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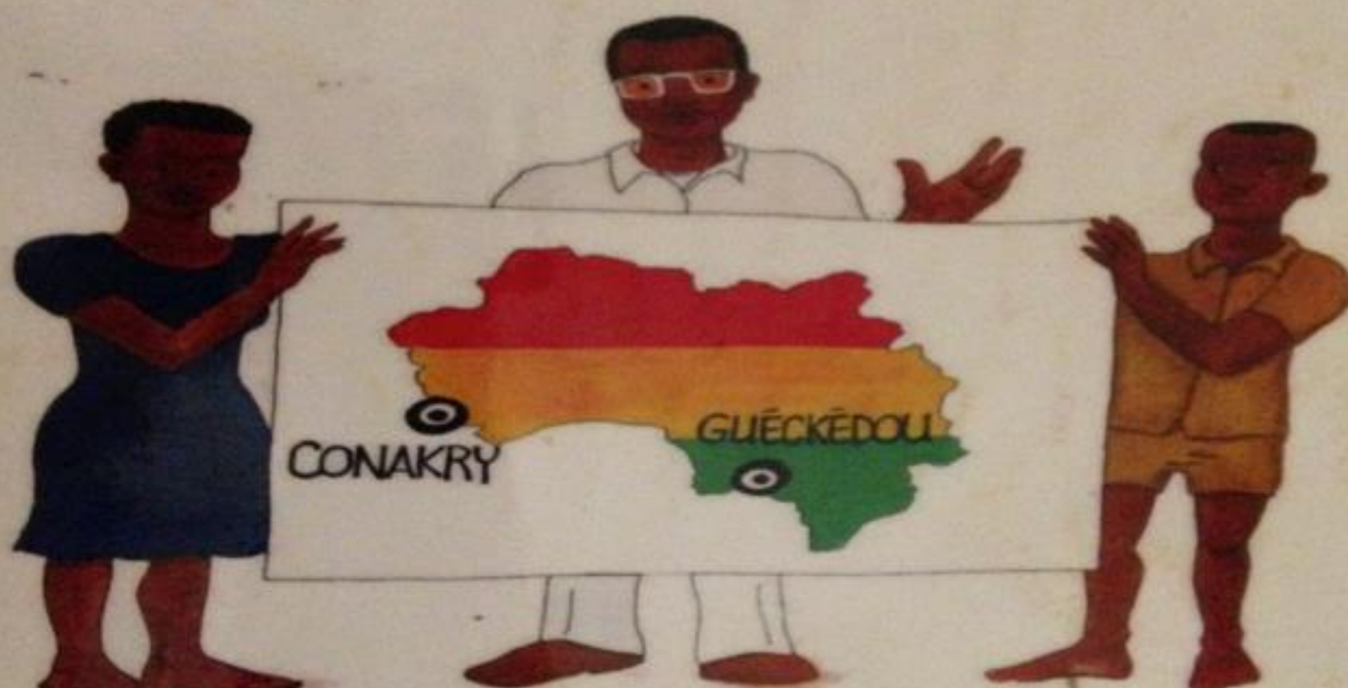

EVALUATION

Evaluation of improving access to care for people with AIDS and /or Tuberculosis project (MSF-OCB Matam project)

[March 2014]

This publication was produced at the request of the Stockholm Evaluation Unit of Médecins sans Frontières. It was prepared independently by by *Dr. Moussa COULIBALY, MD, MPH PhD Health Nutrition Specialist.*

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ATC	Ambulatory Treatment Centre
ARV	Antiretroviral
CM	Case management
DAC/OECD	Development Assistance Committee / Organization for Economic Cooperation and Development,
GDCD	General Directorate of Cooperation and Development
HIV	Human Immunodeficiency Virus
MOHPH	Ministry of Health and Public Hygiene
NACP	National HIV AIDS Control Programme
NTBCP	National TB Control Programme
NAC	National AIDS Committee
NAPHP/STI/HIV/AIDS	National AIDS Program for the Health care and Prevention of STI / HIV /AIDS
OTC	Outpatient Treatment Centre
PLWH	People leaving with HIV
PMTCT	Prevention Mother to Child Transmission
STIs	Sexual Transmitted Infections
TB	Tuberculosis
MSFB	Médecins Sans Frontières Belgium
VCT	Volunteer Centre of Diagnostic
WHO	World Health Organization

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Executive Summary

EVALUATION PURPOSE AND EVALUATION QUESTIONS

The evaluation is conducted at the end of funding cycle agreement with the donor and provides a suitable opportunity in the project cycle to review the objectives. The evaluation will provide analysis and recommendations for the future orientation and implementation of the project in Guinea.

PROJECT BACKGROUND

In public primary Health structures, the top ten causes of consultation are those of any developing country in a tropical environment, with an overwhelming predominance of communicable diseases. According to the 2011 statistical yearbook, in decreasing order of frequency, there is malaria (41%), acute respiratory infections (21%), helminthic infections (13%), non- bloody diarrhoea (7%), vaginal discharge (3.5%), gastritis / ulcers (3.3%), anaemia (2.5%), lower abdominal pain (2.5%), trauma, and dermatological diseases.

The 10 leading causes of death identified in the public hospitals are: severe malaria, anaemia, HIV / AIDS, diabetes, high blood pressure, non-bloody diarrhoea, cardiovascular diseases, and anaemia in women in pregnancy, infections lower respiratory tract and meningitis.

HIV / AIDS, STIs

National HIV prevalence in the general population is 1.7%, higher among women (2.1%) versus 1.2 % for men. Women are twice as vulnerable as men. The highest prevalence is found in the age group 35 to 39 years (2.9 %), 40-44 years (2.1%) and 25 and 29 years (2.0%). In the 15-24 age group, women are two times more vulnerable than men. Early sexual relationships do not seem to be associated with HIV prevalence. Regarding seroprevalence by region, there is an unequal distribution throughout country. HIV prevalence is 2.1 % among women and 2.5 % of pregnant women attending antenatal clinics in 2008. This prevalence among pregnant women has regional disparities.

Regarding the accessibility of people living with HIV (PLWH) to antiretroviral drugs (ARVs), it is reported in 2010 that 20 430 PLWH were receiving treatment on a total of 36 266 [30 819 to 43 514, Spectrum estimation 2010] PLWH eligible, an average proportion of care is 56%.

Tuberculosis (TB) is a major public health problem in Guinea with a fatality rate of 8%. The number of TB cases is increasing year-by-year due to TB / HIV coinfection and improved reporting of cases. The prevalence of tuberculosis is estimated at 407 cases per 100 000 people. The national target in the control of tuberculosis is to achieve a detection rate of 70% and a cure rate of 85% by 2015. Approximately 30% of patients with pulmonary form of TB have TB/HIV coinfection (WHO).

Situation of the management of co-infection TB/HIV in Guinea

According to WHO, TB incidence, all forms combined, is estimated at 183 [151-219] per 100 000 people in Guinea. Thus, it is expected 28 443 TB cases per year. According to 2012 data from Matam Ambulatory Treatment Centre (ATC), seropositivity among TB is 25 %, which is close to the sites figures of National Tuberculosis Control Programme (NTBCP). The number of TB cases related to PLWH is estimated at 5 404. According to data reported by the program NTBCP, 1 670 patients were diagnosed co -infected with HIV and TB in 2012, which corresponds to 30% of expected cases.

The low rate of detection of TB among PLWH is linked to the lack of diagnostic facilities, and the low coverage for antiretroviral therapy is related to the non-integration of the management of these two diseases. Furthermore testing sites and management of TB and HIV are not always in the same facilities.

It is noted that the supply of medicines is not regular depending on whether it is tuberculosis or HIV. Staff does not have the training for concomitant treatment of these two diseases. Multi- Resistant TB is not currently supported. 95% of reported patients are awaiting treatment for 2 years due to lack of drugs for the second -line treatment of TB. This figure could be far lower than reality because culture and drug susceptibility testing of TB is not made systematically according to WHO recommendations.

Psychosocial care: although the importance of psychological support is well recognized by care providers, the lack of expertise as well as of funding it should be noted that psychosocial support for PLWH is underdeveloped. Only a few partners, MSF, DREAM, GIZ, have implemented these activities in HIV sites. There is a well trained and experienced staff in Matam ATC recruited by MSF who is well-appreciated and acting as reference for the other team players. MSF has worked with some PLWH associations to ensure psychosocial care in centres' supported by MSF.

Factors influencing the spread of HIV: (i) Poverty: mining sites are the ideal places for an increasing number of sex workers; (ii) The customs and practices: female genital mutilation, still widely in practice especially in rural areas, polygamy, etc. (iii) The social environment: the status of men and women in society, fear of HIV etc. and (iv) Stigma & Discrimination: HIV is still a taboo subject for fear of being rejected by the community.

PURPOSE OF THE GRANT from DGCD/MSFB

Due to severe shortage in HIV funding in the country as well as other factors, MSF has taken a large substitution role with a heavy commitment of total costs, which, continues to grow and could turn out to be a threat for the sustainability of the program.

SECTOR GOAL AND OBJECTIVES OF THE PROJECT

The sector goal is to contribute to reducing mortality and morbidity due to AIDS and / or tuberculosis of general population and in the project specific areas. The specific objective of the project is to improve access for people with AIDS and / or tuberculosis (in Conakry) through a good quality of care and access in health facilities supported by MSF Belgium (MSFB) including: (i) capacity building in AIDS and / or tuberculosis case management, (ii) the Information, Education and Communication (IEC), screening, prevention and treatment in accordance with WHO guidelines.

BRIEF DESCRIPTION OF PROJECT

The project includes the following 3 components:

- Component I: Capacity building for quality case management in the project target health facilities;
- Component II: Strengthening decentralization and accelerate the integration of AIDS and / or tuberculosis case management in the minimum package delivered in target health facilities;
- Component III: Support to Project Coordination /Management Unit.

The project achievements include:

- Capacity building of Directorates of Health Communal and health centres in the implementation of HIV / AIDS and / or tuberculosis case management algorithm/ protocol;
- Updated Laboratories and health facilities enabling them to monitor patients under antiretroviral treatment;
- Improving access to quality health care and ARV drugs and specific antibiotics for opportunistic infections;
- Scaling up best practices in Water sanitation, personal and collective hygiene...

PROJECT COST AND FUNDING

The cost of the project at evaluation is estimated at 11.177 million euros (87.259 billion GNF) excluding Guinean government contribution in terms of employees of the public service and/or agreement. The project is funded by a grant from the Directorate General for Cooperation and Development for an initial amount of 9,035 million Euros, 81% of total project cost funded the majority of project activities and 2.145 million Euros from MSF. The updated

project cost upon completion as of 31 Dec.2013 is 13.815 million Euros (107.86 billion GNF) in excess of 2.648 million Euros (23.69%). This excess is distributed as follow: GDCD 0.611 million Euros and MSFB 1.724 million Euros.

PROJECT IMPLEMENTATION

The project was carried out by MSF Belgium for over 3 years from January 2011 to December 2013. An Executing Agency namely Project Coordination Unit was established. The Project document and various activities reports at our disposal don't have any project implementation timeline. This should have enabled us to assess the performance in terms of compliance with the actual timeline compared to the one established during the evaluation.

EVALUATION QUESTIONS, DESIGN, METHODS AND LIMITATIONS

The evaluation purpose is: (i) to collect and analyse information on the implementation and acceptance of the management protocol adopted by MSF and (ii) for documenting lessons learned, bottlenecks and risks that could jeopardize the sustainability of project achievements, for a future extension of the coverage of the city of Conakry and /or others regions. This assessment could form the basis of an informative reflection to set up the next steps of ownership of the Project by the Guinean government.

Project Performance Evaluation: from the findings and information available, the consultant assessed the project performance based on six criteria recommended by the Development Assistance Committee (DAC) of OECD including relevance, effectiveness, efficiency, coverage, impact and viability. The added value of MSFB action has also been the subject of a specific topic as the seventh evaluation criteria, Consistency.

The evaluation is based on participatory approach as well as quantitative and qualitative methodologies. This is not an impact study of the program per say, but rather the identification of success factors and challenges as experienced in the short period of implementation of the protocol for HIV/AIDS case management. The methodology includes a review of the literature and available data during the implementation of the program and the use of a series of tools and techniques of data collection (direct observation of the circuit of case management, the semi-structured interviews of key informants, and focus groups involving staff in charge of CM in the Project sites, PLWH and PLWH associations.)

FINDINGS

In order to achieve its objective, the project has to strengthen the capacity of six health facilities in the city of Conakry as defined in the national strategic framework protocol. In the long term, the project will contribute to the increase of life expectancy at birth in the project area. In the mid-term, the project interventions should be able to contribute to the reduction of morbidity and mortality related to HIV / AIDS and Tuberculosis. Although interventions are limited to six health facilities, the results will improve health indicators status at the national level.

The project has contributed to: (i) strengthening the country capacity to make quality health care aiming at reducing the morbidity and mortality of AIDS and / or tuberculosis in the most vulnerable populations, (ii) the implementation of a protocol for Case management of AIDS and / or tuberculosis, and (iii) the harmonization / promotion on the integration of AIDS/TB case management at a "single window".

The intervention of MSFB was considered as a humanitarian emergency (which in principle is limited in time) has become a long-term intervention with a growing need for human resources, financial resources and facilities.

Involvement and accountability of MOHPH Ownership Project: Our observation is that the national partner who is supposed to lead the strategic framework for the fight against AIDS and the national health policy to meeting the implementation of management activities, has neither qualified nor enough human resources, nor the financial resources to fulfil its mission. It is urgent that the MOHPH and the Executive Secretary (ES) of the National AIDS

Committee (NAC) and National AIDS Program for Health Care and Prevention of Sexual Transmitted Infections (NAPHP/STIs) and HIV/AIDS provide the human and financial resources to conduct satisfactory implementation of the national strategic framework. The OHPH must own the project in case of MSFB withdrawal in order to ensure sustainability.

Project Staff future: At the moment more than 120 staff members are in charge of the project in the six Health facilities. The future of these qualified personnel is uncertain in terms of their presence in the health facilities after MSF departure. It is recommend that the MOHPH must schedule an **acceleration of project Staff recruitment and/or integration plan** and benchmarking for December 2017 withdrawal deadline of those MSFB staff for the sustainability of the projects outputs.

Lack of coordination of AIDS and/or tuberculosis: At the time of this assignment, several partners (MSFB, DREAM Solthis, GiZ) were involved in the control of AIDS. There is no structure at national level in charge of coordination of interventions in terms of AIDS care management. The NAPHP/STIs and HIV/AIDS or ES / NAC does not have the human and financial capacity to carry out coordination of ongoing operations in the country. UNAIDS does try for better coordination, but in any case it should not replace the government.

Lack of implementation schedule: The project implementation looks like a routine activity without any timing constraints.

Joint supervision of Communal Directorate of Health and sanitation and the Project coordination team: It appears that only 25% of joint supervision missions planned (1 supervision by quarter for a total of 12) was performed. As such, this timeline could not be met by Guinea.

The analysis of Matam project can be regarded as lessons learned for future scaling up or replication to the entire city of Conakry and possibly to the whole country.

No effective integration of CM AIDS/Tuberculosis in the minimum package of activities: The integration of the CM in the minimum package of activities (MPA) in health centres is not effective or accepted in some project sites. Our finding is that the staff in health centres seem to consider case management activities as extra work with regard to the data collection and analysis; a huge problem is the integration of AIDS and tuberculosis case management in the same facility as a "single window". Actually, these two diseases are managed by two independent national control programs and have no common platform for the implementation.

Nutritional support to PLWH and Tuberculosis patients remains the weak link in the management while under nutrition appears to be a common complication of HIV infection. It is now established that an effective program of care and nutritional support improves the quality of life of PLWHIV and /or TB patients. During this assignment no food and nutritional support algorithm/protocol has been made available to us because it doesn't exist.

CONCLUSIONS

The expected outcomes/results include:

- Project support to Six Health facilities of Conakry in terms of capacity building supporting quality care and access and free for people with AIDS and / or tuberculosis, the size of the cohort of patients (average of 10 500) treated or not and the case management of co- infection AIDS / TB at a "single window";
- Strengthening Decentralization and Acceleration of integration of AIDS and / or tuberculosis case management in the minimum package delivered at the project supported health facilities.

At completion of the project, all health facilities were equipped and operational for AIDS and / or tuberculosis case management.

Having no basis data/indicators between 2003 and 2013 as reference, particularly in the project area, the health statistics from Project database and reports to national authorities show favourable indicators with trend of reducing morbidity and mortality.

The sustainability of the project results is not guaranteed under the non-appropriation of the project by the government. The government should mobilize substantial resources to ensure the sustainability of project achievements.

This project did not follow a formal project cycle in particular the official identification and preparation phase. There was no mid-term review plan. MSF in the future should improve the quality of its project proposals complying with International project cycle standards.

The achievements of the immediate and expected results of the **project are considered highly satisfactory**.[1]

[1] See Evaluation Criteria Table below, adapted from Table No4: Summary Assessment of Project Performance Criteria as the OECD / DAC on p.26

EVALUATION CRITERIAS	**RANKING SCORE**[2]
Overall project rating	4,14 (Highly Satisfactory)
RELEVANCE: Project is part of the national strategic framework of the country and one of MSFB priorities	5
APPROPRIATENESS: Project objectives are relevant because they address to real and pressing needs of the beneficiaries and fit perfectly into the Country strategic framework and in achieving the Millennium Development	5
EFFECTIVENESS: The approach adopted by the project is effective for the implementation because it inflicts a permanent presence and trainer on the field. Strengthening management capacity of health centres and the mobilization of staff and therefore effective adoption of close monitoring have facilitated the implementation Quality of training: caregivers qualified training "complete", "relevant", "successful", located in the "excellence", "not difficult", "beautiful", "extraordinary", and they have improved their knowledge and skills in AIDS/TB case management	5
EFFICIENCY: We can safely say that the price / quality ratio is very satisfying for the reason that life is priceless and in the draft over 10236 patients supported including pregnant and lactating women and children with a unit cost estimated at €195 per year against €120 per day in the West is very satisfying. Factors that helped achieve the level of current efficiency are among others the willingness of partners MSF and MOH) to join forces (human, financial...) and their expertise. MSF has set up appropriate structures and systems (teams monitoring / supervision, planning and follow-up Associations' agents on site) in close collaboration with municipal health authorities	5
COVERAGE: Lacking the recent population figures of Conakry, and on the basis of the prevalence of the target population in 2008 is estimated at more than 17,000 patients. Qualitative information from the discussions trend to confirm the low coverage of the project, while highlighting a number of issues that may affect the project membership. One of the problems raised by the officials interviewed is the geographical accessibility of certain CDS, which is a limiting factor in achieving the maximum target populations. This confirms that the project at this stage does not cover the entire target population Indeed, the coverage rate also depends on the screening and patient decision to accept or not to join the project. In addition the suspension of including new patients from 1 January 2014;	3
IMPACT: The project contributes to the improvement of indicators of health status of vulnerable population targeted by the project.	4
CONNECTEDNESS/Sustainability: Insufficient funding and qualified personnel for the continuation of proper management of AIDS and / or tuberculosis in the country in general threatens the viability and long-term experiences of the project. Project activities involve more attendance (due to the quality and price of care). However, they are not fully integrated into the health centres daily activities package. Ending payment of allowances and incentives packages by the project will affect the future trend of activities; It was suggested that the management might be integrated. Allowances / incentives introduced by the project could not be supported by the Go Guinea for budget constraints	2

[2] 5 if the performance is highly satisfactory
4 if the performance is satisfactory
3 if the performance is Partially satisfactory
2 if the performance is unsatisfactory;
1 if the performance is highly unsatisfactory

Summary Matrix of Findings, Evidence & Recommendations

Findings[3]: problems and issues identified	Evidence (sources that substantiate findings)	Recommendations[4]
Key recommendations		
The intervention of MSFB was considered as a humanitarian emergency (which in principle is limited in time) has become a long-term intervention with a growing need for human, financial and facilities resources	The project is ongoing since 2005 but the formal project started on January 2011. The Project activities will continue until December 2017, official withdrawal deadline.	MSF, in the future, does not engage as a leader in such operation without a second partner who could take over in an acceptable time.
Involvement and accountability of MOHPH Ownership Project: Our observation is that the national partner who is supposed to lead the strategic framework for the fight against AIDS and the national health policy to meeting the implementation of management activities, has neither qualifier and enough human resources nor the financial resources to fulfil its mission.	MSF disengagement from GUECKEKOU HIV Project was not conclusive and the GoGuinea doesn't wish to be face the same situation.	MOHPH must take the ownership of the project before MSFB's withdrawal in order to ensure the sustainability of the project achievements. MOHPH/ ES/NAC and NAPHP/STI HIV/AIDS shall provide the human and financial resources to conduct satisfactorily the implementation of the national strategic framework.
No effective integration of AIDS/Tuberculosis case management in the minimum package of activities: the effective integration of the CM in the minimum package of activities in health centres is not effective or accepted in some project structures.	The effective integration of the AIDS/TB management the minimum package of activities of health centres is not effective / accepted because staff in place seems to consider the activities as extra work too restrictive with regard to the data register and analyse	The integration of AIDS and tuberculosis case management in the same facilities as "single window" must be a challenge for GoGuinea/MOHPH. These two diseases are two independent national programs and have not established a common platform for the implementation of the "single window AIDS / TB ".

[3] A finding uses evidence from data collection to allow for a factual statement.
[4] Recommendations are proposals aimed at enhancing the effectiveness, quality, or efficiency of a project/programme; at redesigning the objectives; and/or at the reallocation of resources. For accuracy and credibility, recommendations should be the logical implications of the findings and conclusions.

Important recommendations		
Joint supervision of Project coordination team and the Communal Directorate of Health and sanitation. This schedule could not be met by Guinea.	The schedule was one joint supervision mission per quarter could not be met by Guinea. Only 25% (3 out of 12 planned) of supervision were effective	Project Coordination and MOHPH must agree to schedule new planning of joint supervision missions and performed them by the Dec. 2017
Acceleration of project Staff recruitment and / or integration and benchmarking for December 2017, MSF withdrawal deadline.	At the moment more than 120 staff member are in charge of the project in the six Health facilities. The future of these qualified personnel is uncertain in terms of their presence in the health facilities after MSF departure	MOHPH must schedule a recruitment plan of those staff for the sustainability of the projects outputs
Nutritional support to PLWH and Tuberculosis patients' remains the weak link in the management while under nutrition status appears to be a common complication of HIV infection. It is now established that an effective program of care and nutritional support improves the adherence to treatment and the quality of life of PLWH and /or TB patients	During this assignment no food and nutritional support formal protocol and or Nutrition Support program has been made available to us because it doesn't exist	GoGuinea with Partners support must launch a study on nutritional support to PLWH as well as Tuberculosis patients and design a nutritional support protocol and program
The analysis of the Matam project can be regarded as lessons learned for future scaling up or replication to the entire city of Conakry and possibly to the whole country.	During the assignment, this issue was discussed and outcomes are expected by the deadline of MSF disengagement	GoGuinea must setup a working group for reflection on Matam project to highlight the best practices and how to extend them …
Lack of coordination of AIDS and / or tuberculosis: At the time of the mission, several partners are involved in the fight against AIDS. There is no structure at national level in charge of coordination of interventions in terms of AIDS care management	The MOHPH/ ES/NAC and NAPHP/STI HIV/AIDS do not have the capacity (human and financial) to carry out coordination of ongoing operations against HIV/AIDS. UNAIDS, tries to coordinate but in any case it should not replace the government	GoGuinea must setup a task force for HIV activities coordination

1 Evaluation Purpose & Evaluation Questions

1.1 EVALUATION PURPOSE

The evaluation is conducted at the end of funding cycle agreement with the donor and provides a suitable moment in the project cycle to review the objectives of the project. The evaluation will provide analysis and recommendations for the future orientations and implementation of the similar project in Guinea or somewhere else.

The evaluation purpose is: (i) To collect and analyse information on the implementation and acceptance of the case management (CM) algorithm/protocol adopted by MSF and (ii) for documenting lessons learned, bottlenecks and risks that could jeopardize the sustainability of project achievements, for a future scaling up to the city of Conakry and /or others regions. This assessment could form the basis of an informative reflection to set the next steps of ownership of the Project by the Guinean government.

The Project Performance Evaluation: From the findings and information available, the consultant evaluates the project performance based on six criteria recommended by the Development Assistance Committee (DAC) of the OECD including relevance, effectiveness, efficiency, coverage, impact and viability. The added value of the action of MSFB has also been the subject of a specific topic examination as and is the seventh endpoint evaluation criteria as Consistency.

The evaluation is based on participative approach as well as on quantitative and qualitative methodologies. This is not an impact study of the program, but rather the identification of success factors and challenges as experienced in short period of implementation of the protocol for HIV / AIDS case management. The methodology includes a review of the literature and available data following the implementation of the program and the application of a series of tools and techniques of data collection (direct observation of the circuit of case management the semi-structured interviews of key informants, and organizing focus groups involving project staff, PLWH and PLWH associations). The evaluation will address the following specific questions:

- **Consistency**: Is the project consistent with national and regional strategy and priorities of countries in support of HIV / AIDS and tuberculosis?
- **Relevance**: Is the intervention appropriate in relation to the development priorities of the country and the national policy of AIDS/TB CM in the target population? Is the strategy appropriate for achieving the objectives?
- **Effectiveness:** Have the objectives been achieved? What are the reasons for the success and / or failure to achieve them? What are the results compared to quality standards (MSF and WHO) and what can be done to improve the effectiveness of the intervention? What do the beneficiaries of this project think; do they have a positive perception of its effectiveness? What are the changes necessary to meet the needs and expectations of the beneficiaries? What can be done to improve the effectiveness of the intervention?
- **Efficiency:** Is the project cost-effective, based on qualitative and quantitative results obtained inputs (cost / efficiency unit cost of processing etc.)? Are the staff, volunteers and partners (at the decentralized level, communities and others) involved in the program? Are they able to implement and support the program as expected? What recommendations can be made to improve the training, supervision and other necessary support for the program?
- **Impact:** Does the project have (or not) a positive contribution to the evolution of the state of health of the population? Does our (MSF) presence have unintended positive or negative effects?
- **Coverage:** Does the project achieve its objectives in the target population in the project area? If not, why? What recommendations can be made to improve coverage? Is the program well integrated with other activities of health services targeted at populations and communities? What recommendations can be made to improve the integration and / or coordination of services and programs focused on project needs of AIDS and / or tuberculosis case management?

- **Sustainability:** What long-term problems that could compromise the project's achievements have / can be identified, and how were they addressed? What are the local and identified resources necessary to ensure continuity and sustainability of acquired abilities/ capacities?

2 Project Background

2.1 COUNTRY CONTEXT

With a population of 10.2 million inhabitants in 2010, the Republic of Guinea covers an area of 245 857 km2, with four natural regions characterized by the diversity of climate and culture. The majority of the population (71%) lives in rural areas where agriculture is still the main activity. The country is faced with a mass exodus of young people to urban centres and mining areas. The level of population growth remains high (3.1%), as does economic growth. Such a growth rate will result in a doubling of the population in the next 25 years. Life expectancy at birth in Guinea is estimated at 58.9 years in 2012. The adult literacy rate (15 years and older) in 2005 was 28.3% and that of adult men (15 years and older) about 55.5 %. At the socio-political level, there is a high flow of refugees and internally displaced populations due to conflicts over fifteen years in the sub-region, which has a visible and negative impact on the environment and basic infrastructure. Internally, the aggravation of poverty and difficulty to access basic social services has caused a socio-political crisis that could jeopardize social peace and the efforts made by the government.

2.2 HEALTH SITUATION

In public primary structures, the top ten causes of consultation are those of a developing country in a tropical environment, with an overwhelming predominance of communicable diseases. According to the 2011 statistical yearbook, in decreasing order of frequency, there is malaria (41% of consultations), acute respiratory infections (21%), helminthic infections (13%), non- bloody diarrhoea (7%), vaginal discharge (3.5%), gastritis / ulcers (3.3%), anaemia (2.5%), lower abdominal aches and pains (2.5%), trauma, and dermatological diseases. Life expectancy at birth in Guinea estimated at 54 years in 1992 to 58.9 years in 2012, an increase of 5 years in 13 years. The overall mortality rate is estimated 10.9.

The main direct causes of maternal deaths are uterine rupture (23%), eclampsia (19%), and complications of induced abortion (16%), infections (16%), haemorrhage (15%), and dystocia (10 %).

The largest indirect causes are malaria, the malnutrition of women before or during pregnancy, micronutrient deficiencies, low availability of services for HIV testing and comprehensive care for pregnant women, low power decision of women, and limited family income.

The 10 leading causes of death identified in the public hospitals are: severe malaria, anaemia, HIV / AIDS, diabetes, high blood pressure, non-bloody diarrhoea, cardiovascular diseases, and anaemia in women in pregnancy, infections lower respiratory tract and meningitis.

HIV / AIDS, STIs: the HIV epidemic in Guinea is generalized type and the national HIV prevalence in the general population is 1.7% and is higher among women (2.1%) against 1.2 % for men. The highest prevalence is found in the age group 35 to 39 years (2.9 %), 40-44 years (2.1%) and 25 and 29 years (2.0%). In the 15-24 age group, women are two times more vulnerable than men. Early sexual relationships do not seem to be associated with HIV prevalence. Regarding seroprevalence by administrative region, there is an unequal distribution on the national territory. HIV prevalence is 2.1 % among women and 2.5 % of pregnant women attending antenatal clinics in 2008. This prevalence among pregnant women has regional disparities. The prevalence of HIV / AIDS can be considered low, however its impact should not be overlooked. In addition, many players consider this as prevalence underestimated. **Finally, more than 61% of HIV + patients do not have access to care.** As part of the access of people living with HIV to antiretroviral drugs (ARVs), in 2010, 20 430 PLWHIV were receiving treatment on a total of 36 266 [30 819 to 43 514] PLWHIV eligible, an average proportion of care is 56%.

Tuberculosis is a major public health problem in Guinea with a fatality rate of 8%. The number of TB cases is increasing

year-by-year due to TB / HIV coinfection and improved reporting of cases. The prevalence of tuberculosis is estimated at 407 cases per 100 000 people. The national target in the fight against tuberculosis is to achieve a detection rate of 70% and a cure rate of 85% by 2015. Approximately 30% of patients with pulmonary form of TB have TB/HIV coinfection.

2.3 SITUATION OF THE MANAGEMENT OF CO-INFECTION TB/HIV IN GUINEA

According to WHO, TB incidence, all forms combined, is estimated at 183 [151-219] per 100 000 people in Guinea. Thus, 28 443 TB cases are expected per year. According to data from 2012 Matam ATC, seropositivity among TB is 25%, which matched the figures sites TB case management. The number of TB cases related to people living with HIV is estimated at 5 404. According to data reported by the national TB control program, 1 670 patients were diagnosed co-infected with HIV and TB in 2012, which corresponds to 30% of expected cases. Only half of the co-infected patients were detected and had both TB and HIV treatment.

The low screening **of TB among people living with HIV** is linked to the lack of diagnostic facilities, and low coverage for antiretroviral therapy is related to the non-integration of the management of these two diseases. Indeed, testing sites and management of TB and HIV are not always in the same health facilities.

The supply of medicines experiences irregularities and stockout depending on whether it is tuberculosis or HIV. Staff does not have adequate training for concomitant treatment of these two diseases. Multi- Resistant TB is not currently supported. 95 reported patients are awaiting treatment for 2 years due to lack of drugs of the second-line treatment of TB. This figure could be far lower than reality because culture and drug susceptibility testing of TB are not made systematically according to WHO recommendations.

Psychosocial care: Although the importance of psychological support is well recognized by care providers, lack of expertise and lack of funding meant that psychosocial support for PLWH is underdeveloped. Only a few partners, MSF, DREAM, GIZ, have implemented these activities in HIV sites. There is a well trained and experienced staff in Matam ATC recruited by MSF who is well appreciated and now serves as reference for the other team players. MSF has worked with some associations of PLWH to ensure psychosocial care in health centres supported by MSF.

Factors influencing the spread of HIV: (i) Poverty: mining sites are attractive sites for increasing number of sex workers; (ii) the customs and practices: female genital mutilation still widely in practice especially in rural areas, polygamy, etc. (iii) the social environment: the status of men and women in society, fear of HIV etc. and (iv) Stigma & Discrimination: HIV is still a taboo subject for fear of being rejected by the community.

2.4 DEVELOPMENTAL CHALLENGES ADDRESSED BY THE PROJECT

Since March 2002 a National Committee for the Fight against AIDS (NAC) was established as the only national body for policy coordination, guidance and decision-making. The NAC was attached to the Prime Minister's Office since its inception, however in February 2009, in order to mark more of the authorities' commitment to support efforts in the response to HIV, was the NAC has been relocated under the authority of the Prime Minister, who is the chairman. This position confirms the decision of the Government of Guinea to consider AIDS, not only as a major public health problem, but also and especially as a development issue and a matter of national survival.

Despite this progress, the period 2008-2009 is characterized by the persistence of a number of challenges that impinge on leadership and coordination according to results of a recent consultation / evaluation of the implementation of the Three Guiding Principles response in Guinea. These challenges include:

- Weak leadership function and coordination of the Executive Secretariat (ES) of the NAC since its creation. Since 2011, there is a brand new ES/NAC, and he has improved the leadership of the NAC;
- Lack of human resources on the organizational chart of the NAC at the central level as well as its absence at the decentralized level;
- Low capacity of NAC/ES to mobilize financial resources both at national level, as well as from technical and financial partners for the implementation of the National Strategic Framework;

- Low capacity of national actors in the management of funds;
- Low availability of financial resources including a weak financial participation of the government and financial partners in the difficult socio-political context that the country is crossing.

As part of the national response, the country has a **national strategic framework**, the third one 2013-2017 following the two others of 2008-2012 and 2003-2007. The National Strategic Framework document is the national agenda of the AIDS response, which all stakeholders and partners should apply as basis for their interventions. The implementation is governed by the principle of **"Three One's" or three guiding principles namely: One instance of coordination, One Monitoring and Evaluation Plan and One National Strategic Framework.** This framework sets out five guiding principles of the national strategy and the five strategic areas of the fight against HIV / AIDS.
The five (5) guiding principles are:

- Strengthening of universal access to prevention, treatment, care and support;
- Consolidation of the multi-sectorial and decentralized approach to the fight against HIV and STIs;
- Taking into account the gender dimension in the fight against HIV and STIs;
- Strengthening of the coordination, harmonization and alignment;
- Strengthening good governance and leadership.

The five (5) strategic priorities are:

- Prevention of transmission of STIs and HIV;
- Supports medical and nutritional care for PLWH;
- Protection and support for PLWH and affected by HIV and other specific groups people;
- Governance, partnership, coordination and resource mobilization;
- Monitoring the epidemic, monitoring and evaluation, strategic communication and promotion of research.

The Act L/2005/025/AN of 22 November 2005 on the prevention, care and control of HIV / AIDS in Guinea was enacted by Ordinance No. 056/2009/PRG/SGG of October 29, 2009. It sets the legal framework for the national response. Support free Anti Retro Viral and medical care by the government were announced in a joint decree of the Ministries of Health and Hygiene, Finance and Social Affairs signed in July 2007 for following aspects: (i) HIV testing, (ii) medicines for Opportunistic Infections management (when available), (iii) Anti Retro Viral (ARV), and (iv) the CD4 count and viral load (when available). The patients, as well as tests for diagnosis and monitoring of treatment of opportunistic infections pay other testing for pre- therapeutic assessment and monitoring.

2.5 MSFB ACTIVITIES AND PERFORMANCE IN THE COUNTRY AND SECTOR IN RECENT PAST

Since 1987 MSF has been working in Guinea on projects related to primary health care. However, in 1990, Liberian, Sierra Leonian and from 2002 Ivorian displaced populations have sought refuge in Guinea following the socio -political conflicts in these countries. The MSF program has then developed medical assistance programs to refugees in addition to long-term programs. MSF has intervened in partnership with the Government in the following programs: (i) supporting the National TB Control Programme to Conakry from 1990 to 2005, (ii) managing cholera outbreak in Conakry (1994), (iii) managing measles epidemic in Conakry in 2000, (iv) starting of the project " Street Children in Conakry " and Inner City Health Project in 2000, (v) starting HIV/AIDS program in 2003 in Gueckedou (vi) managing cholera outbreak in Conakry in 2005, (vii) supporting Matam ATC (2005) and (viii) managing wounded cases during social unrest and strike in 2007, an Important emergency response to cholera outbreak, which has claimed thousands of victims in Conakry CM CLC Kaporo Rail. At the mission date, MSF was leading the vaccination campaign against the measles outbreak since January 2014.

2.6 MSF ONGOING ACTIVITIES COMPLETING and OVERLAPPING IN RELATION TO THE PROJECT

During this assignment, the project was extended in phase II for four years (January 2014-December 2017). During this phase, MSF will no longer be supporting PLWH and TB co-infected of Matam Project. The withdrawal phase is very important because it will enable the Government to prepare to take over the project achievements for sustainability.

3 Evaluation Methods & Limitations

3.1 TOOLS DEVELOPED FOR THE EVALUATION

All project sites (Matam, CHU Donka; Gbessia Port; Wanidara, Flamboyant, Bernay Fotoba and FMG representing 100% of sites) have been included in the evaluation to ensure a variety of sites representative of different contexts. It is understood that the centre of Matam, the largest and oldest sites have required more time to be conducted for the team. The activities included an assessment of the case management field, a qualitative analysis of the entire project from January 2011 to December 2013 in addition to a qualitative data analysis of users and beneficiaries.

The evaluation is based on participative approach as well as quantitative and qualitative methodologies. This is not an impact study of the program, but rather the identification of success factors and challenges as experienced in the short period of implementation of the protocol for of HIV / AIDS. The methodology includes a review of the literature and available data following the implementation of the program and the use of a series of tools and data collection (direct observation of the Case Management process during semi-structured interviews of key informants, and focus groups involving staff in charge of case management of, PLWH and PLWH associations.)

The **quantitative indicators** are derived from the analysis of statistical data available to us (not the project) and from reviewing records when visiting sites; each site visited took into account records and input process for data centralization, the statistics provided in the quarterly progress reports and / or annual reports. The inclusion criteria for patients in active cohorts; (iii) a collection of quantitative from indicators from an observation data available at the management structure of the project.

The **choice of qualitative Methods**: the objective of the main qualitative data collection is to identify the challenges and successes of the project implementation. Conducting individual interviews and focus groups allowed us to carefully assess the opinions and feelings of those responsible for the implementation of the project, as well as considering beneficiaries of services (PLWH on ARVs or not, members of associations of PLWH). In addition to this network we followed patients during the consultation in order to assess the operating modes. The qualitative method consists of: (i) semi-structured interviews recorded according to a guide (Appendix in 4), (ii) as well as focus groups using dictation record tool.

3.2 LIMITATIONS OF THE EVLUATION APPROACH AND TOOLS

Following interviews at the central level have been made: the Executive Secretary of the NAC, the Director of the National Program for the Health Prevention of STIs / HIV /AIDS and the Chief of Dermatology Service at the Donka University Hospital and the project coordinating team members. At the site level, managers and consultants' doctors in all project sites were interviewed.

However, interviews with directors of Communal Health could not be held due to timing conflict. In all the sites visited, an individual interview was conducted with the heads of health centres as well as with each responsible for service delivery covered by the CM; in addition a group interview (Matam ATC) including 13 members of the team in charge of the CM in terms of feedback.

Regarding the PLWH Associations, the difficulty was related to shyness that beneficiaries feel before the discussion because of the socio-cultural context of the Muslim population and especially the appearance and rejection due to stigmatizing the disease in Guinean society. There is need to build confidence and communicate before obtaining the community support and participation. In order to identify resources in the PLWH we had to sample among the group of patients attending the meeting of psychosocial support of the day (12 persons including 2 chaperones). Their commitment to the project varies from one month to two years and ARV and / or no ARVs.

The second group interview was conducted with beneficiaries as meeting discussions with representatives of four (04)

PLWH involved in the implementation of the project, (09 members in total). These discussion groups have contributed on how the beneficiaries, target people perceive the project.

These interviews were rich in information. However, due to the problem of language and interpretation, we have some doubt about the reliability of the translation especially when interviewing PLWH. To ensure the correct interpretation, the discussions should have been taped and then translated by 2 different interpreters for validation / confirmation of beneficiaries' opinions. That was not the case.

Regarding the analysis of the quantitative data, it was pretty easy because of the quality of the data made available by the project team. Monthly activity and annual reports provided to us by the Project Coordination seemed complete and of satisfactory quality. This could be explained by the regularity of the formative supervision conducted by the project teams and the data clerks trained in the collection and record keeping.

These criteria are explained in a table in Appendix 4. For each of these criteria, the consultant provides a valuable judgment on each of the evaluation questions with regards to the review criteria. This judgment is summarized for each evaluation synthesis according to the model in Appendix 4.

Data collection covers the period from January 2011 to December 2013 and relates to all sites covered by the project and supplemented by qualitative data analysis of beneficiaries (see scorecard evaluation criteria in Appendix 4).

4 Findings, Conclusions & Recommendations

4.1 FINDINGS

4.1.1 PROJECT BACKGROUND DESIGN AND READINESS FOR IMPLEMENTATION

Given the situation that Guinea knew in the 90s and sub-regional conflicts with displacement (Liberia, Sierra Leone and Cote d'Ivoire in 2002), the situation of HIV / AIDS was invisible and was a major public health problem and development. Faced with this situation, which was exacerbated by the socio-political crises, MSF despite its huge mission-managing emergency and / or humanitarian situation is still committed to the fight against HIV/AIDS, which is currently considered as a humanitarian intervention that lacks visible action in the area. It is in this context that in April 2003, a first contact with the Ministry of Public Health has focused on free health care, the signing of an agreement, participation in the development of national guidance on decision management of opportunistic infections (OIs) and Anti Retro Viral (ARV), lobbying for the importation of generic ARVs in Guinea.

HIV / AIDS program in Conakry and Guékedou was launched in July 2003 and the activities began with the opening of the Volunteer Diagnostic Centre (VCT) and the Ambulatory Treatment Centre in Matam. Finally, treatment with ARVs Conakry began only in May 2004. HIV program was supported by MSF through the national TB Control program. Initially, the target population was TB patients co-infected with HIV and vulnerable groups. Activities were undertaken to promote HIV testing among the population. 2006 was the year of consolidation of the project, with major building to increase the centres' capacity and changes in work organization to provide greater capacity and more efficient use of available resources. At the end of 2007, a component of decentralization initiated in order to address the ongoing increase in the number of patients as well as improve access to treatment.

The control of HIV / AIDS remains underfunded in Guinea: the State covers 5 % to 7 %; donor partners 9-11 % and 80% patients through cost recovery; although more than 50 % of the population lives below the poverty line. The largest donors in the fight against HIV / AIDS are: PEPFAR, UNITAID, and CHAI, which are unfortunately absent in Guinea. Although the Guinean government has increased its HIV budget, resources remain largely insufficient. The Global Fund remains the only donor in Guinea with 30.7 % of the funding allocated to HIV. The talking is ongoing among others potential donors including World Bank, Muscoda Fund (French Cooperation) USAID and NGOs MSF GiZ, DREAM, AEDES-Belgium NGO. After Global Fund, MSF remains today the main actor involved in the field of CM HIV in the country.

MSF using its resource mobilization policy received funding from the General Directorate for Development and Cooperation (DGDC) for this project. An assessment was made for the justification that needs additional funding to ensure the long-term CM of PLWH in Conakry.

The Project Appraisal Document in our possession seems to be the original report dated August 2010. We have not had the opportunity to discuss with the authors. Upon review, it appears to us that the project was not sufficiently prepared and therefore did not follow the entire process of the project cycle i.e. from identification to evaluation. Thus, it is not clear for us that the document clearly indicated the analysis points justifying the merits of assistance from MSF. It appears that at the time of preparation of the project document, the Government in the context of the national response, had another national strategic framework 2008-2012 that defined the five guiding principles of the national strategy and five strategic areas of the fight against HIV / AIDS.

The project Appraisal document is well formulated but does not present a procurement procedures plan for goods and services. It does not indicate cost by the project in case of recovery of recurrent costs by the government, and the process of internal control and external audit. Some information available has not been mentioned probably because not deemed necessary (internal control processes and certification of accounts). The specific objective does not meet the SMART (Specific, Measurable, Agreed, Realistic and Time-bound) and indicators for most do not meet the criteria

(Quality and Quantity Time) and are more for the majority indicators of activities. This has led to a project reformulation in 2011. This review has focused on: (i) the specific objective to meet the SMART criteria and MSF vision in terms of service use and (ii) expected results were ranked in order of priority and some were reformulated adding 2 results in relation to decentralization in two new sites and the inclusion of PMTCT.

We find inconsistencies in the Project document (2 titles of project (i) Improving access to care for people with HIV and / or TB and (ii) Epidemic HIV / AIDS in Conakry is supported in an integrated manner, contributing to the reduction of mortality and morbidity related to the epidemic.) Even though the document took into account the priorities of the Strategic Framework, it certainly has not been the subject of extensive consultation and participatory approach in its evaluation. This would allow the involvement of stakeholders to participate in setting goals and achievements of the project. Objectives and indicators identified in the original document do not meet the usual criteria. Three main indicators in the logical framework of the project are acceptable against most of those in the descriptive results that do not meet the criteria thus are more as activities than indicators. There is no reference to the nutritional support of patients with AIDS and / or tuberculosis.

Some changes were made as reformulation and introduction of new indicators and results. Expected results increased from 4 to 6 and indicators from 23 to 33 in the new formulation. At the end of this reformulation, no implementation timeline and procurement plan of goods and services has been developed making it difficult to assess the project performance.

The project is complementary to the operations financed by other providers and donors: World Bank, African Development Bank, European Development Fund, German Development Cooperation (GIZ), USAID and others.

The project is located in the city of Conakry. The strategy adopted by the project is to achieve its objectives of the CM of HIV / AIDS and TB co-infection case management through effective integration in daily activities that include the minimum package of activities. The project also could anticipate an extension in a near future to all health facilities in the city of Conakry, if not all health facilities on the country.

The visibility of the MSF intervention remains diffuse in health facilities of the project. The original document of the funding proposal was not the working document of the project coordination team. For what reason? We did not get a satisfactory answer.

4.1.2 PROJECT DESCRIPTION AND BASIC DATA

Objectives and project components

The sector goal is to contribute to reducing mortality and morbidity due to AIDS and /or tuberculosis in the city of Conakry. To this end, the project aims to improve access for people with AIDS and /or tuberculosis (in Conakry), to support quality and access in facilities supported by MSF Belgium (MSFB) through: (i) capacity building for AIDS and/or tuberculosis case management, (ii) the outreach implementation, screening, prevention and treatment in accordance with WHO international guidelines and (iii) the establishment of a system for collecting and processing data (statistics and health information). According to the evaluation report (August 2010), no component and/or operational axis is indicated. The concept of focus intervention is not adopted until after the roundtable conducted in August 2012. After reorganizing the intervention axes, we could consider that the project would include the following components:

Component I: Capacity building in support of quality: ARV protocol, TB/HIV, psycho-social care and PMTCT in health facilities supported by the project. It consists of (i) the training and sensitization of health personnel, recruited officers and associations' agents for the implementation of the project, (ii) improvement of health facilities reception areas and care through extension, rehabilitation, biomedical equipment and furniture, office and supply of ARV / drugs and inputs / consumables laboratories of health facilities supported by the project.

Component II: Strengthening decentralization and acceleration of integration of AIDS and / or tuberculosis case management in the minimum package delivered in health facilities supported by project through the selection of new sites as well as the training, equipment and procurement of drugs and consumables and making them accessible for health care quality to the target groups of the project.

Component III: Support to the Project Management Unit: Involves the Project Coordination, Advocacy with national authorities and Operations Research and Outreach Communities / population sensitization on HIV / AIDS and tuberculosis through information education communication (IEC) accountability of members / religious and traditional leaders of the community to actively participate in their health and hygiene individual and collective.

Project Basic Information /Data

The baseline data of the project are presented below:

Date of approval:	September 2010 (to be confirmed by MSFB)
Signature Date:	September 2010 (To be confirmed by MSFBBC)
Term forecast for completion:	36 months (3 years)
Total Project Cost:	EUR 11.177 millions
DGDC contribution:	EUR 9.035 millions
MSFB Fund:	EUR 2.142 millions
Start Date:	January 2011
Date of first disbursement:	January 2011
Initial Closing Date:	December 31, 2013
Actual Closing Date:	December 31, 2013
Amount disbursed to 31/12/2013:	EUR 13.816 million (Rate: 123.61 %)
Implementing agency of the project:	MSFB / Coordination MSF

Institutional Capacity Building

At the Governance level a single national body of policy coordination, guidance and decision-making composing the National Committee for the Fight against AIDS (NAC) was set up and attached to the prime minister office since its inception, the reason for which is to mark more of the authorities' commitment to support efforts in the response to HIV. Other challenges impeding the leadership and coordination of the NAC include:

- Weak leadership function and coordination of the Executive Secretariat of the NAC;
- Lack of human resources at the ES/NAC and its absence at the decentralized level;
- Low capacity of ES/NAC to mobilize financial resources both at national level as well as partners' technical and financial support;
- Low capacity of national actors in the management of funds;
- Low availability of financial resources, including a weak financial participation of the government as well as financial support from partners in the difficult socio-political context that the country is in the process of crossing.

At the Ministry of Health and Public Hygiene, the National AIDS Program for Health care and Prevention of STIs / HIV/AIDS (NAPHP STI/HIV/AIDS) is the entity responsible for case management. From an operational point of view, the issue of management of AIDS is the responsibility of NAPHP STI/HIV/AIDS whereas supporting Tuberculosis is the responsibility of the National TB Control Program. The budget allocated by the government does not allow NAPHP STI/HIV/AIDS to carry out its leadership role in the conducting of the various projects / programs against AIDS and especially the psychosocial case management. The result is a lack in coordination among the different actors involved in the fight of AIDS at the central and the regional levels. This lack of coordination is accentuated at the NAPHP STI/HIV/AIDS by a lack of appropriate expertise that has been raised, the insufficient number of staff, logistics and funding at NAPHP STI/HIV/AIDS. UNAIDS is playing the technical and coordination support to HIV / AIDS program in Guinea.

At Community Health Directorates level, the HIV / AIDS focal point, among other duties, should ensure compliance with the protocol of the case management, monitoring and evaluation. This staff is not in place. This compromises the implementation of HIV/AIDS response both in Conakry and the rest of the country.

4.1.3 PROJECT IMPLEMENTATION ANALYSIS AND ACHIEVEMENTS

The project is implemented by MSFB in partnership with the Ministry of Health and Public Hygiene / Sanitation Department of the City of Conakry. As part of monitoring the implementation of the project, MSF has set up in Matam

Health Centre a team for the implementation of the project. For the 5 others, it is just an MSF supervision team in charge of assessing and coaching the daily performance of the project activities implementation. This team was composed of expatriate and national experts, labourers and volunteers of Associations of PLWH. The staff of an accumulated number of 414 agents over 3 years (95 in 2011, 100 in 2012 and 219 in 2013) including 28 expatriates (10 in 2011, 10 in 2012 and 8 in 2013) that provided implementation and monitoring of project.

COMPONENT I: Capacity building on quality in health facilities supported by the project.
This involves capacity building through training: (i) training/sensitization of health personnel, recruited health officers and associations 'agents, (ii) improvement of reception areas and care through the extension / rehabilitation, biomedical equipment and office furniture, and ARV/drugs and consumables for laboratories to make them operational in AIDS and/or tuberculosis case management (iii) and evaluation of all health workers to determine their performance for proper management of patients with AIDS and / or tuberculosis in five health facilities. The case management activities took place at the following facilities: Donka Hospital, Matam, Flamboyant, Wanidara, Gbessia Port, FMG, and Bernay Fotoba.

Office spaces (consulting rooms, waiting rooms, care, hospital rooms, storage of goods and medicines) have been built and equipped by the project. At the time of the evaluation, the overall structure of the project has received the equipment, materials, staffing, drugs, consumables and laboratory inputs and is operational (the list of equipment by health facility and the stock situation drugs at the time of the mission).

Ongoing assessment of health workers involved in the care of AIDS and / or tuberculosis is conducted by a team of monitoring/supervision of MSFB. This assessment: (i) determine the level of ability (strengths and weaknesses) of health providers and (ii) plan training / refreshing sessions aiming at areas covering gaps / shortcomings in proper management of AIDS according to the protocol.

The training component included: (i) basic and Advanced Training on HIV with paediatric component (PMTCT) with regular coaching in 2013; training in laboratory technics with regular coaching in 2013; psychosocial training and coaching. The committee conducted the trainings following the establishment of 6 zones for waste disposal with regular coaching; and implementation of health structures. 97 volunteer members instead of 75 expected of the four associations of PLWH involved in the project, which was trained in the psychosocial support and community awareness for improving the prevention and desire to know their status. The completion rate is 129.33 % (97 members trained instead of 75).

Supervising CM activities is a close monitoring provided by the staff of MSFB, communal Directorate of Health officials for knowledge transfer. Joint supervision with Conakry City Directorate of Health on a quarterly basis did not take place as planned in 2011 and 2012. This close monitoring was effective only in 3 supervisions visits (25%) out of 12 in 2013 as planned during the implementation period the project. This could be explained by the difficulties of a non-availability of a team from Conakry City Directorate of Health.

Health information system (collection and processing) project has developed a first system for collecting and processing data (Base Fuchsia data) between 2005 and 2011. This involved training officers for the operation of Fuchsia. This component consists of: (i) training in the use of Fuchsia system and (ii) office equipment, computer equipment and consumables to health facilities in order to ensure sound statistical quality data. In 2013, Fuchsia system was abandoned in favour of a more efficient and friendly user Tier.Net system. At the time of the visit, this system was effective.

COMPONENT II: Strengthening decentralization and accelerate the integration of AIDS case management and / or tuberculosis in the minimum package of activities
This involves the selection of new sites in the context of decentralization (4 new sites selected) and the training of health workers, equipment and staffing, drugs and consumables available to new sites making them accessible to CM and health care quality of target groups. The 3 new sites including Tombolia (waiting for clearance of the MOH), Miniére, and Coléah Sonfonia, in which the project activities were supposed to be supported from the 4th quarter of 2013, were not effective at the mission date.

Decentralization seems mandatory because of the influx of medical visits / new patients in the CMC Matam in particular. However, because of the upcoming withdrawal of MSFB, new HIV + patients were no longer supported since 31 December 2013. A waiting list of patients tested HIV + is open and these patients will be priority patients for ARV treatment at the reopening of the cohorts. The implementation of this component will cover the period of withdrawal of MSF.

COMPONENT III: Support to Project Management
This consists of the provision of resources for the Project Coordination, Operational Research, Advocacy with national authorities, Community Outreach (population at risk from HIV / AIDS and TB) through information education and communication; to be conducted by religious and traditional leaders from the community for active participation in (community and individual) good health and hygiene.

At the completion (31-Dec.2013), the project covered costs for 13 temporary fix term contract, 64 permanent fix term contract, awarded 19, and 38 agent's daily transportation allowances and 8 expatriates positions. At the time of the mission (March 2014), the project had initiated the merging of its coordination unit with MSF National Coordination of Operations Office, Phase I of the gradual withdrawal with immediate effect leading to reducing costs through job cuts and office rental. This merging was supposed to be completed by the end of March.

At the completion, the project has financed: (i) the training of 53 journalists from the public and private press; 5 TV stations were involved in outreach activities as part of the World Day against AIDS led by the PLWH Association namely REGAP +, (iii) 15 interventions radio / TV in the fight against stigma / discrimination, (iv) one public talk show with the NAC (iv) 1 Magazine on Radio Espace FM- Guinea (v) 43 sessions of sensitization in 5 communes of Conakry (vi) 18 social events, (vii) 55 public testimonies in the 5 communes of Conakry, and (viii) one giant Carnival in Kaloum for closing the fortnight awareness " UNIT 15 ".

4.1.4 ANALYSIS OF PROJECT COST, FINANCING PLAN AND DISBURSEMENTS

Project cost at evaluation
The project initial cost at evaluation is estimated at EUR 11.177 million (GNF 87.259 Billion (Tab 1a) according to the sources provided. Another presentation could be made by results, components and/or categories of expenditure. Conventional Categories of expenditure of projects and or investment programs are: Civil Works, Goods and Services. The cost of the project is presented in terms of currency (EURO). While salaries of local staff and local procurement are expected to be quoted / traded in local currency (GNF).

At appraisal, although the partnership with the Ministry of Health and Public Hygiene provides a contribution in kind (inputs, food, medicines, and personal) no quantitative estimate was available. It is understood that the contribution of the MOH PH through the employees of the public and / or public convention should be taken into account in the initial and actual project cost

Table No1a: Project Cost at Evaluation by source of financing (millions EUR /€)

SOURCES	FOREIGN CURRENCY	LOCAL CURRENCY (GNF)	TOTAL (€)	% Sources
CDGC+ FS (5,47%)	9, 035	70 536,723	9, 035	80,81%
MSF	2, 142	16 721,930	2, 142	19,19%
Gov. Guinea	NA	-NA	NA	NA
TOTAL	11,177	87 258,653	11,177	100,00%

Project actual cost at completion
The Project cost at completion is estimated at EUR 13.816 million for an initial cost of EUR 11.177 million. There has been an increase of EUR 2.638 million (23.60%). Table 1b shows the actual project cost at the date of December 31,

2013 without estimating the significant contribution of the Government (employees of the public service / public agreement) without which the results would probably not be those that we consider through this report.

Tableau No1b: Project actual Cost at completion by financing sources (millions EUR /€)

SOURCES	FOREIGN CURRENCY	LOCAL CURRENCY (GNF)	TOTAL	% Sources
DGDC +FS (5,47%)	9.887	77 184.744	9, 887	71,56%
MSF	3.929	30 676.414	3, 929	28,44%
Government Guinea	NA	-NA	NA	NA
TOTAL	13.816	107, 861.158	13.816	100,00%

GDCD contribution increased from EUR 9.035 to 9.887 million (9.45% increase) and the MSF contribution from EUR 2.142 to 3,929 million (83.43 % increase). This increase could be explained by the variations in the drugs cost according to the prescription of new drugs other than AZT and changes in the exchange rate of the Euro to Guinea Francs over the 3 years 2011-2013.

Amounts and dates of disbursements (eur millions)

Disbursements from the GDCD fund and MSF -B at the project completion are respectively EUR 13.815 million (100%). At the date of the mission, there is a EUR 5.575 million disbursed, but under certification. Table 2 below summarizes the status of disbursements by source of financing.

Table No2: Disbursement Amounts and dates by sources of financing (EUR millions)

Item	DGD	MSFB	TOTAL
Total Approved	9.887	3.929	13.816
Amount Cancelled	0.00	0.00	0.00
Available Balance	0.00	0.00	0.00
Total Disbursed	**9.887**	**3.929**	**13.816**
Annual Disbursement			
Year 2011	4.616	1.098	5.714
Year 2012	4.661	1.107	5.768
Year 2013	0.609	1.725	2.334
Year 2011 to 2013	**9.887**	**3.929**	**13.816**

4.1.5 PROJECT PERFORMANCE AND ACHIEVEMENTS IN THE LIGHT OF IMPLEMENTATION SCHEDULE AND OBJECTIVES

The project has implemented cascade strategy training on the basis of the current MSFB protocol and in accordance with international requirements. It is clear from the assessment that there is no focal point HIV / AIDS Tuberculosis in Communal Sanitation Directorates. The chief Communal Sanitation Directorates and / or Health Centres and medical officers interviewed indicated that they have a good knowledge of the content of the project. One of the problems raised by the officials interviewed is the problem of workload due to the increasing number of outpatients coming from outside their coverage of health centres areas.

The participation in training on AIDS / Tuberculosis CM and the presence of treatment algorithm in health centres do not guarantee the quality of care for people with HIV / TB. Document review management program shows that the quality of the case management should be improved, particularly in the newly included Gbessia Port Wanidara, Fotoba health centres.

In the centres visited, the various performance indicators (mortality rates, dropout rates / lost views, rate of non-response /fail 1st line) are calculated and recorded in the individual files and the database. This is due to the permanent presence of monitoring teams helping during heavy workload. Following the consultations, the project team conducted audits of records, drug stocks and inputs for their activity reports.

Performance indicators presented in the table below covers the period September 2011 to June 2012. They argue in favour of efforts and resources deployed by MSF to meet or exceed the original goals set during the assessment of this project.

A performance indicator of the project such as hospital mortality rates of PLWH indicated a significant decrease of 12 points (down from 28% in 2010 to 16 % in 2013). However patients' mortality taking ARV indicated a slight downward trend from 7.8 % in 2010 to 7% in 2013. Indicators related to the proportion of patients in the second line (0.6% or less able than 2% threshold) and children born to HIV + mothers followed at 6 weeks of age (93% for threshold set at 90%) are satisfactory.

Indicators related to awareness, community involvement; community and the fight against stigma and / or discrimination leaders are also satisfactory, however, the indicator on the joint supervision with Communal Sanitation Directorates is highly unsatisfactory 3 out of 12 joint supervision planned In 3 years.

We noticed the lack of a quality indicator related to processes, such as reception area, or the results of laboratory analysis tests, X-ray etc. We proposed two indicators namely reception/welcome: wait time less than 1 hour, exam results not returned on time equal to 0 and the average waiting delays before lab test less than 1 H, missed examination/testing rates less than 5% rate of programmed examinations/testing more than 20%; delay in reading test results not exceeding one day, obtaining appointments for laboratory analysis less than 7 days, the duration of outages laboratory equipment less than 1 day etc.

The inclusion of new patients in the cohort has been suspended since January 1, 2014 due to the decision of MSFB withdrawing and weak government capacity to make available inputs and drugs for correct AIDS patients and / or tuberculosis case management.

Table No3: Logical framework of achieving results

EXPECTED RESULTS	ACTIVITIES	OUTPUTS	EXPECTED OUTCOMES	INDICATORS
Specific Objective: Conakry population has access to free quality case management delivered through health facilities supported by MSF B	- Identification / development of CS 7 (3 of the project) operating in AIDS / TB case management equipped and operational; - Diagnosis of new cases; - New inclusions for ARV treatment	- 2 of 3 sites supported by the project at completion date - 1,904 new cases expected; - -2,088 new patients on ARVs Treatment	- Increase the availability of quality case management services in the Project Health centres - HIV/TB Mortality and morbidity rates reduced in the project areas - Newly registered 4301; - 5935 new inclusions	Mortality and morbidity rates of HIV / AIDS & TB Mortality rate of patients under ARV for 1 year % Of eligible patients to put under ARVs
Result No1: Matam ATC and decentralized health centres provide to PLHIV quality medical and Psychosocial care	- Capacity building of Case management by training 30 consultants Staff - Review of the protocol for passing from TDF +3 TC + NVP to TDF +3 TC + EFV; - Equipment of laboratories with 2 CD4 1 PIMA and 1microspcopic GeneXpert - Rehabilitation / construction of Water Sanitation area in the 6 facilities	- 24 consultants and executives staff from DSC trained in HIV case management; - Protocol TDF +3 TC + EFV available and follow up in the project health facilities; - 6 CS Laboratories equipped with 2 CD4, 1 PIMA and 1 GeneXpert microscopic - Water reserve available and 6 Incinerators built and equipped	Reduction of hospital mortality rate of PLHIV and AIDS patients under treatment - Eligible patients under treatment - Reduction in the proportion of patients in the second line S / ART; - Effective Decentralization in 2 new CS	Mortality rates; % Of patients under treatment % Of patients in second line treatment;
Result No2: Integrated quality Management of HIV and co-infected patients is provided project facilities	- Decentralization of HIV / TB management reinforced by referral to others health facilities; - Integration of AIDS and TB management in the minimum package of activities; - Joint project supervision / DSC and Project Coordination team	- Implementation of the sheet screening sheet for TB; - INH prophylaxis in HIV + patients without TB symptoms; - 1 joint supervision by quarter for the project implementation duration years	- TB Screening sheet effective in Project facilities; - INH for TB Prophylaxis effective for HIV+ - 3 of 12 joint supervision provided	% TB patients lost Mortality rate of TB under treatment % Of new TB patients treated
Result No3: The quality PMCT is provided in the Supported Project facilities	- Maternities rehabilitated and equipped - PMCT and paediatric quality care ensured and increased paediatric cohort;	- Pregnant women tested HIV + supported - Children born to HIV + mothers monitoring; - HIV / TB integrated in prenatal consultation	Systematic Screening for HIV / TB at first Prenatal consultation in 3 of 6 project facilities Children born to HIV + Mothers have a PCR at 6 weeks of age	Test t acceptance rate among % Of children born from moth mothers diagnosed HIV +

Result No4: Advocacy to fight against stigma and discrimination are conducted in Conakry	- Training of 10 district heads and 10 journalists; - Training of 10 youth leaders; - Training of 30 members associations; - Sensitization of 60 artists	- 10 journalists from the private and public press and 10 neighbourhood leaders trained - 10 youth leaders trained; - 28 members of the four PLHIV associations sensitized; - 60 artists sensitized	236 public testimonials for 9 planned	- Number of public testimonial - -Number of associations involved in the project - Number of community leaders sensitized
Result No5: National and international actors are aware of the medical and humanitarian situation of PLHIV sharing witnesses, testimony, advocacy and lobbying	- Sensitization of community leaders; - PLHIV Associations involved in the project sensitized;	- 30 community leaders sensitized; - 4 PLHIV associations involved in the project - 2 sessions awareness PLHIV Associations on the functioning of the CCM; - Pool of trainers of PLHIV Associations	- 310 community leaders sensitized for 30 Scheduled; - 97 member PLHIV associations involved in the project for 75 scheduled;	Number of meetings with Associations
Results No6: Performing at least one operational research based activities within the project	Not Applicable	Not Applicable	Not Applicable	Not Applicable

4.1.6 COMPARISON OF INTITIAL AND ACTUAL IMPLEMENTATION SCHEDULE

Project documents and various activity reports available to us do not have project implementation timeline that would allow us to assess the performance in terms of compliance with the schedule in the execution of project activities through December 31, 2013. It should be noted that the original project document dated August 2010 had a quarterly timetable from 2011 to late 2013. Activities originally planned are not all completed by 31 Dec. 2013. Those carried out were in the initial period of implementation of the project (Jan.2011-Dec.2013) and we are not able to locate their implementation according to a provisional timetable. The remaining activities were reprogrammed in 2014.

4.1.7 REVIEW OF SOCIAL AND ENVIRONMENTAL PROJECT IMPACT

Social impact:

Infrastructure supported by the project of AIDS and / or tuberculosis reinforce the geographical and financial access to quality care, given the presence of qualified staff and the availability of free drugs, consumables and materials/equipment provided by the project.

Improving the health of populations will provide more time to devote to their occupation, thus increasing their productivity as well as reducing the poverty rate. CM activities exempted strengthen health services for the populations of the areas covered / served, in particular the reduction in overall morbidity and mortality, particularly for people with AIDS and / or Tuberculosis and Opportunistic Infections.

The interrelationship of nutrition and vulnerability to infections is well documented. An unbalanced quantity and / or quality diet is one of the causes of immune deficiency making the individual more vulnerable to infectious diseases. This confirms the positive impact of nutritional support for patients with AIDS and / or tuberculosis expressed in the good adherence to treatment and improves the quality of life of PLWH/TB patients. Nutritional support for PLWH / TB aspect is not visible because no national policy on nutritional support to patients with AIDS and / or tuberculosis is adopted.

Environmental Impact:

There is little construction, but rather rehabilitation or extension. Therefore no negative impact on the environment. It should be noted that all health centres were equipped with incinerators for the disposal of solid waste including packaging and medical waste. Safety boxes for the collection of used needles and syringes are available to structures.

4.1.8 KEY ISSUES AND OBJECTIVES OF THE EVALUATION

The purpose of the evaluation is: (i) collect and analyse information on the operational implementation and acceptance of the CM protocol adopted by MSF and (ii) for documenting lessons learned, bottlenecks and risks that could jeopardize the sustainability of project achievements, for a possible future extension of the coverage of the city of Conakry and regions. This assessment could form the basis of an informative reflection to set the next steps of ownership of the Project by the Guinean government

Evaluate project performance based on the observations and existing information available to the consultant, using six criteria recommended by the Development Assistance Committee (DAC) of the OECD (relevance, effectiveness, efficiency, coverage, impact, and viability), the added value of the action of MSFB has also been the subject of a specific assessment and is the sixth endpoint (Consistency).

These criteria/ key evaluation questions are explained in Table # 4 below. For each of these criteria, the consultant provided a valuable judgment (reasoned assessment) on each of the evaluation questions raised by the review criteria. This judgment is summarized in a few lines for each evaluation in table synthesis according to the model of these report criteria.

Data collection covers the period from January 2011 to December 2013 and relates to all sites covered by the project and supplemented by qualitative data analysis beneficiaries (see Appendix IV). At the end of the interviews, we identify strengths and weaknesses of Matam Project summarized in Table # 5.

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Table No4: Summary Assessment of Project Performance Criteria as the OECD / DAC

CRITERIAS	Ranking Score[5]					JUSTIFICATIONS
	1	2	3	4	5	
RELEVANCE: - Do project objectives correspond with identified needs? - Are our intervention choices appropriately prioritized to meet the most urgent needs first? - Was an independent needs assessment possible and carried out appropriately?					X	Project is part of the national strategic framework of the country and one of MSFB priorities
APPROPRIATENESS: - Is the intervention appropriate according to the perception (expressed needs/demand) Of the target population and/or according to national policies? - Is the strategy appropriate in order to achieve the objectives?					X	Project objectives are relevant because they address to real and pressing needs of the beneficiaries and fit perfectly into the Country strategic framework and in achieving the Millennium Development
EFFECTIVENESS: - To what extent have the agreed objectives been achieved? - Were the activities' carried out as originally planned? - What were the reasons for achievement or non-achievement of objectives? - What are the limitations/opportunities inherent in the approach? - How well do the achieved results compare to quality standards (MSF guidelines, WHO standards, etc.) - What can be done to make the intervention more effective?					X	The approach adopted by the project is effective for the implementation because it inflicts a permanent presence and trainer on the field. Strengthening management capacity of health centres and the mobilization of staff and therefore effective adoption of close monitoring have facilitated the implementation Quality of training: caregivers qualified training "complete", "relevant", "successful", located in the "excellence", "not difficult", "beautiful", "extraordinary", and they have improved their knowledge and skills in AIDS/TB case management

[5] 5 if the performance is highly satisfactory
4 if the performance is satisfactory
3 if the performance is Partially satisfactory
2 if the performance is unsatisfactory;
1 if the performance is highly unsatisfactory

EFFICIENCY: - How cost-efficient is the program, in terms of the qualitative and quantitative outputs achieved as a result of the inputs? - How does the program ˜cost per beneficiaries™ compare to other similar programs? - In what ways has MSF utilized available ˜pooled™ financial and logistics arrangements to contribute to the efficient use of resources and economies of scale? - What improvements can be made? - Is the programme structure and staffing efficient? How does it compare to other similar programs?					X	We can safely say that the price / quality ratio is very satisfying for the reason that life is priceless and in the draft over 10236 patients supported including pregnant and lactating women and children with a unit cost estimated at €195 per year against €120 per day in the West is very satisfying. Factors that helped achieve the level of current efficiency are among others the willingness of partners MSF and MOH) to join forces (human, financial...) and their expertise. MSF has set up appropriate structures and systems (teams monitoring / supervision, planning and follow-up Associations' agents on site) in close collaboration with municipal health authorities
COVERAGE: - To which extent do the activities reach the target population? - Are there any factors that hinder us in reaching the population most in need? - To which extent do beneficiaries have access to project services? - Is anyone group excluded from the services?			X			Lacking the recent population figures of Conakry, and on the basis of the prevalence of the target population in 2008 is estimated at more than 17,000 patients. Qualitative information from the discussions trend to confirm the low coverage of the project, while highlighting a number of issues that may affect the project membership. One of the problems raised by the officials interviewed is the geographical accessibility of certain CDS, which is a limiting factor in achieving the maximum target populations. This confirms that the project at this stage does not cover the entire target population Indeed, the coverage rate also depends on the screening and patient decision to accept or not to join the project. In addition the suspension of including new patients from 1 January 2014;

IMPACT: - Does the programme make a difference? - Can a contribution to changes in the health status be attributed to the project? - What do beneficiaries and other stakeholders affected by the intervention perceive to be the effects of the intervention on themselves? - Does our presence have any unforeseen positive or negative impact?				X		The project contributes to the improvement of indicators of health status of vulnerable population targeted by the project.
CONNECTEDNESS/Sustainability - What long-term problems can be identified, and how have they been taken into consideration? - What local capacities and resources have been identified? How does the project connect with these?		X				Insufficient funding and qualified personnel for the continuation of proper management of AIDS and / or tuberculosis in the country in general threatens the viability and long-term experiences of the project. Project activities involve more attendance (due to the quality and price of care). However, they are not fully integrated into the health centres daily activities package. Ending payment of allowances and incentives packages by the project will affect the future trend of activities; It was suggested that the management might be integrated. Allowances / incentives introduced by the project could not be supported by the Go Guinea for budget constraints
<u>Overall project rating</u>	4,14 (HS)					The overall assessment ratings as follows : Highly satisfactory (HS) 4 <R< =5 Satisfactory (S) 3< R<=4 Partially Satisfactory (PS) 2 < R<= 3 Unsatisfactory ((US) 1< R <=2 Highly Unsatisfactory (HUS) 1 <=R

Table no5: Strong Points and Weaknesses of the Project

Strong Points	Comments	Weaknesses	Comments
Quality of patients welcome	Psychosocial care provided by PLWH associations members involved in the project	The situation of the staff responsible for the psychosocial care is uncertain after the withdrawal of MSF Few members of PLWH Associations on some sites	Encourage the consolidation of PLWH Associations to favoured their presence in terms of quantity in all sites
Quality and free health care and management of PLWH patients	Few patients in the second line; Significant increase in CD4 of patients with immunity collapsed More and more undetectable viral load; Net regression of mother-child transmission of the virus	Closing of project VCT and stopping new inclusion of patients in the cohort	The target populations misperceive situation in need. Opening of registry waiting list does not solves the problem that has become an ethical problem
Geographically Care viability or the target population	Decentralization is approach is positive	Risk of degradation of the care quality following the decentralization	The decentralized health facilities technical platforms are not updated to provide a quality AIDS care management
Quality of close monitoring of Health facilities	Daily and permanent presence of the Project Coordination Team at the sites according to a schedule	Non-compliance with planning joint supervision Directorate of Health and sanitation/ Project and technical meeting for the withdrawal of MSF	MOHPH must send a formal notice to the Communal Directorate of Health and sanitation for compliance with quarterly joint supervision programs
Quality of training of staff responsible for providing care to all patients circuit level	Evidence is the quality of care AIDS management and the close monitoring process of health facilities	Little or no AIDS/TB focal point in the Directorate of Health and sanitation of Conakry	Insufficient training in terms of number and/or quality of Directorate of Health and sanitation staff

4.1.9 ANALYSIS OF PROBLEMS AND OBSTACLES IN THE PROJECT IMPLEMENTATION and LESSONS LEARNED

Problems and Obstacles and Actions to be taken by the Government-/MOHPH

In order to achieve its objective, the project has to strengthen the capacity of six health facilities in the city of Conakry as defined in the national strategic framework protocol. In the long term, the project will contribute to the increase of life expectancy at birth in the project area. In the mid-term, the project interventions should contribute to the reduction of morbidity and mortality related to HIV / AIDS and Tuberculosis. Although interventions are limited to six health facilities, the results will improve health indicators status at the national level.

The project has contributed to: (i) strengthening the country capacity to make quality health care aiming at reducing the morbidity and mortality of AIDS and / or tuberculosis in the most vulnerable populations, (ii) the implementation of a protocol of AIDS and / or tuberculosis case management, and (iii) the harmonization / promotion on the case management integration in a "single window" AIDS/TB.

The intervention of MSF considered as a humanitarian emergency (which in principle is limited in time) has become a long-term intervention with a growing need for human resources, financial resources and facilities.

Involvement and accountability of MOHPH project ownership: Our observation is that the national partner who is supposed to lead the strategic framework for the fight against AIDS and the national health policy to meet the implementation of management activities, has neither qualified nor enough human and financial resources to fulfil its mission. It is urgent that the MOHPH / ES/NAC and NAPHP/STI HIV/AIDS shall provide the human and financial resources to conduct satisfactory implementation of the national strategic framework. The MOHPH must own the project in case of MSFB withdrawal in order to ensure sustainability.

Lack of coordination of AIDS and/or tuberculosis: At the time of the mission, several partners (MSFB, DREAM Solthis, and GiZ) are involved in the fight against AIDS. There is no structure at national level in charge of coordination of interventions in terms of AIDS care management. The NAPHP/STI HIV/AIDS or ES / NAC does not have human and financial capacity to carry out coordination of ongoing operations in the territory. UNAIDS does try for better coordination, but in any case it should not replace the government.

Project Staff future: At the moment more than 120 staff member are in charge of the project in the six Health facilities. The future of these qualified personnel is uncertain in terms of their presence in the health facilities after MSF departure. It is recommend that the MOHPH must schedule an **acceleration of project Staff recruitment and/or integration plan** and benchmarking for December 2017 withdrawal deadline of those MSFB staff for the sustainability of the projects outputs.

Lack of timing and implementation schedule: The project implementation looks like a routine activity without any timing constraints.

Joint supervision of Communal Directorate of Health and Sanitation/Project coordination team: It appears that only 25% of joint supervision missions planned (1 supervision by quarter for a total of 12) was performed. As such this schedule could not be met by Guinea.

The analysis of the Matam project can be regarded as lessons learned for future scaling up or replication to the entire city of Conakry and possibly to the whole country.

No effective integration of AIDS/Tuberculosis case management in the minimum package of activities: The integration of the CM in the minimum package of activities in health centres is not effective or accepted in some project structures. Our finding is that the staff in Health Centers seems to consider the activities of case management as extra work with regard to the data collection and analysis. A huge problem is the integration of AIDS and tuberculosis CM in the same

facility "single window". GoGuinea should set up a task force for these two diseases managed by two independent national programs to prepare a common platform for implementation through an "AIDS/TB single window".

Nutritional support to PLWH and Tuberculosis patients remains the weak link in the management while under nutrition status appears to be a common complication of HIV infection. It is now established that an effective program of care and nutritional support improves the adherence to treatment and the quality of life of PLWH and /or TB patients. During this assignment no food and nutritional support protocol has been made available to us because it doesn't exist. It is recommended that Go Guinea with partner's assistance must undertake a study for the preparation of a nutrition support program /protocol for PLWH and TB patients.

Generic problems

- **Water Sanitation Electricity**: Some of the health facilities visited are facing water availability although drilling / castle / tank exist. They are also facing irregular electricity supply. The allocation of generators could be an alternative but the problem of operating costs would arise. The alternative would be the generalization of solar panels as an energy source. The incinerator for waste disposal in the Gbessia Health Centre is very poorly maintained.

- **Limited and or restricted space of Health centres:** It appears that in the first place there was anticipation of possible extension of the sites. Thus, we feel that beside Flamboyant, there is possibility for expansion in height, which could be hazardous if the foundations were not designed for this purpose.

Lessons learned

- Low involvement of MOHPH / NAPHP/STI/HIV/AIDS and ES/NAC: The fact is that the NAPHP, supposed to lead the political and social medical Psycho AIDS case management, does not have the human resources quality and quantity nor the financial resources to assume its leadership role in the fight against HIV / AIDS. An organizational audit is possible to propose recommendations for urgent strengthening as of today. It must own the project for an upcoming withdrawal of MSFB in order to ensure the sustainability of project achievements.

- Lack of coordination of AIDS and / or tuberculosis case management: At the time of the mission, several partners (MSFB, DREAM Solthis, GiZ) are involved in the fight against AIDS. There is no structure at national level in charge of coordination of interventions in terms of CM AIDS. The NAPHP or SE / NAC does not have the capacity (human and financial) to carry out coordination of ongoing operations in the territory. UNAIDS, as a leading partner in coordination, will not replace the government.

- Lack of Visibility of MSFB: The project supports 6 health centres but covers four of the five municipalities in Conakry, which contributes to facilitating access to quality care and free people with AIDS and / or no indication of tuberculosis in facilities for support MSF. This may be a deliberate choice.

- Nutritional support to people living with HIV and patients with Tuberculosis remains the weak link in the management while under nutrition appears to be a common complication of HIV infection. It is now established that an effective program of care and nutritional support improves the quality of life of PLWH. It is the same for TB patients. At the time of the assignment no protocol for food and nutritional support has been made available to us because non-existent. It is recommended that Go Guinea with partner's assistance must undertake a study for the preparation of a nutrition support program /protocol for PLWH and TB patients.

- This project did not follow the formal stages of the project cycle i.e. formal identification and preparation. There was no mid–term review. MSF in the future will improve the quality of its projects in strict compliance with the International standards based on the of the project sizes cycle.

4.2 CONCLUSIONS

The project has contributed to: (i) strengthening the efforts of countries to make quality health care accessible to target populations reducing morbidity and mortality of AIDS and / or tuberculosis in the most vulnerable populations, (ii) the implementation of a protocol for management of AIDS and / or tuberculosis, and (iii) the harmonization / promotion on the integration of AIDS / TB case management in a "single window".

The intervention of MSFB considered as a humanitarian emergency, which in principle is limited in time, has become a long-term intervention with a growing need for human, financial resources and structures entitled to the management of these pathology resources.

The expected outcomes/results include:

- Project support to Six Health facilities of Conakry in terms of capacity building support quality care access and free for people with AIDS and / or tuberculosis, the size of the cohort of patients (average of 10 500) under treatment or not and the management of co- infection AIDS / TB at a "single window";
- Strengthening Decentralization and Acceleration of integration of AIDS and / or tuberculosis case management in the minimum package delivered at the project supported health facilities.

Upon completion, all health facilities are equipped and operational of AIDS and / or tuberculosis case management.

The Sustainability of the project results is not guaranteed under the non-appropriation of the project by the government. The Government of Guinea should mobilize substantial resources to ensure the sustainability of project achievements.

Having no basis data/indicators between 2003 and 2013, particularly in the project area, the health statistics of from Project database and reports to national authorities show favourable indicators with trend of reducing morbidity and mortality.

This project did not follow the formal project cycle. It also had no mid -term review. MSF in the future will improve the quality of its projects in strict accordance with the standards of the International project cycle.

The achievements of the immediate and expected results of the **project are considered highly satisfactory**.

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4.3 RECOMMENDATIONS

4.3.1 GENERAL RECOMMENDATIONS:

Establish a working group to further analyse Matam Project data, in order to consider any further extension of the approach in the city of Conakry, even in other regions. Its role will be to propose and agree on an extension of the integrated approach to the management of AIDS and / or tuberculosis. The task group would consider more specifically how to effectively integrate case management and prepare the disengagement of MSFB. This group could recommend a more general and uniform implementation program for the city of Conakry and / or in the country. It seems sensible to better identify opportunities and challenges encountered on a small scale before a comprehensive approach.

4.3.2 SPECIFIC RECOMMENDATIONS

Low involvement of MOHPH / NAPHP/STI/HIVAIDS and ES/NAC: The fact is that the **NAPHP** is supposed to lead the political and psychosocial and medical AIDS case management, is does not have the human resources (quality and quantity) nor the financial resources to assume its leadership role in the fight against HIV / AIDS. An organizational audit is possible to propose recommendations for urgent strengthening today. Ownership of the project is essential for an upcoming withdrawal of MSFB in order to ensure the sustainability of project achievements

Nutritional support to people living with HIV and Tuberculosis patients remains the weak link in the management while under nutrition appears to be a common complication of HIV infection. It is now established that an effective program of care and nutritional support improves the quality of life of PLWH. It is the same for TB patients. At the time of the mission no protocol for food and nutritional support has been made available to us because non-existent. It is recommended that the Go Guinea with partner's assistance must undertake a study for the preparation of a nutrition support program /protocol for PLWH and TB patients.

Acceleration of project Staff recruitment and/or integration and benchmarking for December 2017 withdrawal deadline of MSFB.

Joint supervision of Project coordination team: It appears that only 25% of joint supervision missions planned (1 supervision by quarter for a total of 12) was performed. As such this schedule could not be met by Guinea. It is recommended that stakeholders (MSFB, MOHPH, NAC/ES and NAPHP/STI/HIVAIDS) commit now according to a schedule of joint supervision and be regular briefing meetings.

No effective integration of CM in the minimum package of activities: The effective integration of AIDS and / or TB case management in the minimum package of activities health centres is not completely effective. The staff seems to consider the case management activities as an additional binding work in relation to the data register and operate. It is recommended that stakeholders (MSFB & Guinea) make every effort to ensure that the integration of case management is effective within a reasonable time (realistic develop the second half of 2014 calendar).

This project did not follow the formal stages of the project cycle i.e. formal identification and preparation. There was no mid–term review. MSF in the future will improve the quality of its projects in strict compliance with the International standards based on the of the project cycle.

Water and Sanitation, Electricity: Visited health centres face a problem of water supply, electricity and solid waste management. This presents a risk to the proper functioning of such health centres in acceptable hygienic conditions. It is recommended that the Guinean national party to make every effort to make it worth the investment for waste treatment areas, regular water supply and electricity.