régions ?

Sonder : leurs compétences, leurs attitudes, etc.

C. Conclusion

Merci beaucoup ! Ce sont toutes les questions que je me pose.

- Souhaitez-vous ajouter quelque chose d'autre ?
- Y a-t-il une question que vous auriez aimé que je pose, mais que j'ai laissée de côté ?
- Avez-vous des questions à me poser ?

_____

Enregistrer l'heure de fin de l'IDI : __ __ hr __ __ min

Merci d'avoir participé à cette étude. Les informations que vous avez partagées seront très utiles. Y a-t-il quelque chose que vous aimeriez me demander ? *(pause)*. N'oubliez pas que toutes les informations que vous partagerez avec moi resteront confidentielles. Merci encore de m'avoir parlé.

Notes de terrain :

_____

_____

_____

3.4. IDI guide for Community Health worker

Date de l'IDI	___ ___ / ___ ___ / ___ ___
ID de l'enquêteur	
ID du site	

Enregistrer l'heure de début de l'IDI : ___ hr ____ min

INTRODUCTION :

Nous aimerions vous interroger sur vos expériences et vos opinions concernant l'utilisation et l'accès aux soins de santé primaires en matière de SSR et de VIH, y compris les schémas d'utilisation dans les centres de santé et les communautés soutenus par MSF. En outre, nous vous demanderons votre point de vue sur les obstacles à la prestation de services de santé sexuelle et reproductive et de lutte contre le VIH. Je vous poserai une série de questions fermées, puis des questions ouvertes où vous pourrez parler librement de vos expériences pendant que je prendrai des notes.

I. QUESTIONS INTRODUCTIVES

Sauf indication contraire, une seule réponse doit être sélectionnée.

Q#	Question	Réponse
1.	Quel est votre sexe ?	❒ (1) Femme ❒ (2) Homme ❒ (3) Autre identité: _____
2.	Quel est votre âge ? *(en années)*	____ ____
3.	Quelle est votre profession dans ce centre de santé/cette communauté ?	❒ (1) Infirmier(e) assistant(e) ❒ (2) Infirmière ❒ (3) Sage-femme ❒ (4) Infirmier clinicien ❒ (5) Conseiller ❒ (6) Agent de santé communautaire ❒ (8) Technicien en pharmacie ❒ (88) Autre, précisez : _____
4.	Depuis combien de temps travaillez-vous dans ce centre de santé/cette communauté ? (en années)	__ __

5.	Combien d'années d'expérience professionnelle avez-vous dans le domaine de SSR et/ou VIH ? (en années)	___ ___
6.	Avez-vous été formé par MSF pour fournir des services de SSR et VIH à la communauté?	❒ (0) Non ❒ (1) Oui
7.	Quand avez-vous été formé par MSF pour la dernière fois ?	___ ___
8.	Quelle formation avez-vous reçue de MSF ? ***Cochez toutes les cases qui s'appliquent***	❒ (1) Soins prénatals ❒ (2) Soins postnatals ❒ (3) Compétences en matière de conseil ❒ (4) Mobilisation communautaire ❒ (5) Conseil et dépistage du VIH ❒ (6) Recherche des contacts avec la tuberculose ❒ (8) Suivi des clients séropositifs perdus de vue ❒ (9) Renvois à l'établissement ❒ (10) VBG ❒ (11) Distribution de produits de planification familiale ❒ (12) Gestion communautaire des IST ❒ (88) Autre, précisez : _____

INSTRUCTIONS : *Les questions suivantes ne sont qu'un guide. Il ne s'agit pas d'une ligne de questions obligatoires, mais plutôt de questions suggérées. L'enquêteur doit formuler ces questions de la manière qui convient le mieux au participant.*

Allumez maintenant l'enregistreur audio.

Nous souhaitons tout d'abord comprendre les comportements de recherche des services de SSR et VIH par les membres de votre communauté. Il s'agit des services, tels que les soins prénatals, les soins de maternité, le planning familial et le dépistage du VIH, lorsqu'ils en ont besoin.

D. DISPONIBILITÉ ET ACCESSIBILITÉ DES SERVICES LIÉS AU VIH

9. Quels types de services liés au VIH sont fournis dans votre communauté ? Qui les fournit ?

10. La communauté a-t-elle accès aux services disponibles ? Pourquoi ou pourquoi pas ? Comment l'accessibilité à ces services peut-elle être améliorée ?

    Sondez : sensibilisation, peur, confidentialité, stigmatisation/honte ?

11. Quels sont les services liés au VIH dont les clients ont besoin mais dont ils ne savent pas qu'ils sont disponibles au point de service communautaire ? S'il s'agit de services : comment mieux informer la communauté de la disponibilité de ces services ?

E. DISPONIBILITÉ ET ACCESSIBILITÉ DES SERVICES DE SANTÉ SEXUELLE ET REPRODUCTIVE

12. Quels types de services liés à la SSR sont fournis dans votre communauté ? Qui les fournit ?

13. La communauté a-t-elle accès aux services disponibles ? Pourquoi ou pourquoi pas ? Comment l'accessibilité à ces services peut-elle être améliorée ?

    Sondez : sensibilisation, peur, confidentialité, stigmatisation/honte ?

14. Quels sont les services liés à la SSR dont les clients ont besoin mais dont ils ne savent pas qu'ils sont disponibles au point de service communautaire ? S'il s'agit de services : comment la disponibilité de ces services peut-elle être mieux communiquée à la communauté ?

F. PROCESSUS D'ORIENTATION

15. Dans quelle mesure l'orientation des patients fait-elle partie de votre rôle en tant qu'agent de santé communautaire ? Comment/où se fait l'orientation ? Quelles sont les difficultés rencontrées dans ce processus, le cas échéant ?

    Sondez : diagnostics, triage, gravité de la maladie, transport, documentation, suivi, disponibilité, distance, etc.

16. Quels sont les services de santé sexuelle et reproductive pour lesquels vous orienteriez les membres de votre communauté vers le centre de santé ?
    Sondez: VBG, TB, thérapie antirétrovirale, grossesses présentant des signes de danger, etc.

17. Où orientez-vous les clients qui recherchent des services de santé sexuelle et reproductive ou de lutte contre le VIH sur le site ? Pouvez-vous nous décrire le fonctionnement de ce processus d'orientation ?
    a. Comment sélectionnez-vous les clients à orienter vers les services de SSR ou de VIH ?
    b. Comment partagez-vous les informations entre le point de prestation de services de la communauté et l'établissement de référence ?
    c. Comment ce processus pourrait-il être amélioré ?

G. COMPORTEMENTS EN MATIÈRE DE RECHERCHE DE SOINS DE SANTÉ POUR LES MALADIES SEXUELLEMENT TRANSMISSIBLES ET LE VIH

18. Quelle est la probabilité que les membres de la communauté se rendent au centre de santé lorsqu'ils sont malades ou ont besoin de services ?

    f. Quelles sont, selon vous, les principales raisons ou les principaux obstacles qui empêchent de rechercher ou d'accéder à des services ?

    ***Sondez** : sensibilisation ? accès ? pression ? qualité de l'information/des services ? connaissance/manque de connaissance du processus ? La confiance ? Mauvais comportement en matière de recherche de santé ? Stigmatisation/discrimination? Commodité ? disponibilité des traitements ? disponibilité des services ?*

    g. Cela a-t-il tendance à se produire avec certains groupes de personnes (par exemple, les femmes, les hommes, les personnes âgées, les personnes vivant avec un handicap) ? Ou les personnes qui recherchent certains services **(par exemple, la violence liée au sexe, le VIH, les soins prénataux**) ? Quels groupes ou services ?

    h. Quelles sont, selon vous, les principales raisons ou les principaux obstacles qui empêchent de rechercher ou d'accéder aux services de VIH et de santé sexuelle et reproductive ?

    ***Sondez :** sensibilisation ? accès ? pression ? qualité de l'information/des services ? connaissance/manque de connaissance du processus ? La confiance ? Mauvais comportement en matière de recherche de santé ? Stigmatisation/discrimination ? Commodité ? disponibilité des traitements ? disponibilité des services ?*

19. Quels sont les facteurs qui motivent les personnes de votre communauté ( ) à accéder en temps voulu aux services de santé sexuelle et reproductive et de lutte contre le VIH nécessaires au dépistage de routine, aux soins préventifs, diagnostiques et thérapeutiques ?

    ***Sondez :** facteurs communautaires ? facteurs liés à l'établissement ? famille/amis ? expériences individuelles ?*

20. Que faudrait-il faire pour que davantage de membres de la communauté cherchent à obtenir des soins de santé sexuelle et reproductive et de lutte contre le VIH au niveau du centre de santé ?

    i. De la communauté ?

j. Du centre de santé ?

21. Quels sont les services de SSR et de VIH dont les clients ont besoin mais dont ils ne savent pas qu'ils sont disponibles au centre de santé ? S'il s'agit de services, comment peut-on mieux informer la communauté de la disponibilité de ces services ?

22. Quels sont les services de SSR et de VIH dont les clients ont besoin mais qui ne sont pas proposés au centre de santé ? Pourquoi ? Quelles sont les difficultés rencontrées pour offrir ces services ?

Sondez : problèmes de personnel, nombre de patients, infrastructure de laboratoire ou transport, disponibilité des médicaments ou des produits de base.

H. MOYENS, MOTIFS, POSSIBILITÉS

Moyens

23. Dans quels domaines vous sentez-vous le plus à l'aise pour soutenir les membres de votre communauté qui ont besoin de services de SSR et/ou de VIH ? Pourquoi ? Quels sont les groupes de personnes ou les services concernés ?

Sondez : services spécifiques (STIS, VBG, dépistage du VIH, etc.), conseils, orientation vers des établissements, mobilisation communautaire, jeunes, personnes handicapées, hommes, femmes, etc.

24. Dans quels domaines de votre travail avez-vous l'impression d'être moins bien informé ou d'avoir moins de compétences ? Dans quels domaines vous sentez-vous moins bien informé ou moins compétent ?

25. Quels types de boîtes à outils et de lignes directrices sont à votre disposition pour accroître votre confiance et vos compétences ? Pourquoi ?

26. De quoi avez-vous besoin pour fournir des services optimaux de SSR et de sensibilisation à la SSR et au VIH dans votre communauté ? Pourquoi ?

Sondez : charge de travail, infrastructure, sécurité, engagement des membres de la communauté, connaissances/formation, personnel, ressources matérielles (par exemple, infrastructure, équipement, fournitures)

Motivations

16. Quels sont les facteurs qui vous motivent à fournir des services optimaux de SSR et de sensibilisation à la SSR et au VIH dans votre communauté ? Pourquoi ?

Sondez : engagement communautaire, connaissances/formation, personnel, ressources (par exemple, infrastructure, équipement, fournitures, salaires)

Opportunités

27. Comment pensez-vous que la disponibilité des soins de santé sexuelle et reproductive et des soins liés au VIH peut être améliorée dans votre communauté ?

28. Comment pensez-vous que l'accessibilité des soins de santé sexuelle et reproductive et des soins de santé liés au VIH peut être améliorée dans votre communauté ?

CONCLUSION

Merci beaucoup ! Ce sont toutes les questions que je me pose.

- Souhaitez-vous ajouter quelque chose d'autre ?
- Y a-t-il une question que vous auriez aimé que je pose, mais que j'ai laissée de côté ?
- Avez-vous des questions à me poser ?

_____

Enregistrer l'heure de fin de l'IDI : __ __ hr __ __ min

Merci d'avoir participé à cette étude. Les informations que vous avez partagées seront très utiles. Y a-t-il quelque chose que vous aimeriez me demander ? *(pause)*. N'oubliez pas que toutes les informations que vous partagerez avec moi resteront confidentielles. Merci encore de m'avoir parlé.

Notes de terrain :

_____

3.5. Interview guide for external stakeholders

Date de l'entretien	___ ___ / ___ ___ / ___ ___
ID de l'enquêteur	
ID de l'organisation	

Identifiant de l'entretien IDI :

Heure de début : ___ hr ____ min

INTRODUCTION :

Merci encore d'avoir accepté de participer à cet entretien. Nous évaluons l'initiative de décentralisation du projet MSF Bangui, c'est-à-dire le soutien apporté par MSF aux centres de santé pour améliorer la disponibilité des services de SSR et de VIH plus proches de la population cible à Bangui. Pour cette évaluation, nous nous intéressons particulièrement à obtenir vos perspectives sur la pertinence de cette initiative dans le contexte du système de santé de Bangui, les comportements de recours aux soins de santé liés à la SSR et au VIH à Bangui, et le potentiel de succès, d'impact et de reproductibilité de l'initiative de décentralisation.

Laissez-moi vous expliquer brièvement le processus. L'entretien durera environ 30 minutes et j'aimerais l'enregistrer pour pouvoir capturer ce que vous dites. Cependant, votre nom et d'autres informations identifiantes ne seront partagés qu'avec les autres membres de l'équipe de recherche. Nous n'attribuerons pas non plus de citations ou d'autres informations à vous dans les rapports ou présentations résultant de cette évaluation. Vous pouvez nous demander d'éteindre le magnétophone à tout moment.

Consentez-vous à participer à l'entretien ?

□Oui

□ Non

Consentez-vous à l'enregistrement de l'entretien ?

□Oui

□Non

INSTRUCTIONS : Les questions suivantes ne sont qu'un guide. Ce n'est pas une ligne de questionnement obligatoire, mais plutôt des questions suggérées. L'intervieweur doit formuler ces questions de manière qu'elles conviennent le mieux au participant.

Allumez maintenant l'enregistreur audio.

Section 0 : Informations générales

1. Veuillez commencer par me parler un peu de vous. Pistes : Rôle professionnel, expérience éducative, durée de travail dans le district sanitaire ?
2. Veuillez me parler (davantage) de votre implication dans le projet MSF Bangui, le cas échéant.

Section I : Pertinence de l'initiative de décentralisation

Je voudrais maintenant vous poser quelques questions sur la mesure dans laquelle l'initiative de décentralisation du projet Bangui est pertinente pour le contexte du système de santé de Bangui.

3. Pour commencer, parlez-moi des problèmes les plus pressants en matière de SSR et de VIH à Bangui.

4. Quels sont les défis que vous rencontrez pour fournir des services de santé de qualité en matière de SSR et de VIH dans le contexte de Bangui ?
5. Dans quelle mesure les objectifs et les stratégies de mise en œuvre de l'initiative de décentralisation sont-ils alignés sur les priorités en matière de VIH et de SSR du système de santé de Bangui ? Comment cette initiative peut-elle répondre aux problèmes les plus pressants en matière de SSR et de VIH à Bangui ?
6. Si ce n'est pas pertinent, comment les objectifs et les stratégies de mise en œuvre de cette initiative pourraient-ils être améliorés pour les rendre plus pertinents par rapport aux priorités en matière de VIH et de SSR du système de santé de Bangui ?

Section II : Améliorer la disponibilité et l'accessibilité des services de SSR et de VIH

7. Quels sont les facteurs qui empêchent les gens de votre communauté d'accéder en temps voulu aux services de santé liés à la SSR et au VIH nécessaires pour le dépistage de routine, les soins préventifs, diagnostiques et thérapeutiques ?

Sondez: *Facteurs communautaires (stigmatisation, tabous entourant la sexualité, croyances culturelles et religieuses) ? Facteurs organisationnels (manque de médicaments essentiels, services peu accueillants, mauvaises attitudes des prestataires de soins, frais à la charge des patients, etc.) ? Facteurs interpersonnels (soutien du réseau social, etc.) ? Facteurs individuels (littératie en santé, âge, sexe, statut de handicap, etc.) ?*

8. Que faudrait-il pour que plus de membres de la communauté recherchent des services de santé de SSR et de VIH au point de soins communautaire ou au niveau du centre de santé ?

Sondez *: De la part des agents de santé communautaires ? Du centre de santé ? Pistes : Accès pour les populations vulnérables (adolescents, personnes en situation de handicap, etc.) et les populations clés.*

9. Quels sont les services de SSR et de VIH dont les clients ont besoin mais ne savent pas qu'ils sont disponibles au centre de santé ? Si des services : comment la disponibilité de ces services peut-elle être mieux communiquée à la communauté ?
10. Quels sont les services de SSR et de VIH dont les clients ont besoin mais qui ne sont pas proposés au centre de santé ? Pourquoi ? Quels défis rencontrez-vous pour offrir ces services ?

Sondez *: Problèmes de personnel, volumes de patients, infrastructure ou transport de laboratoire, disponibilité des médicaments ou des produits de base.*

Section III : Succès, impact et perspectives de reproductibilité de l'initiative de décentralisation

11. Parlez-nous des changements positifs clés que l'initiative de décentralisation a apportés dans la prestation des services de SSR et de VIH dans les centres de santé soutenus par MSF et les points de soins communautaires au sein du système de santé de Bangui.

Sondez *: Qualité des informations/services ? Commodité des services ? Disponibilité des traitements ? Disponibilité des services ? Frais des services ? Amélioration de l'utilisation des services de SSR et de VIH ? Amélioration du processus de référence pour les soins avancés du VIH et les soins maternels et néonatals d'urgence complets ? Amélioration des résultats de santé des patients ?*

12. Dans quelle mesure les changements apportés dans les centres de santé soutenus par MSF et les points de soins communautaires sont-ils susceptibles d'être maintenus et reproduits ailleurs par les autorités du district sanitaire / le ministère de la Santé en cas de retrait du soutien de MSF ?

***Sondez** : Pourquoi ? Pourquoi pas ?*

13. Quels facteurs organisationnels peuvent faciliter la reproduction de certains des succès des initiatives de décentralisation, telle que la gratuité des soins ?

***Sondez**: Changements de politiques ?*

CONCLUSION

Merci beaucoup ! Ce sont toutes les questions que j'ai.

- Y a-t-il autre chose que vous aimeriez ajouter ?
- Y a-t-il quelque chose que vous auriez aimé que je demande, mais que j'ai oublié ?
- Avez-vous des questions à me poser ?

Heure de fin de l'entretien: __ __ hr __ __ min

Merci d'avoir participé à cette étude. Les informations que vous avez partagées seront très utiles. Y a-t-il quelque chose que vous aimeriez me demander ? (*marquer une pause ici*). Veuillez-vous rappeler que toutes les informations que vous partagez resteront confidentielles. Merci encore de m'avoir parlé.

Notes de terrain : _____

3.6. Interview guide for Ministry of Health (MOH) stakeholders

Date de l'entretien	___ ___ / ___ ___ / ___ ___
ID de l'enquêteur	
ID de l'organisation	

Enregistrer l'heure de début de l'entretien : ___ hr ____ min

INTRODUCTION :

Merci encore d'avoir accepté de participer à cet entretien. Nous évaluons l'initiative de décentralisation du projet MSF Bangui, c'est-à-dire l'appui fourni par MSF aux centres de santé pour améliorer la disponibilité des services de SSR et de VIH au plus près de la population cible à Bangui. Pour cette évaluation, nous sommes particulièrement intéressés par votre point de vue sur la pertinence de cette initiative dans le contexte du système de santé de Bangui, sur les parcours de recherche de soins de santé sexuelle et reproductive et sur le potentiel d'efficacité, d'impact et de reproductibilité de l'initiative de décentralisation.

Permettez-moi de vous expliquer brièvement le processus. L'entretien durera environ 30 minutes et j'aimerais l'enregistrer afin de pouvoir saisir ce que vous dites. Toutefois, votre nom et les autres informations permettant de vous identifier ne seront communiqués à personne, à l'exception des autres membres de l'équipe de recherche. Nous ne vous attribuerons pas non plus de citations ou d'autres informations dans les rapports ou présentations résultant de cette évaluation. Vous pouvez nous demander d'éteindre l'enregistreur à tout moment.

Consentez-vous à participer à l'entretien ?

Oui ☐

Non ☐

Consentez-vous à l'enregistrement de l'entretien ?

Oui ☐

Non ☐

INSTRUCTIONS : *Les questions suivantes ne sont qu'un guide. Il ne s'agit pas d'une ligne de questions obligatoires, mais plutôt de questions suggérées. L'enquêteur doit formuler ces questions de la manière qui convient le mieux au participant.*

Allumez maintenant l'enregistreur audio.

Section 0 : Informations générales

1. Commencez par me parler un peu de vous.
   Sondages : Rôle professionnel, expérience éducative, durée du travail dans le district sanitaire ?
2. Veuillez m'en dire plus sur votre participation au projet MSF Bangui, le cas échéant.

Section I : Pertinence de l'initiative de décentralisation

J'aimerais maintenant vous poser quelques questions sur la pertinence de l'initiative de décentralisation du projet Bangui dans le contexte du système de santé de Bangui.

3. Pour commencer, parlez-moi des problèmes les plus urgents en matière de santé sexuelle et reproductive et de VIH à Bangui.
4. Quels sont les défis auxquels vous êtes confrontés pour fournir des services de santé sexuelle et reproductive et de lutte contre le VIH de qualité dans le contexte de Bangui ?
5. Dans quelle mesure les objectifs et les stratégies de mise en œuvre de l'initiative de décentralisation s'alignent-ils sur les priorités du système de santé de Bangui en matière de VIH et de SSR ? Comment cette initiative peut-elle répondre aux problèmes de SSR et de VIH les plus urgents à Bangui ?
6. Si ce n'est pas le cas, comment les objectifs et les stratégies de mise en œuvre de cette initiative pourraient-ils être améliorés pour les rendre plus pertinents par rapport aux priorités du système de santé de Bangui en matière de VIH et de SSR ?

Section II : Améliorer la disponibilité et l'accessibilité des services de SSR et de VIH

7. Quels sont les facteurs qui empêchent les membres de votre communauté d'accéder en temps voulu aux services de santé sexuelle et reproductive et aux services de santé liés au VIH nécessaires au dépistage de routine, aux soins préventifs, diagnostiques et thérapeutiques ?

Sonder : facteurs communautaires (stigmatisation, tabou entourant la sexualité, croyances culturelles et religieuses) ? Facteurs organisationnels (manque de médicaments essentiels, services peu conviviaux, mauvaise attitude du prestataire de soins, frais à la charge du patient, etc.) Facteurs interpersonnels (soutien du réseau social, etc.) ? Facteurs individuels (connaissances en matière de santé, âge, sexe, handicap, etc.)

8. Que faudrait-il faire pour que davantage de membres de la communauté recherchent des services de santé sexuelle et reproductive et de lutte contre le VIH au niveau du point de contact communautaire ou du centre de santé ?

   Sonder : De la part des agents de santé communautaires ? Du centre de santé ?
   Sonder : l'accès des populations vulnérables (adolescents, personnes handicapées, etc.) et des populations clés.

9. Quels sont les services de SSR et de VIH dont les clients ont besoin mais dont ils ne savent pas qu'ils sont disponibles au centre de santé ? S'il s'agit de services, comment peut-on mieux informer la communauté de la disponibilité de ces services ?

10. Quels sont les services de SSR et de VIH dont les clients ont besoin mais qui ne sont pas proposés au centre de santé ? Pourquoi ? Quelles sont les difficultés rencontrées pour offrir ces services ?

    Sondages : problèmes de personnel, nombre de patients, infrastructure de laboratoire ou transport, disponibilité des médicaments ou des produits de base.

Section III : Efficacité, impact et perspectives de reproductibilité de l'initiative de décentralisation

11. Parlez-nous des principaux changements positifs que l'initiative de décentralisation a entraînés dans la prestation de services de SSR et de VIH dans les centres de santé soutenus par MSF et les points de soins communautaires au sein du système de santé de Bangui.

    Sondes : Qualité de l'information/des services ? Commodité des services ? disponibilité des traitements ? disponibilité des services ? honoraires des services ? Amélioration du processus d'orientation vers des soins avancés en matière de VIH et des soins maternels et néonatals d'urgence complets ?

12. Quelle est la probabilité que les changements apportés dans les centres de santé et les points de soins communautaires soutenus par MSF soient maintenus et reproduits ailleurs par les autorités du district sanitaire/MOH en cas de retrait de l'aide de MSF ?

    Sondes : Pourquoi ? Pourquoi pas ?

13. Quels sont les facteurs organisationnels qui peuvent faciliter la replication de certaines des réalisations des initiatives de décentralisation, telle que la gratuité des soins ?
    Sondages : Changements de politiques ?

CONCLUSION

Merci beaucoup ! Ce sont toutes les questions que j'avais à vous poser.

- Souhaitez-vous ajouter quelque chose d'autre ?
- Y a-t-il une question que vous auriez aimé que je pose, mais que j'ai laissée de côté ?
- Avez-vous des questions à me poser ?

Enregistrer l'heure de fin de l'entretien : __ __ hr __ __ min

Merci d'avoir participé à cette étude. Les informations que vous avez partagées seront très utiles. Y a-t-il quelque chose que vous aimeriez me demander ? *(pause)*. N'oubliez pas que toutes les informations que vous partagerez avec moi resteront confidentielles. Merci encore de m'avoir parlé.

Notes de terrain :

_____

_____

_____

_____

_____

_____

_____

_____

3.7. Client Exit flow Survey

Formulaire de déroulement de la visite du client

Date de la visite __ / __ __ / __ __ __ __

Type de client : □Adulte (seul), □Adolescents et jeunes adultes âgés de 15 ans et plus, □Adulte accompagnant un enfant (âge de l'enfant : ____ mois), □Adulte accompagnant un adolescent de moins de 15 ans (âge de l'adolescent : ____ ans).

Heure d'arrivée du client : .....HH....MM

Instructions pour le client : Veuillez emporter ce formulaire avec vous et le présenter à chaque infirmière, médecin ou autre prestataire de soins que vous rencontrerez au cours de votre visite dans cet établissement aujourd'hui. Veuillez me remettre le formulaire dûment rempli avant de partir.

Instructions pour le prestataire : Lorsqu'un client vous présente ce formulaire, repérez la **première section non cochée** correspondant au prestataire vu et cochez la case correspondante (1er prestataire, 2ème prestataire, etc.). Fournissez vos services comme d'habitude. À la fin de la séance, cochez la case correspondant à la durée de la consultation (courte, normale ou prolongée) à côté de « Prestataire vu ». Dans la section A, indiquez les services que vous avez fournis au client en cochant les cases correspondantes. Dans la section B, indiquez toute référence interne en cochant la ou les cases correspondantes, le cas échéant. Si aucune référence interne n'a été faite, laissez cette section vide. Dans la section C, indiquez toute orientation externe vers un autre prestataire ou établissement de soins de santé.

Objet de la visite (cochez TOUT ce qui s'applique) :	□Vaccination ou visite de l'enfant en bonne santé	□Conseils, Dépistage ou soins en matière de VIH

[A remplir par le membre de l'équipe d'évaluation qui interrogera le client] □Soins prénatals(CPN) □Soins postnatals (CPoN) □Visite d'un enfant malade	□Planification familiale □Counseling/provisionnement évaluation, conseil ou traitement en matière de nutrition	□Conseils, Dépistage ou soins en matière d'IST □Laboratoire VIH ou SSR □Pharmacie pour le VIH ou la SSR Autre (précisez) : .....

1er prestataire vu Durée de la consultation : □Court □Normal □Extendu

1A. Quel(s) service(s) avez-vous fourni ? **(cochez TOUT ce qui s'applique)**		1B. Vers quels services avez-vous orienté le client **dans votre établissement ?**	
□Soins prénatals □Soins postnatals visite-mère □Soins postnatals visite-enfant □Vaccination des enfants □FP conseil □LAM conseil □FP provision □Conseils/tests de dépistage du VIH □Soins VIH (ART) □PTME □Dépistage/Diagnostic des IST □Traitement IST □ Soins aux victimes de violences sexuelles	□Visite/traitement TB □Pesée d'enfants/MUAC □Conseil en nutrition infantile □Soutien à la nutrition maternelle, infantile et juvénile □Supplémentation en fer-mère □Supplémentation en fer-enfant □Vitamine A-enfant □Dispensation de médicaments □Test de laboratoire □Autre (préciser) : _____	□Soins prénatals □Soins postnatals visite-mère □Soins postnatals visite-enfant □Vaccination des enfants □FP conseil □LAM conseil □FP provision □ Conseils/tests de dépistage du VIH □Soins VIH (ART) □PTME □Dépistage/Diagnostic IST □Traitement IST □ Soins aux victimes de violences sexuelles	□Soins/Traitement TB □Pesée d'enfants/MUAC □Conseil en nutrition infantile □Soutien à la nutrition maternelle, infantile et juvénile □Supplémentation en fer-mère □Supplémentation en fer-enfant □Vitamine A-enfant □Dispensation de médicaments □Test de laboratoire □Autre (préciser) : .....

1C. Avez-vous orienté le client vers une autre formation sanitaire ? □Oui □Non

Si oui, où ? .....

☐ **2e Prestateur vu** Temps de consultation : □Court □Normal □Extendu

1A. Quel(s) service(s) avez-vous fourni ? **(cochez TOUT ce qui s'applique)**		1B. Vers quels services avez-vous orienté le client **dans votre établissement ?**	
□Soins prénatals □Soins postnatal visite-mère □Soins postnatals visite-enfant □Vaccination des enfants □FP conseil □LAM conseil □FP provision □Conseils/tests de dépistage du VIH □Soins VIH (ART) □PTME □Dépistage/Diagnostic des IST □Traitement IST □ Soins aux victimes de violences sexuelles	□Soins/traitement TB □Pesée d'enfants/MUAC □Conseil en nutrition infantile □Soutien à la nutrition maternelle, infantile et juvénile □ Supplémentation en fer-mère □ Supplémentation en fer-enfant □Vitamine A-enfant □Dispensation de médicaments □Test de laboratoire □Autre (préciser) : _____	□Soins prénatals □ Soins postnatal visite-mère □ Soins postnatals visite-enfant □Vaccination des enfants □FP conseil □LAM conseil □FP provision □ Conseils/tests de dépistage du VIH □Soins VIH (ART) □PTME □ Dépistage/Diagnostic des IST □ Traitement IST □ Soins aux victimes de violences sexuelles	□Soins/traitement TB □Pesée d'enfants/MUAC □Conseil en nutrition infantile □Soutien à la nutrition maternelle, infantile et juvénile □ Supplémentation en fer-mère □ Supplémentation en fer-enfant □Vitamine A-enfant □Dispensation de médicaments □Test de laboratoire □Autre (préciser) : .....

1C. Avez-vous orienté le client vers une autre formation sanitaire ? □Oui □Non

Si oui, où ? .....

APPENDIX 4: ADDITIONAL SUPPORTING DATA (HEALTH INDICATORS, BUDGET BREAKDOWN)

3.1. Terms of reference (TOR)

Annex I. Terms of Reference (003).pdf

3.2. Logic framework

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3.3. HIV and SRH road maps

Feuille de route VIH Projet Bangui.docx

Feuille de route SSR.docx

APPENDIX 5: DATA ANALYSIS MATRIX

Quantitative analysis:

We analyzed the quantitative data collected from 134 exit survey respondents using descriptive statistical methods. After data cleaning in Microsoft Excel, we applied binary coding where applicable to facilitate aggregation of closed-ended responses. Using pivot tables and functions, we summarized categorical variables through frequencies and percentages. Our analysis focused on describing results in service availability, utilization, costs, affordability, and client experiences. We also conducted cross-tabulations to compare select variables, such as reported costs and their perceived affordability.

Qualitative analysis:

Two members of the evaluation team transcribed the interviews conducted in French verbatim, while two local research assistants transcribed the interviews conducted in Sango verbatim, and simultaneously ensuring their translation into French. Qualitative data, including interview transcripts, field notes, and memos, were then imported into NVivo for data coding and organization. Two members of the evaluation team analyzed the data using a predefined codebook. This codebook included a-priori codes based on the OECD evaluation criteria and new codes that emerged from our data. We employed deductive and inductive thematic analysis techniques to examine the coded data (Braun & Clarke, 2006).