

EVALUATION OF

MSF'S DECENTRALIZATION INITIATIVE IN BANGUI, CENTRAL AFRICAN REPUBLIC

IMPROVING THE AVAILABILITY AND ACCESSIBILITY OF SRH AND HIV SERVICES

SUMMARY REPORT

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

The evaluation was conducted independently by Cambridge Reproductive Health Consultants, USA.

This report is a summarized version of the full evaluation report and was developed by the SEU.

DISCLAIMER

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

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**. 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

A mixed-methods approach was used 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.

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 services¹. Similar patterns have been documented in Uganda, Malawi, and Kenya, where men's disengagement persists despite targeted efforts to enhance their involvement¹. 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 waived¹. In the CAR, including Bangui, where the majority of the population lives below the poverty line¹, 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

¹ For references and the complete bibliography, see the final evaluation report.

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 disparities². 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 reliable². 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

²For references and the complete bibliography, see the final evaluation report.

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 behaviour³.

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)³: 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

³ For references and the complete bibliography, see the final evaluation report.

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 exit⁴. In CAR, where health governance and public financing mechanisms are weak, the absence of structured transition planning risks reversing current gains.

⁴ For references and the complete bibliography, see the final evaluation report.

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.