

New approaches in a new HIV era

ART/TB scale-up in Gokwe North by MSF-OCA

EVALUATION REPORT

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MANAGED BY THE VIENNA EVALUATION UNIT

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The Vienna Evaluation Unit

The Vienna Evaluation unit started its work in 2005, aiming to contribute to learning and accountability in MSF through good quality evaluations. The unit manages different types of evaluations, learning exercises, anthropological studies and organises training workshops for evaluators.

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Executive summary

Since 2012 OCA has been implementing a new approach to HIV/TB programming in Gokwe North district of Zimbabwe. In September 2014, towards the end of its handover, an evaluation was commissioned with the objective to examine the intended goals, outcomes (including quality standards) and implementation process of the project. MSF wanted to know whether the strategic approach performed in the Gokwe North intervention was an approach that could be recommended for use again by MSF-OCA, which contexts it would be suitable for and what possible improvements of the strategy could be considered in future implementations.

During the field visit 6 medical facilities out of the overall 18 were visited in the Gokwe North district. Information gathered through numerous interviews of different types with a wide range of stakeholders and community members was triangulated with a document review. Epidemiological analysis provided by an MSF-OCA epidemiologist was included in the report and collated with qualitative information.

Even though a more integrated approach to the implementation of HIV/TB projects has been practiced within the MSF movement in different countries¹, for MSF-OCA the experience in Zimbabwe was one of the first of its kind and is therefore valuable in terms of lessons learned.

Gokwe North project has built on the experience of the Gweru project and benefited from the recommendations given in the evaluation of its handover. It managed to implement the integrated supportive approach, has reached its objectives and handed the activities over to the Ministry of Health and Child Care of Zimbabwe in a timely manner. Success factors of this project were the high degree of communication and positive engagement with the national counterparts as well as the rigorous planning, monitoring and follow-up of the achievement of common goals. MSF staff understood their roles as coaches and catalysts for acceleration of supported programmes relying heavily on implementation of the national guidelines. Lobbying was mostly directed to the allocation of human resources and enabling of the decentralisation process through task-shifting. An exit strategy was defined at the beginning of the project and was given a strong consideration throughout the implementation process. The handover was implemented in an organised way that offers high chances of continuation after MSF's departure.

The collaboration process and programme outcomes received high appreciation from the national counterparts and MSF staff. Patients and communities expressed their delight and gratitude for the services they are benefiting from.

One of the few possible improvements could be a faster scale-up of the services (including paediatrics and second line) and a linkage with the community-based and PLWHA organisations to support the sensitisation, referral and follow-up activities.

¹ E.g. in Uganda, OCG in Swaziland, OCB in Lesotho, Mozambique or Gutu district in Zimbabwe etc. - based on internal MSF interviews and evaluation experience of the author.

All in all, MSF-OCA has sustainably boosted the capacity of HIV/TB services in a very remote and disadvantaged region of the country.

The following circumstances were conditional for the successful implementation of the integrated approach:

- Regulatory environment: updated protocols and guidelines, allowance for task-shifting and decentralisation at primary health care level
- Functional health-care system and well educated staff employed in the health sector
- Certain stability in drug procurement and medical supplies
- Effective and collaborative national counterparts
- MSF staff feeling comfortable as coaches and lobbyists for improved practices and protocols when needed

An input from the other health-care partners (National Healthcare Trust, Zimbabwe Health Transition Fund and Global Fund) contributed to some of these achievements in the TB/HIV programs in Gokwe North.

Summary recommendations targeted to future MSF HIV/TB programmes in high prevalence and resource-limited settings

1. MSF should use integrated supportive programmes to tackle a new era of HIV/TB epidemic when the conditions are favourable for their implementation, such as: availability of trained human resources in the country, stable context and functional public health care system, updated guidelines and effective national/international counterparts.
2. To cover human resources gaps MSF should encourage national authorities to hire their own staff with temporary financial help from MSF, as needed. This facilitates integration of services and an easier handover process.
3. Implementation of the capacity building activities, a core for an integrated approach, should be monitored regularly by well-defined criteria to assess the health facilities' capacity and individual staff skills.
4. A baseline independent assessment of the health care needs and available services should define the support activities of MSF to guarantee good quality care.
5. Trustful relations between the counterparts (national or others) must guarantee the joint efforts in terms of defining goals, planning, supervision and monitoring.
6. National protocols and monitoring systems should be preferred when they are at standard level. If a separate MSF system is in place, the handover phase must incorporate the shift to the national systems in terms of required time and resources.
7. Lobbying the national counterparts for required support and changes leading to the intervention goals must be part of an integrated approach.
8. An exit strategy should be defined at the inception of the programme and be thoroughly implemented.

Abbreviations

ART	antiretroviral therapy
ARV	antiretroviral drugs
CMH	Chireya mission hospital
DR TB	drug-resistant TB
DS Tb	drug-sensitive TB
EPMS	Electronic Patient Management System, Zimbabwe HIV data management system
GoZ	Government of Zimbabwe
LTFU	lost to follow up
MDR TB	multidrug-resistant TB
MoH	Ministry of Health
MoHCC	Ministry of Health and Child Care (of Zimbabwe)
MoHCW	Ministry of Health and Child Welfare (of Zimbabwe)
MSF	Médecins Sans Frontières
NGO	non-governmental organisation
OCG	Operational Centre Geneva
RHC	rural health centres
SGBV	sexual and gender based violence
TDF/3TC/NVP ARV regimen	Tenofovir/Lamivudine/Nevirapine
WHO	World Health Organization

Definitions of vertical and integrated programmes

Vertical programmes (also known as stand-alone or free-standing programmes or the vertical approach) are provided through delivery systems that typically have separate administration of resources and budgets and where “the solution of a given health problem is addressed through the application of specific measures through single-purpose machinery”.²

Integrated programmes (also known as horizontal programmes, integrated health services or horizontal approaches) seek to “tackle the overall health problems on a wide front and on a long-term basis” and are typically³ delivered through health facilities that provide routine or general health services. They include “a variety of managerial or operational changes to health systems to bring together inputs, delivery, management and

² Msuya J. *Horizontal and vertical delivery of health services: what are the tradeoffs?* Washington, DC, World Bank, 2005, in (WHO; Rifat A. Atun, Sara Bennett and Antonio Duran 2008)

³ Refer to footnote 2

organization of particular service functions”.⁴ Both approaches have been widely implemented in low- and middle-income countries and in high-income countries.

In practice, verticality of programmes takes very different forms and degrees. They may be defined according to the

1. nature of the service provided (such as a stand-alone programme for reproductive health services and sexually transmitted infections or mental health),
2. the nature of the population they serve (such as programmes targeted at sex workers, prisoners or injecting drug users) and the
3. organisational aspects of a programme such as
 - a. governance and decision making,
 - b. funding and resource provision,
 - c. supervision and organisation and
 - d. service delivery.

For example, tuberculosis clinics in many countries in the Commonwealth of Independent States have dedicated budgets with limited flexibility, separate management structures and separate service delivery channels.⁵ Other programmes may be stand-alone in some dimensions but not in others (Expanded Programme of Immunization to Integrated Management to Childhood Illnesses). A fully integrated approach of health service delivery is a as primary health care.⁶

Most health services combine vertical and integrated elements, but the balance between programmes in these elements varies considerably.

⁴ Briggs CJ, Garner P. Strategies for integrating primary health services in middle- and low-income countries at the point of delivery. *Cochrane Database of Systematic Reviews*, 2006, (2):CD003318; in (WHO; Rifat A. Atun, Sara Bennettand Antonio Duran 2008)

⁵ Coker RJ et al. Tuberculosis control in Samara Oblast, Russia: institutional and regulatory environment. *International Journal of Tuberculosis and LungDisease*, 2003, 7:920–932, in (WHO; Rifat A. Atun, Sara Bennettand Antonio Duran 2008)

⁶ Oliviera-Cruz V, Kurowski C, Mills A. Delivery of health interventions: searching for synergies within the vertical versus horizontal debate. *Journal of International Development*, 2003, 15:67–86, in (WHO; Rifat A. Atun, Sara Bennettand Antonio Duran 2008)

1 Introduction

1.1 Background for Gokwe North project

Gokwe North is a solely rural, large and impoverished district of the Midlands Province which was established in 1993 after Gokwe district split into two parts: North and South. Being left with worse infrastructure from the two new districts and having never received adequate investments since then, the Gokwe North is distinguished by poor roads, communication possibility, water and electricity supply. The roads are mostly unpaved and get flooded during the rainy season, cutting some areas (e.g. Vumba and Simchembo) away from the rest of the district for 6 months in a year. Its administrative seat is Nembudziya which is still referred to as a “growth point” and has not received town status.

The majority of its population (estimated at 235 000 at the beginning of 2012)⁷ are subsistence farmers. The cotton growers, who were originally displaced from other, more productive regions of Zimbabwe due to colonial land-grab policies, were facing harsh living conditions in uninhabited forests, full of wild animals and Tsetse flies.⁸ Malaria and sleeping sickness were wide-spread. There is a high influx of seasonal migrant workers during the cotton picking season and rampant illegal gold miners in the east of the district along the Sanyati River.⁹ Both activities attract commercial sex work.¹⁰

In the beginning of 2012, before MSF’s arrival, the district had two mission hospitals and a network of 15 rural health centres (RHC). The latter was connected with village health workers (VHW) and made up a primary health care level. Each centre was supposed to be staffed by four health professionals: two nurses (one of them a midwife), an environmental health technician (EHT) and a nurse aid.¹¹ Each RHC should have catered for 10 000 catchment population and should be accessible within 8 kilometres of walking distance.¹² Instead, in Gokwe North the health facilities served bigger populations (up to 13 693) with lower accessibility due to far distances (the furthestmost villages served ranging between 12 km and 40 km) and difficult roads.

National statistics estimated the HIV prevalence at 16.1% in 2009 in Midlands Province and TB at 714 cases per 100 000 in 2008.¹³ Similarly, in Gokwe North 14% HIV prevalence was estimated in adults.¹⁴ Available figures from Gokwe North in 2011 suggested that fewer than 10% of people living with HIV¹⁵ and barely 5% of people affected by TB were receiving

⁷ Estimate from Provincial Administrator based on 2002 census number – 214 652; as quoted in: (MSF OCA Head of Mission, Paul Foreman end of 2011)

⁸ Reference:- numerous interviews done during this evaluation

⁹ (MSF-OCA Zimbabwe mission August 2011)

¹⁰ (MSF-OCA, GOKWE NORTH, MIDLANDS, ZIMBABWE, September 2014)

¹¹ (MSF-OCA Zimbabwe mission August 2011)

¹² (MoH Zimbabwe 2010)

¹³ (MSF OCA Head of Mission, Paul Foreman end of 2011)

¹⁴ (Casas, visit report, January 2012)

¹⁵ There were no children in HIV care, only 1432 patients ever initiated on ART. Reference: (MSF-OCA Zimbabwe mission August 2011)

treatment before the MSF project started.¹⁶ The fact that the coverage rates were lower than the reported national averages was a reflection of the devastating condition the health-care system was in. There was no single doctor in the entire district, the HIV services were mostly limited to the Mtora mission hospital in Nembudziya¹⁷ (temporarily replacing the role of the district hospital), which could only provide limited HIV services (ARV follow-up) of reportedly poor quality. The Gokwe North district hospital was built in Nembudzia 10 years ago but never functioned due to a lack of staff and laboratory services. None of the RHC of Gokwe North were ARV follow-up sites. As the doctors were the only health professionals allowed to initiate patients on ARVs and as there was no TB screening possibility at district level, the HIV/TB patients were referred to Gokwe South district hospital. There was no follow-up of referrals. The Gokwe South District Hospital on its end suffered from a lack of essential supplies and expertise, so they had to refer the emergency patients to the Gweru Provincial Hospital.¹⁸

Sexual and gender based violence (SGBV) was not included in the package of services and nurses were not trained in 'survivor-friendly management'.

The clinics of the Gokwe North district did not charge fees for consultations or family planning drugs, but the mission hospitals did (e.g. Chereya Mission Hospital charged 2 USD per consultation from adults for non-HIV related services).

Long and expensive travels prohibited access to HIV and TB care for the vast majority of the low-income population of Gokwe North. The earlier attempts of the provincial medical directorate to bring and retain a doctor in the district vanished in vain due to poor living and working conditions.

MSF did an assessment in Gokwe South and Gokwe North (upon a request from the provincial medical director) and decided to implement a project in Gokwe North.

1.2 Methodology

Since 2012 OCA has been implementing a new approach to HIV/TB programming in Zimbabwe (after the two vertically implemented projects of Gweru and Epworth), which was internally labelled as 'light approach'.

In September 2014 an evaluation was commissioned to the Vienna Evaluation Unit with the objective to examine the outcomes and implementation process of the projects. Data analysis and perception of different stakeholders was part of the terms of references.¹⁹

The visit of the evaluator in Zimbabwe took place from 30 September to 21 October 2014.

The following medical facilities were visited in Gokwe North: District hospital and Chireya mission hospital, Gumunyo, Denda, Vumba and Simchembo clinics (6 out of the overall 18).

Numerous interviews were done with the provincial medical executive team (PME), OCA Gokwe North office staff, nurses of the clinics, patients, the community (including village

¹⁶ (MSF OCA Head of Mission, Paul Foreman end of 2011)

¹⁷ Mtora mission hospital was downgraded to a health centre after opening of the District hospital in Nembudziya; (source: interviews)

¹⁸ (MSF-OCA Zimbabwe mission August 2011)

¹⁹ See 5.1 Terms of reference

heads and traditional leaders, community health workers) and partners (World Vision and MoHCW seconded to EGPAF).

On top of this staff members of the OCA office, country coordination, operational cell in Berlin and technical support people of the OCA headquarters in Amsterdam were interviewed. Country coordinators of the other MSF sections in Zimbabwe were also visited.

A document review covered a wide range of relevant literature including MSF-OCA documents (proposal, planning and reporting documents) as well as country reports and other technical documents (guidelines).

Methods of primary qualitative data collection varied from individual in-depth interviews to group discussions and focus group discussions. A thematic analysis method was used for the compilation of the qualitative data from the interviews and from the document review.

Quantitative data analysis is based on monitoring data collected by the MoHCW and made available to MSF, based on the national data registration systems. The data were collated by the mission data manager and the mission epidemiologist and analysed by the mission epidemiologist in prior.

Systematic triangulation of different sources and methods was used to consider and accommodate for potential bias in the overall results of the evaluation.

1.3 Limitations

Some gaps and at times a rather poor quality of data could be seen as a limitation. The short time frame for such a comprehensive evaluation was also a challenge.

2 Findings

2.1 Context change

In earlier years of ARV provision a higher focus on quality for individual patients requiring a vertical implementation approach was required, as MSF had to achieve the following goals:

- Demonstrate feasibility of ART programme implementation and scale-up in resource-poor settings
- Test the effectiveness of the old regimens in the public sector, therefore closely monitor and document the outcomes (using MSF monitoring system FUCHIA)
- Deal with the higher side effects of the older regimens and low adherence rates within the environment due to high stigma imposing more risk of treatment failure
- Overcome the fact that access to ART is only available in the advanced HIV/AIDS stage according to old protocols legitimating treatment with CD4 < 200 at first and then <250 and <350
- Gain the expertise in ART/TB clinical management as well as in cohort and data management
- Fully finance HIV programmes as there were no (or only a few) alternatives sources

Undoubtedly, the vertical programmes were best supporting this focus.

Recent developments in the HIV/AIDS and TB context worldwide have changed the landscape of ART and TB treatment in Zimbabwe and brought up new demands:

- The amount of people on ARVs has grown and so did the need of decongestion of central referral facilities.
- In order to support ARV scale-up and decentralised health services Zimbabwe allowed nurse-initiated ART and task-shifting from nurses to lower cadres (e.g. testing and counselling, some clerical work).
- The older ART regimens have been replaced by their newer alternatives in recent years based on the WHO recommendations that reduced toxicity and side effects for patients on ARV therapy, thus made ART follow-up processes are less demanding.²⁰
- The CD4 threshold for ARV initiations has been raised from 350 to 500 after adopting the WHO 2013 recommendations resulting in a bigger pool of treatment eligibility.²¹
- More regular financial support became available for HIV/TB-related drugs and supplies from the Global Fund and other donors.²²

²⁰ Zimbabwe adopted Tenofovir-based formulations instead of Stavudine-based in 2010, Tenofovir-Lamivudine-Nevirapine (TDF-3TC-NVP) and Tenofovir-Lamivudine-Efavirenz (TDF/3TC/EFV) combinations outdated Triviro (D4T/3TC/NVP) as first-line treatment. (Esther C. Casas October 2010)

²¹ (Esther C Casas and Musa Hamdan, MSF-OCA April 2014)

2.1.1 Major challenges persisting

- Restrictive or overly bureaucratic processes that reduce MSF's effectiveness as a medical organisation and patients' access to treatment
- Lack of human resources (amount and skills) to cover the increased demand of health-care, mainly in HIV and TB areas; official establishments for cadres are outdated
- Lack of laboratory facilities, equipment, supply and cadres
- Underdeveloped and centralised paediatric diagnostic and treatment
- Poor health-care infrastructure, which was built before the HIV/TB epidemic stroke and did neither accommodate the demands of such a big patient influx nor infection control mechanisms
- Lack of roads, water, electricity and communication infrastructure
- Emergence of DR-TB as a public health threat
- Increasing demand for second-line ART

These developments at regional and country level were accompanied by the accumulated experience and maturity of conducting HIV and TB support programmes within MSF itself. Valuable lessons were learned from own experience²³ as well as from cross-fertilisation across different sections and countries.²⁴

2.1.2 Definition of 'light approach' in Zimbabwe

For some reasons two very different interventions in Zimbabwe – Gokwe North and city of Harare clinics – became known as the projects with a 'light approach' (after the experience of vertically implemented expensive projects in Gweru and Epworth). Despite an extensive discussion²⁵ quite a bit of confusion still remained around this issue. Partly the confusion was caused by the word 'light' itself – whether it referred to a low budget or implementation strategies. Probably this confusing term played a role in combining the Gokwe North and CoH clinics project under one umbrella and contributed to misunderstandings between different levels of coordination about the desired strategies under this approach. In fact Gokwe North used clearly defined integrated strategies versus CoH clinics, which basically employed vertical elements in dealing with HR gaps and protocols.

²² GFATM injected almost USD 500 million, HTF injected 400 million, MOHCC goes for universal access for ART 1014, 1500 health facilities provide ART, 253 initiate ART, national ART coverage: adults 77%/ children 45.8%, ZIM adopts WHO guidelines 2013 – Epworth project presentation, Sept 2014

²³ E.g. lessons learned from the handover evaluation of the Gweru project were instrumental for designing the Gokwe North intervention.

²⁴ Formal and informal interactions through evaluations, personal meetings and project visits

²⁵ (Healy Sean and Foreman Paul: Catalyst for change 2012)

2.2 Gokwe North Project

2.2.1 Measuring success towards the goals

The overall goal of the project, as defined in the respective documents, is the reduction of mortality and morbidity through improved access to free comprehensive HIV / AIDS / TB services in rural clinics in the Gokwe North District and access to a referral system for secondary healthcare.²⁶

According to the available programme data (see the analysis below) the big majority of the programme objectives were achieved. This is supported by a strong perception of the interviewees from all different respondent groups that the overall goal of MSF's three-year presence in Gokwe North is well achieved.

Achievement of the specific objectives as for October 2014

- Integrated HIV / AIDS service available in 15 rural health clinics that includes testing, counselling, treatment of OIs, ART initiation

Achieved: Decentralised HIV services are available in 16 rural health clinics and 1 mission hospital (CMH). Among the 17 accredited OI clinics 11 provide ART initiation and 6 are ART follow-up sites.

The initial project proposal was aiming at a swift decentralisation of HIV care within the first year (5 clinics at 4M, 10 clinics at 8M and 15 clinics at 12M), this ambition was achieved later.

- Provision of laboratory services in Nembudzia Mission hospital to support integrated rural HIV / AIDS and TB services

Achieved: The laboratory of Nembudzia District Hospital is well equipped and fully functional, a laboratory scientist is available.

Equipment: MSF-donated GeneXpert machine to identify TB infection and resistance to rifampicin (RIF) ; BD FACSCount™ system, which provides absolute and percentage results of CD4 T lymphocytes to guide treatment decisions for HIV-infected persons; Automated Haematology Analyser – KX-21N; Automated chemistry analyser – BS 200; two air conditioners; a solar panel with batteries; a water distiller; a generator for the laboratory.

- TB and MDR-TB diagnosis and treatment available through 15 rural clinics

Achieved: TB outcomes in Gokwe after MSF intervention can be considered as a huge success according to the epidemiological data and perception of medical personnel (see detailed analysis below). 921 patients were put on TB treatment from January 2012 until September 2014 (> 70% TB treatment success rates). RHCs are capable of dealing with DS-TB and RD-TB diagnostic and treatment.

Gokwe North district has turned to the best performing district in the Midlands province (according to the MoHCW data on ART initiation and follow-up sites) and one of the best performing in the country.

²⁶ (MSF OCA Zimbabwe, Gokwe Project proposal October 2011)

- Nembudzia district Hospital staffed by MoHCW and functional by end of year 3 and emergency room services including emergency surgery (laparotomy and C-section) available at Gokwe North Mission Hospital in Nembudzia

Achieved: The district hospital is open and functional; with the services of the surgeon medical doctor (DNO) since the opening of its operating theatre in September 2014 it provided 21 successful surgeries: 18 C-sections and 3 cataract extractions.²⁷ Intensive lobbying for additional human resources resulted in better HR allocation: currently 4 MD assigned as well as some nurses and a lab technician.

- Referral service available between rural clinics and Mission Hospital

Achieved for HIV/TB referrals: Referral of HIV and TB patients between the 2 levels of care is established. Laboratory test samples and their results are also sent between them. Emergency referral transportations are not documented and investigated.

- Comprehensive integrated SGBV response available in 15 rural clinics

A significant progress is achieved. There is still room for improvement because of the hard-to-change cultural norms and practices.

- Reduction of morbidity and mortality linked to outbreaks and violence in Midlands.

Achieved: MSF responded to all suspected epidemic outbreaks (e.g. MSF assisted MoH in responding to a rubella outbreak in 2014 that was initially thought to be measles). National counterparts expressed high appreciation for MSF's action in these situations. Fortunately no outbreaks of violence took place.

- Conduct operational research to measure the effect of decentralised model on lost to follow up.

This objective was abandoned.

Exit strategy and timing

A clear exit strategy defined at the inception of the programme was followed consistently. Timing was also well met. Initially the duration of the Gokwe project was expected to be no less than three years (but may be longer). It was possible to hand it over exactly after 3 years.

Infection control and infrastructural improvements

Despite the absence of specific objectives and success criteria in the MSF proposal, many activities were carried out to improve the inadequate infrastructure of the district allowing to accommodate more space for additional patients and for adequate infection control measures. MSF also installed solar power devices for the District Hospital and CMH (for the EPMS).

²⁷ (M Moyo, District Medical Officer, presentation to the provincial team, 2014)

Other logistical support

MSF organised and maintained the car fleet, necessary for the intensive transportation on long distances and dust roads.

Shortcomings

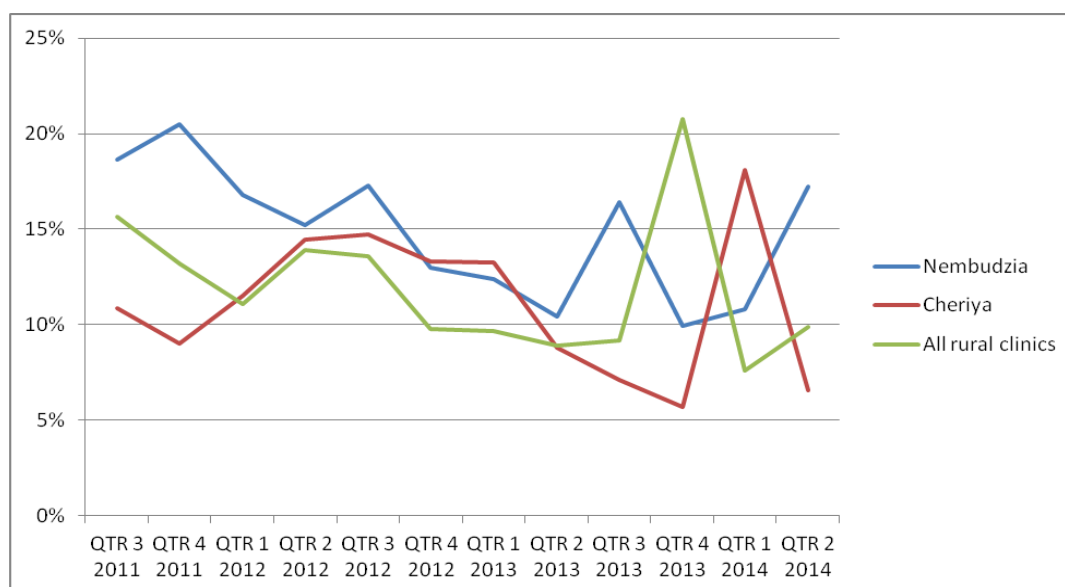
- Lack of collaboration with the community-based organisations: the initial MoU did not include the clause allowing MSF to work on community level. This became an obstacle for the team as the national authorities referred to the agreement.
- There is still a high proportion of late presenters in the HIV programme²⁸, despite the progress that has been made.

2.2.2 Project outcomes

HIV diagnostic and treatment

In the period from Qrt1 of 2012 to Qrt2 of 2014, among the total of 34 930 adults tested, 4 354 were HIV-positive (11%). The positivity rate has varied over time and only slightly decreased from 12% to 11% in the given period. Positivity rate among children has seen a more significant reduction from 23% in Qrt2 2011 to 11% in Qer1 2014.²⁹ However, stratification at the health facility level shows a clear decrease of the positivity at PHC level (from 15% to 10%).

Figure 1: positivity rates among adults at different health facilities of GN, 2011-2014³⁰



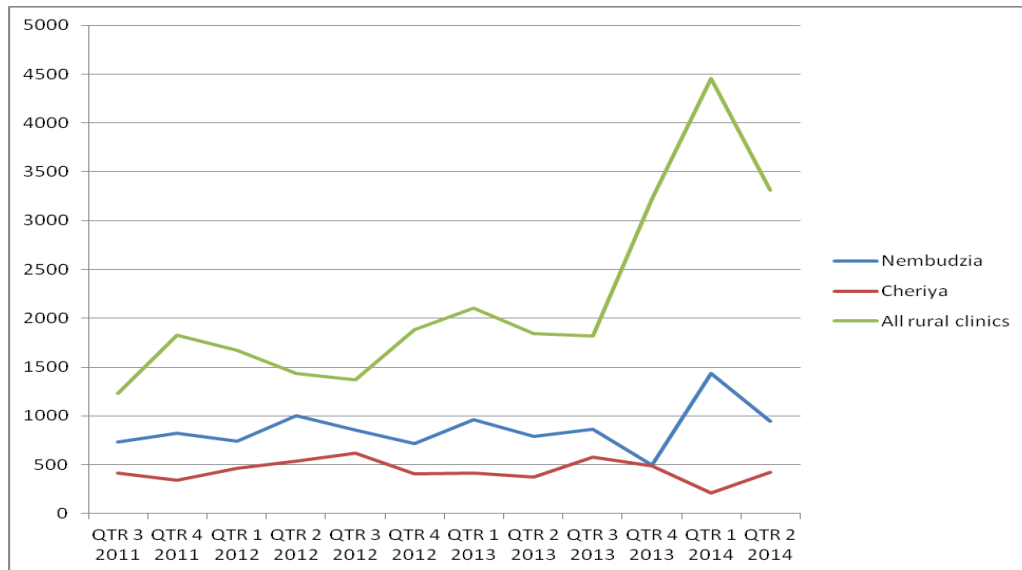
²⁸ Own observation, data analysis and documents (Esther C Casas and Musa Hamdan, MSF-OCA April 2014)

²⁹ (Rebecca Harrison, *VCT and OI data entry with cleaned up analysis 4.xls 2014*). this information was collected (by MSF epidem team) using the soft copies of the entered monthly return forms from the district hospital, and then from the 4th qtr 2013 from DHIS2 exports from the centralized online system.

³⁰ Refer to footnote 29. It is noteworthy that these numbers are not in accordance with the data that MSF has previously recorded: the positivity rate was lower and the spikes seen in this graph were absent. Overall decreasing trend was the same.

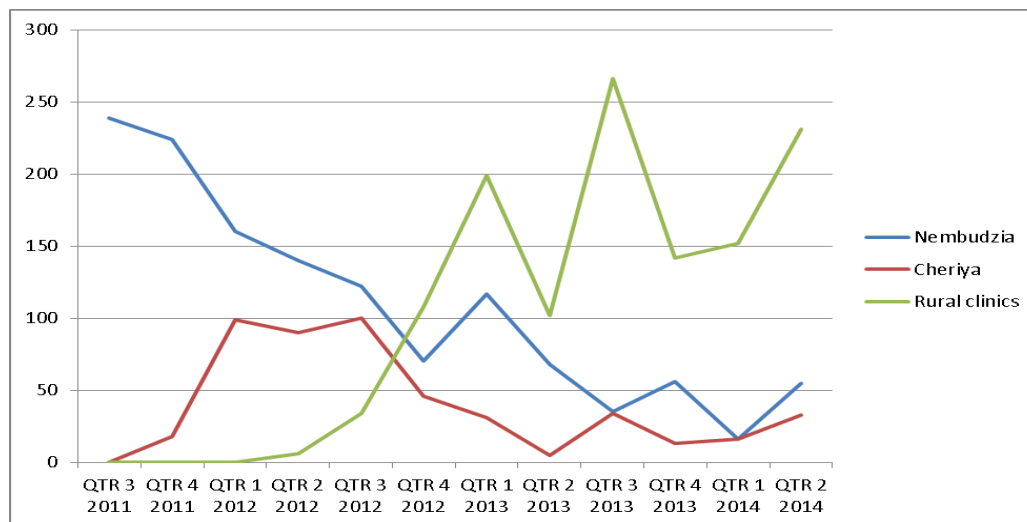
The distribution of the testing and counselling sessions between the different levels of health care shows a picture of decentralised care where the main burden of work is done at PHC level.³¹

Figure 2: number of HIV testing at different health facility levels in GN, 2011-2014



After the MSF intervention (up to Qtr3 of 2014) there were **2546** ART initiations in the district.³² This figure looks rather modest as compared to the initial ambitious target of 3600 new ART patients within the first year of the intervention³³. However, the trend is very positive over time with the primary care level taking the main workload from Qtr3 2012 onwards.

Figure 3: ART initiations at different health care levels in Gokwe North, 2011-2014³⁴



³¹ (Rebecca Harrison, epidemiologist OCA Zimbabwe, VCT and OI data entry with cleaned up analysis 4.xls 2014), refer to footnote 29 for info sources

³² (Rebecca Harrison, epidemiologist OCA Zimbabwe, VCT and OI data entry with cleaned up analysis 4.xls 2014), refer to footnote 29 for info sources

³³ (MSF OCA Zimbabwe, Gokwe Project proposal October 2011)

³⁴ (Rebecca Harrison, epidemiologist OCA Zimbabwe, VCT and OI data entry with cleaned up analysis 4.xls 2014); refer to footnote 29 for info sources

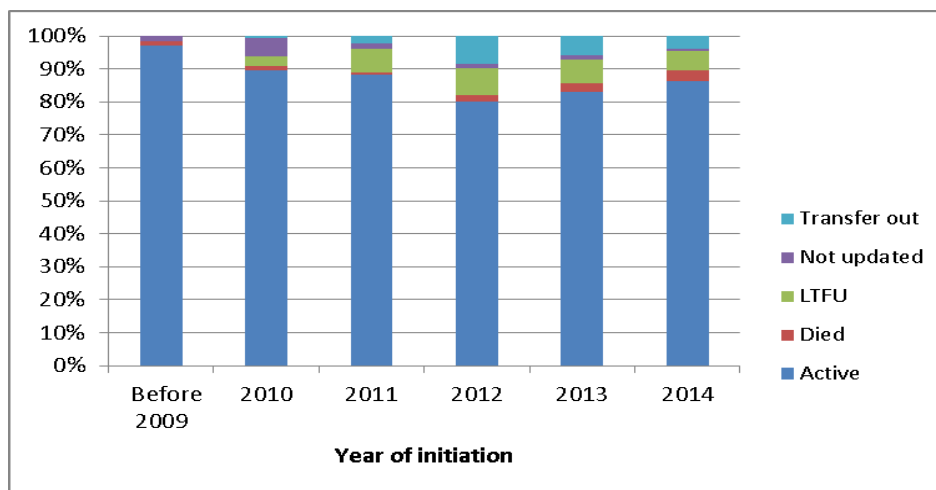
One very important indicator showing a level of success of any HIV programme is the ART coverage. At the start of the MSF intervention, in February 2012, the ART coverage was 28% for adults and 17% for children (eligible population counted with the threshold of CD4 < 350). As for September 2014, the coverage had increased to 49% and 33% respectively (with the threshold of CD4 < 500).³⁵

Quality of care indicators in HIV/AIDS

In the overall existing ART patient pool as for September 2014, we can see very high transfer rates: both transfer-in (2359 patients, 44% out of total 5379 ART initiations in the District) and transfer-out (1217 patients, 23% out of total), which indicates high mobility of the patients. From the remaining balance of movements (6521 ART patients) 19% were lost to follow up (1265 patients).³⁶ It is very likely that many of them have changed their clinic without a proper transfer registration. However, some of them could have died.

The officially registered death record is very low at 220 cases, making only 3% of the 6521 ART patients and the survival rate on ART is 74%.³⁷ It is noteworthy that the different age groups, above 15 and below 15, show quite similar outcomes (see table 3 in the annex). ART cohort analyses (at 6 and 12 months) show good overall outcomes with positive trends after 2012. The low quality of data collection before 2012 should be taken into account when interpreting high survival rates of the earlier years' cohorts.³⁸

Figure 4: ART cohort outcomes at 6 months, all health facilities of Gokwe North



³⁵ (Rebecca Harrison, epidemiologist OCA Zimbabwe; ARV coverage calculations.xls 2014) - most of the assumptions are taken from the file "MINISTRY OF HEALTH AND CHILD WELFARE of Zimbabwe; AIDS & TB PROGRAMME. HIV estimates report final 2012" and for the HIV prevalence for Gokwe from the MSF MMR forms. They are explicitly detailed in the Annex (tables 4, 5 and 6). The patients on ART are taken from the: Cohort analysis write up 2014, refer to footnote 36 for data sources

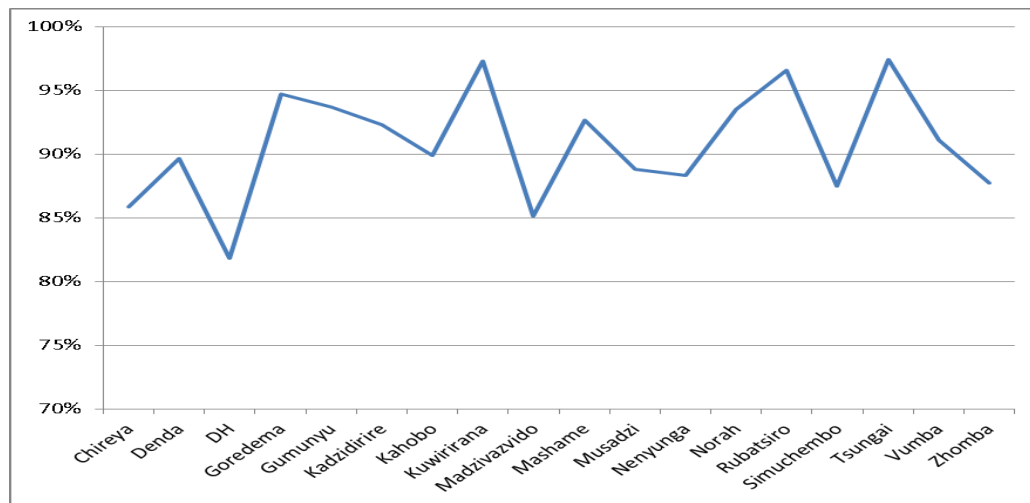
³⁶ (Rebecca Harisson, Cohort analysis write up 2014) - this analysis is based on data collected by the MSF team from the registers at each clinic in Gokwe North directly, using tally sheets to calculate the number of patients on art at 6months, 12months and at date of analysis -Sep 2014.

³⁷ (Rebecca Harisson, Cohort analysis write up 2014) Refer to footnote 3636 for data sources

³⁸ (Rebecca Harisson, Cohort analysis write up 2014); Refer to footnote 3636 for data sources

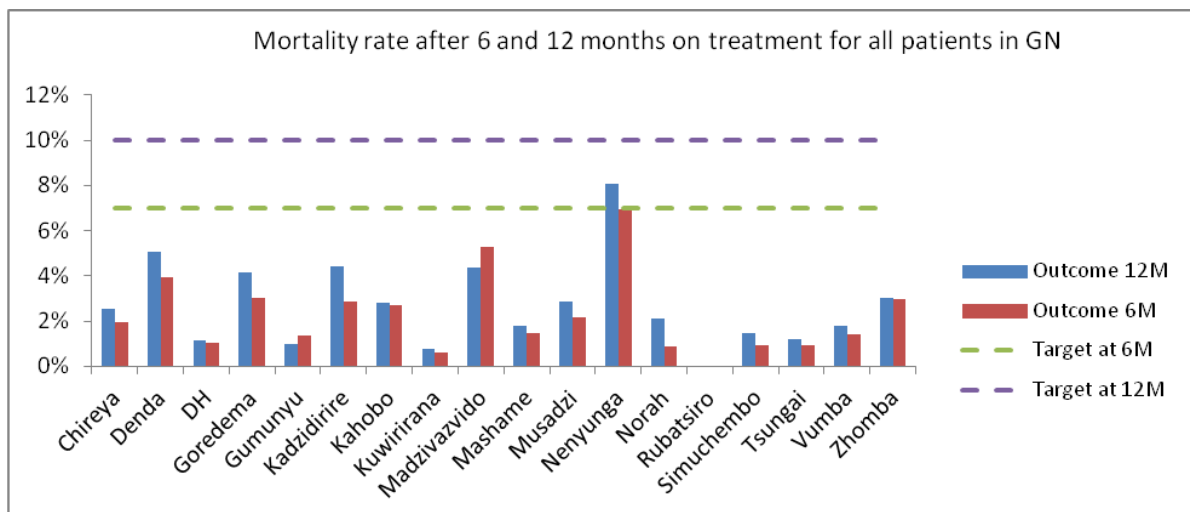
Survival rate in the 12 months ART cohort (after excluding the transferred patients) is well above 80% in all health facilities as seen in the figure below.³⁹

Figure 5: Proportion of active ART patients in 12 months cohort (after adjusting for transfer outs), Gokwe North



Mortality rates are well below desired targets in the cohorts of patients at 6 months and 12 months. We cannot exclude, however, that some of the LTFU patients have died.

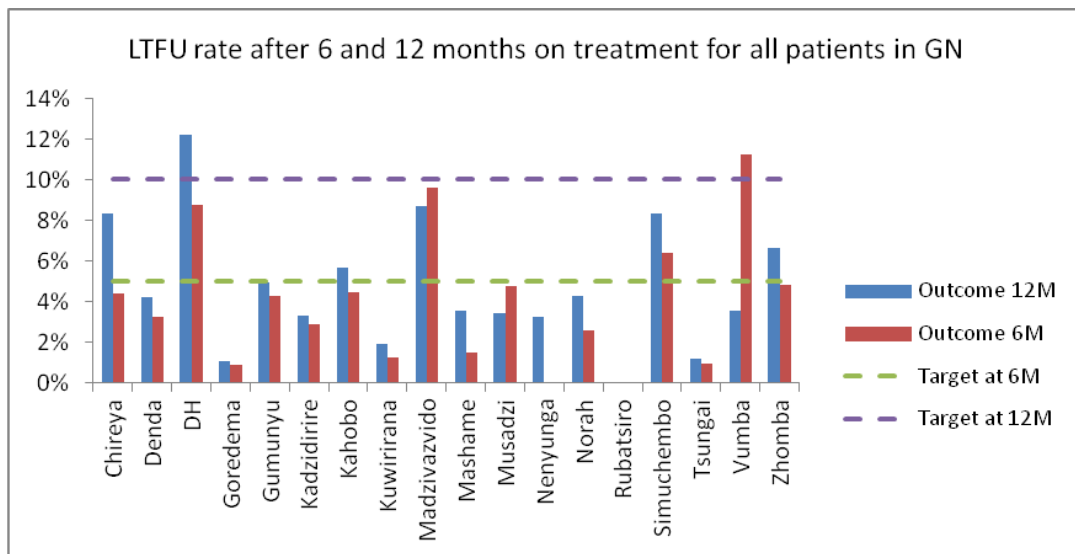
Figure 6: mortality of 6 months and 12 months ART cohorts in Gokwe North



Cohort analysis also shows that LTFU is higher in the 6 months cohorts but then falls within the targets at 12 months (except of the District Hospital).

³⁹ (Rebecca Harisson, Cohort analysis write up 2014) Refer to footnote 36 for info sources 3636

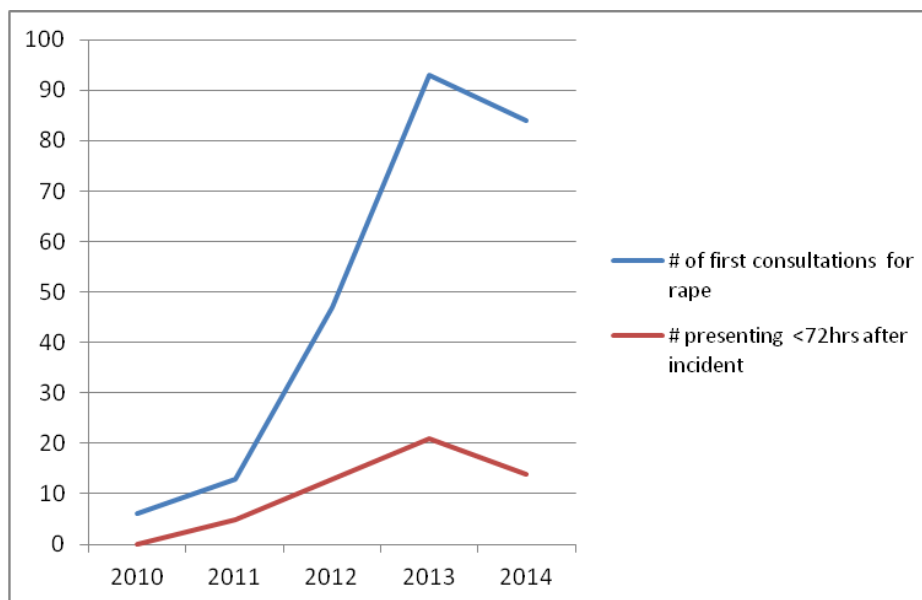
Figure 7: Lost to follow up in the 6 months and 12 months ART cohorts, Gokwe North



Response to sexual and gender-based violence

Reported cases of SGBV significantly increased after the sensitisation of the community and training of health workers and police and reached 224 cases in the intervention period. This is exceeding the initial target of 50 SGBV supported cases per year. However, the proportion of early presenters was at 21% (< 72 hours after incident), still falling short of national average and MSF targets (> 25% presenting < 72 hours after incident).⁴⁰

Figure 8: SGBV cases reported in the health facilities of Gokwe north⁴¹



Among the early presenters the coverage of PEP and other preventive measures is high.⁴²

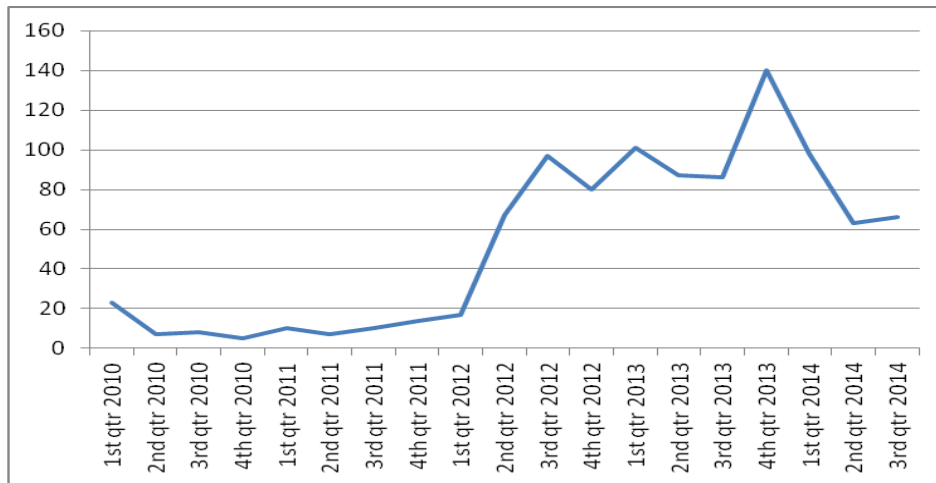
⁴⁰ (Rebecca Harisson, "SGBV, lab surgery.xls" 2014), the laboratory data was collated by the MSF lab advisor from his own MSF records and reports the district lab data, the surgery data was taken from the District hospital records and the SGBV data from the district data for before 2012 and the MSF SGBV database after 2012

⁴¹ (Rebecca Harisson, "SGBV, lab surgery.xls" 2014), for information sources refer to footnote 40

TB diagnostic and treatment⁴³

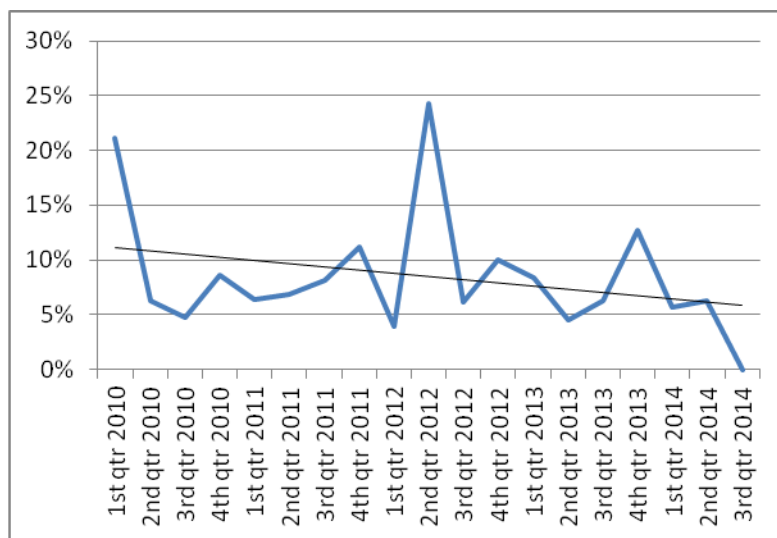
The notification rate of TB cases has dramatically increased after MSF’s intervention. The number of quarterly cases is steadily growing and reaching its pick in Qrt4 2013 (6 times more cases than before intervention), which shows better case finding and is linked to the access to diagnostic means as well as integration of TB with HIV (screening of HIV patients). The recent fall of the notification rate could be linked with the genuine decrease of TB incidence, which resulted from the improved ARV coverage in the district.

Figure 9: Number of notified TB cases in Gokwe North, 2011-2014



Decreasing sputum positivity rate (with the more sensitive GeneXpert machine) also supports the assumption of TB incidence decreasing over time.

Figure 10: sputum positivity rate among TB suspected cases, Gokwe North, 2010-2014⁴⁴



⁴² See annex, graph 1: PEP and other prevention among the SGBV victims presented in < 72 hours; for information sources refer to footnote 40

⁴³ All epidemiological data on TB is based on (Rebecca Harrison, TB data entry.xls 2014) - this data is taken by MSF teams from the district hospital from the paper copies of the quarterly TB results sent by the TB coordinator to the province.

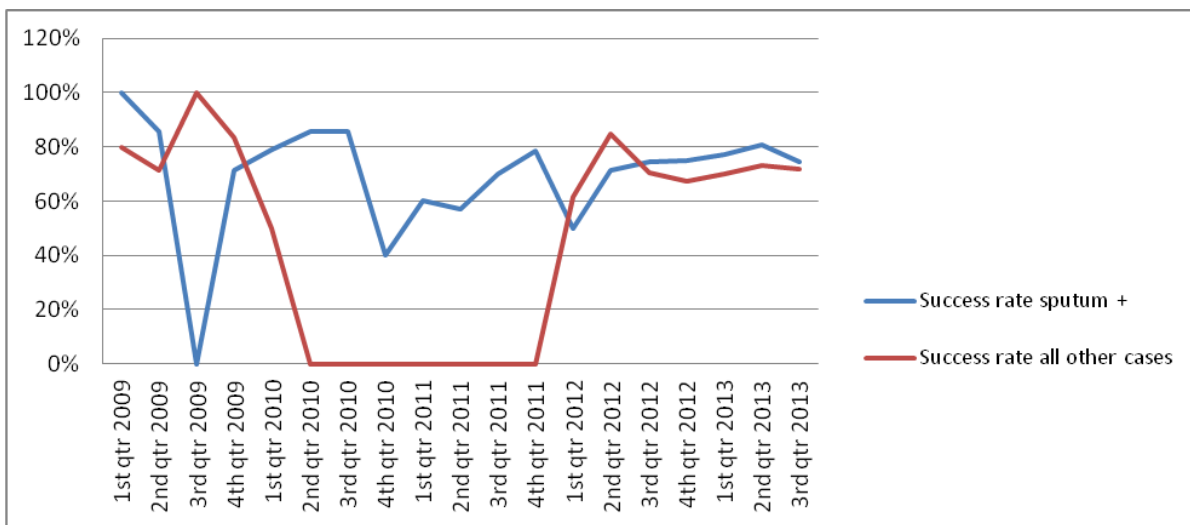
⁴⁴ Refer to footnote 43

The amount of TB workload is impressive. From 2012 to September 2014, **902 cases of TB were treated**. Most importantly, among them considerable proportion of **sputum – pulmonary TB (264)** and **extra pulmonary TB (172)**! Before MSF these patients were neither identified nor treated in the District (see table 1 in the annex).

Quality of care indicators in TB treatment

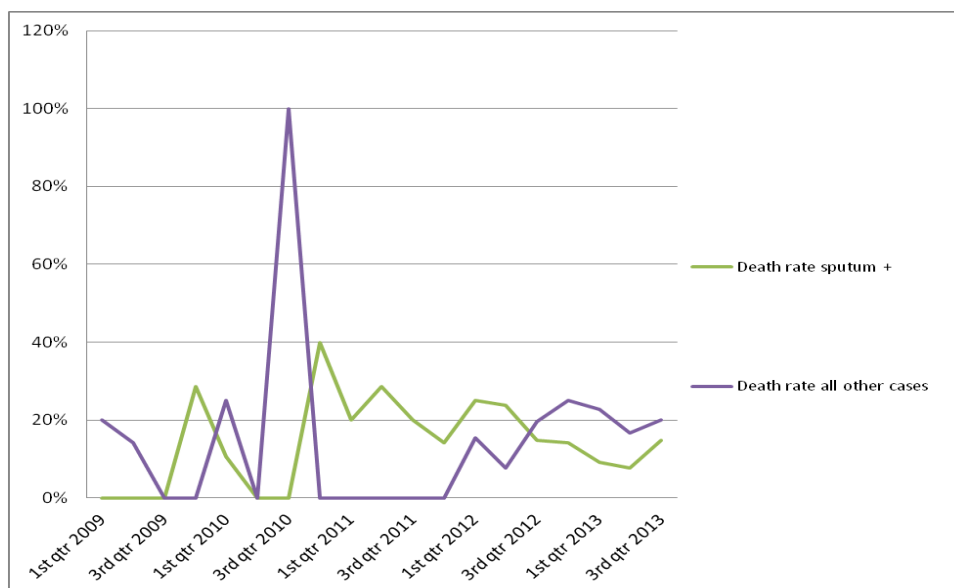
Treatment success rates for DS-TB have improved since 2012. It falls slightly below the benchmark of > 85% targeted by MSF, but it is a very good figure for Gokwe North reality. The data before the MSF intervention could be questioned in terms of their accuracy (and statistical insignificance of changes due to low numbers of patients).

Figure 11: TB treatment success rates, sputum-positive vs. all other cases, GN, 2009-2013⁴⁵



Mortality among DS-TB is slightly above MSF targets but has a decreasing trend.

Figure 12: mortality in patients treated for TB, sputum positive cases versus all other cases, Gokwe North, 2009-2013⁴⁶



⁴⁵ Refer to footnote 44

⁴⁶ Refer to footnote 43

Defaulter rate stays well below the targeted 10% after Qrt2 2012.⁴⁷

There have been 17 RIF-positive diagnoses through Genexpert at the laboratory in Gokwe North. The DR-TB patients are commenced on their treatment in Gweru provincial hospital, but the follow-up phase is done at the hospital or PHC level. The outcome data are not available at this point.

Gokwe North compared to other districts

The MoH national database shows > 12 000⁴⁸ cumulative ART initiations in Gokwe North in adults by 2013 year. There is, however, a lack of confidence in this figure (in MSF coordination) and is attributed to an error. Therefore it is probably not trustworthy to show the comparative increase of ART initiations over other districts in the province or at the national level using this figure.

Data provided from the provincial level (table 1) show cumulative 7160 patients on ART (both adults and children) by June 2014 in Gokwe North.⁴⁹ Based on this data set Gokwe North has achieved the highest increase, as compared to Gokwe South and Mberengwa – two districts which were perceived to be somewhat similar to Gokwe North setting. According to the provincial medical executive (PME) team, this comparative increase in ART numbers in Gokwe North was attributable to the input of MSF.

Table 1: ART scale-up in Gokwe North, Gokwe South and Mberengwa

All patients on ART			
Year	Gokwe North	Gokwe South	Mberengwa
2011	1672	8655	5087
2012	3551	8906	7884
2013	4813	10908	9602
2014	7160	11052	10731
% increase in number of ART patients	328%	28%	111%

The following charts (fig 13 and fig 14) show the Gokwe North district rates in regards to the facilities that provide ART initiation and follow-up as compared to the national average and other areas.⁵⁰

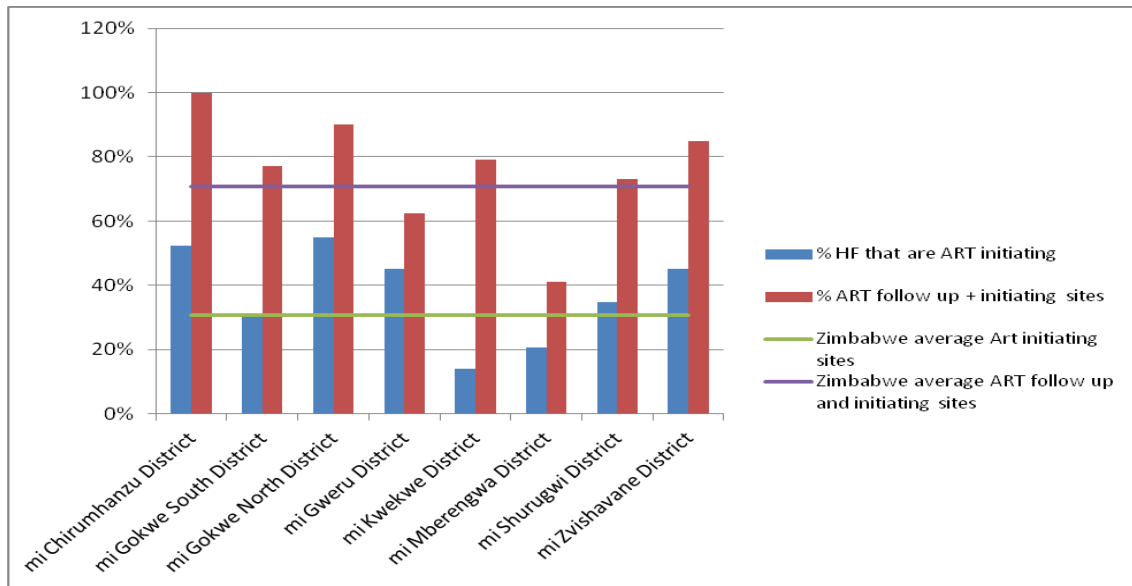
⁴⁷ See annex, figure 2: Defaulter rate DS TB treatment, Gokwe North

⁴⁸ (Rebecca Harrison, OCA Zimbabwe, "patients on ART each year countrywide.xls" 2014), this data is from the MoH national database, given to us in Softcopy; the number of initiations is collated at district level from the monthly return forms sent by each facility every month.

⁴⁹ This figure correlates better with the data collected by the MSF team from the registers at each clinic in Gokwe North directly, showing about 6500 ART patients by September, 2014. (Rebecca Harrison, Cohort analysis write up 2014)

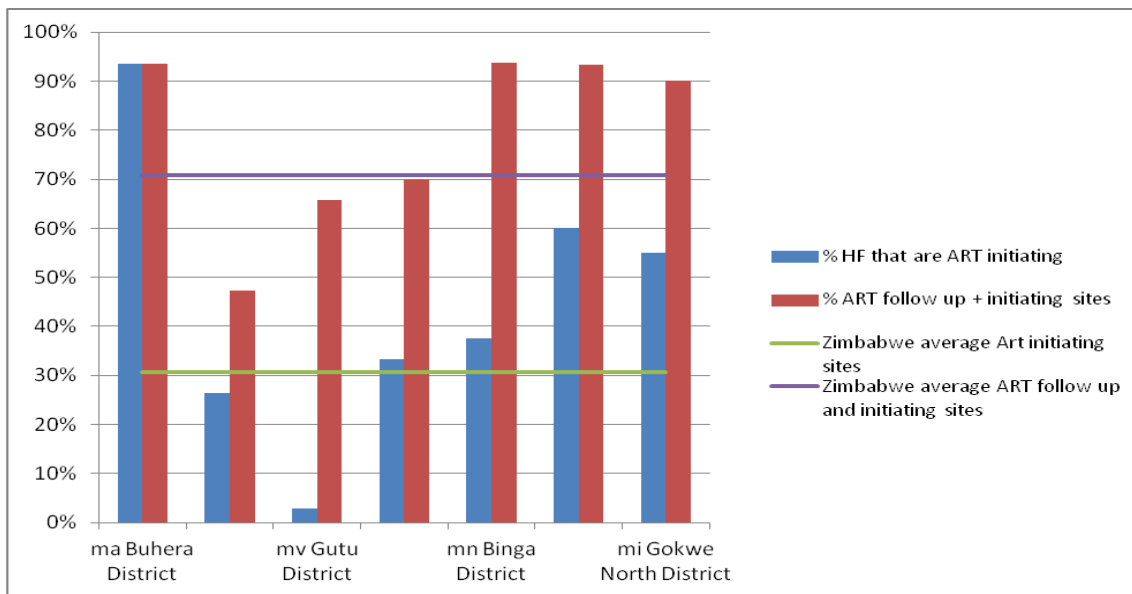
⁵⁰ (Rebecca Harrison, OCA Zimbabwe, "National ART inventory-June 2014.xls" 2014), this is from MoH National database on ART initiating and follow-up sites, given to MSF in soft copy

Figure 13: proportion of health facilities that are ART initiation of follow-up sites compared to national average levels, Midland province, by June 2014



It looks also impressive in comparison to the other districts of the country.⁵¹

Figure 14: proportion of health facilities that provide ART initiation and follow-up compared to national average levels, selected districts of Zimbabwe, by June 2014



2.2.3 Perceptions on achieved goals

Objectives of MSF intervention in GN were understood unambiguously and consistently among different groups of respondents and this perception was well reflecting the internally documented goals.

⁵¹ Refer to footnote 50

The MSF headquarter has recognised that the accreditation of the clinics for ART provision took some time in the beginning and delayed a process of scaling up. In the opinion of some of them more scrutiny was needed to demarcate the impact of MSF from the impact of the progress achieved by national authorities.

From the MSF headquarters' perspective the quality of care was somewhat compromised due to high defaulter rates. However, it was also recognised that the main reason behind was rather a change of addresses of the patients (accessing their treatment in other places) than a real default from treatment or mortality.

The counterparts at the provincial and district level perceived the goals of tackling HIV and TB (including DR-TB) epidemic and addressing SGBV victims' needs as very well achieved. Similar understanding was expressed by the medical and non-medical staff of the clinics and offices of MSF at GN and Harare level. ART and TB treatment access and coverage were spectacularly improved according to them. The provincial medical executive team was very aware of the challenges faced by GN district. It was one of the most resource-depleted districts without any MD, no functional district hospital or a laboratory and with worrisome medical data, such as very low annual TB notifications and high maternal mortality (due to referrals to Gokwe South hospital).

All respondents at the provincial and district level were unanimously stating the importance of MSF's presence in achieving the improved health outcomes in the district. Without MSF's support the current level of ART and TB services (rated now as the best in the province) could not have been achieved. There was no financial and HR capacity for this according to them.

Through the coaching and supportive supervision the medical staff of the clinics felt empowered and confident in fulfilling their daily tasks. In general their performance and level of independence was positively assessed by their national and MSF supervisors as well.

For the patients the biggest achievement and a sign of good quality of care was an access to treatment in the first place. The perspective of long and expensive travels to the Gokwe South Hospital or even to the Nembudzia district hospital was for respondents as good as no access at all. Living on the scarce income of their cotton farms and suffering from money problems, they would not have been able to travel regularly, if at all. For the residents of some areas travelling by car is physically impossible due to the flooding in the rainy season. While commenting on the quality of care, they also mentioned very welcoming staff that took care of them, availability of drugs and diagnostics. They were served quickly.

Quality of care has dramatically improved from the MoHCH and medical professionals' perspective after the MSF intervention. Improved TB notification and treatment outcomes, successful ART programme, functional and well equipped district hospital with the functional OT and laboratory was like a dream fulfilled for many of them. Decentralised services through capacity of the PHC and their staff to manage ART/ TB patients and attend the SGBV survivors were highlighted.

As observed during the evaluation process, all interviewed patients had initiated their treatment within the last 3 years, after the MSF intervention, inside the Gokwe North

clinics. This may be indicative of the difficulties that PLWHA people of the district had to access a treatment before MSF intervention.

2.3 Implementation process in Gokwe North

2.3.1 Strategies chosen

Clear strategic lines of implementation were outlined from the very beginning of the Gokwe North intervention. The principles of the approach were planned around the strategies of decentralisation, integration and task-shifting. These were the key advocacy points for OCA in Zimbabwe aiming at encouraging the Government of Zimbabwe (GoZ) to achieve durable scale-up of HIV services. The approach was to achieve a volume of scale-up by developing the capacity of the MoHCW, rather than by employing large numbers of MSF staff. The 2013 WHO guidelines (Tenofovir first-line) should be implemented from the start, and a new health information system (ePMS, based on “green-book” and an electronic database) designed in Zimbabwe should be piloted.

The exit strategy aimed to reach objectives in a sustainable manner with the engagement of the MOHCC to ensure only minimum gaps of service provision after the handover.

These strategic considerations were very different from the former approaches used for implementation of the historically older MSF projects (e.g. Gweru and Epworth of OCA, Buhera of OCB) with more vertical approach in terms of resource management and decision-making structures⁵². It took into account contextual changes (see chapter 2.1 on context change) and was capitalising on the strong working relationship already established with the Midlands’ provincial medical team.⁵³ Most importantly, this approach was based on the lessons learned from the Gweru project.

Lessons learned from the Gweru handover evaluation have influenced the setup of the Gokwe North intervention

- A more integrated approach to the MSF programme implementation was desired as it would have improved the handover and continuity of care provided. Areas that were independently run by MSF during the programmes left greater gaps than departments that were run in closer collaboration and integration with MoHCW.
- Parallel patient data management system was the most widely criticised aspect of the handover. Nurses were not trained in the MoHCW system as they were used to patients being entered into FUCHIA. The variety of consequences included a worsened quality of care, ineffective drug ordering and follow-up of patients immediately after the handover. The district’s statistics suffered from a degree of disorder in the long term, which proved to be very difficult to fix. (see page 27)
- Communication and collaboration on the handover process and its pace was criticised as having been done quite inconsistently. This meant that some patients were left for the MoHCW to continue treatment without any handover and without easily accessible records; and some departments were handed over quickly without a possibility from the

⁵² See definitions of vertical versus integrated under abbreviations

⁵³ (MSF OCA Head of Mission, Paul Foreman. Annual Plan of 2012 Zimbabwe end of 2011)

MoHCW to absorb (e.g. pharmacy management).

- More gradual and closer monitored withdrawal based on a closer evaluation of the capacity on the ground and the effectiveness of the trainings was suggested.
- MSF provided trainings were highly appreciated; extension to more topics and different cadres was desired.
- Greater use of MoHCW guidelines during the programme implementation and training was suggested to ensure that staff were trained fully in MoHCW systems before leaving. This was particularly important for the data and pharmacy management systems, as some MoHCW staff were left unable to fill in the clinic registers or make drug orders, due to being reliant on MSF systems before the handover.
- Desire that MSF leaves more resources behind after a handover, such as donation of cars, specialised drugs, computers, laboratory testing facilities etc.

The country policy of OCA in Zimbabwe, 2012, lays supportive grounds for the Gokwe approach, specifying that OCA's response to the restrictive political climate is that OCA has to be seen as a partner to the MoHCW. The ambition is to find the space to challenge restrictive or overly bureaucratic processes that reduce effectiveness as medical practitioners or patients' access to treatment, but efforts and approaches need to be seen as those of a trusted partner within the system.⁵⁴

2.3.2 Implementation of the chosen strategies

The strategies chosen for Gokwe North were adequate in regards to the current internal and external situation and they were implemented with a lot of rigour and patience throughout. After an initial phase of difficulties in finding correct communication lines and integration techniques with the MoHCW, strong and reliable relations were established with the national counterparts. The focus on goals was maintained without scarifying MSF principles. The following steps were taken in close collaboration with national counterparts:

- The lack of human resources was addressed by lobbying the MoHCW to recruit the staff with financial support from MSF (e.g. cover their salaries for a given time or to add some incentives to increase motivation at the start)
- Capacity building of the MOHCW staff in managing HIV/TB/MDR-TB and SGBV patients was done by mobile-teams (consisting of national and international staff) visits to the clinics and mobile sites
- Capacity building had two axes: official training⁵⁵ and on-job coaching. Systematic skills assessment of the MoHCW staff was incorporated into monitoring activities

⁵⁴ (MSF-OCA COUNTRY PROFILE AND POLICY ZIMBABWE 2012)

⁵⁵ See the detailed training schedule in the annex

- Clinical work was largely performed by the MoHCW staff. Limited hands-on work of MSF staff served to demonstrate the best practice and sometimes to fill the gap in an emergency situation (e.g. C-Section)
- Data collection was based on the national Electronic Patient Management System (EPMS).

Very trustful relations were achieved between the MoHCW staff and MSF staff at the health facility level as well as at the coordination levels of Gokwe North and Gweru PME.

Intensive lobbying was mostly done for the assignment of human resources, and for the ART site accreditation.

Until the time of this evaluation, the handover went very smoothly due to the efficient integration of services from the start, intensive communication and common planning. The handover process was accompanied by a rigorous monitoring of the supported health services⁵⁶. It was monitored monthly from June 2014 based on a systematic checklist and included

- systematic assessment and documentation of each supported health facility in terms of infrastructure, services and HR skills as well as
- targeted coaching activities based on the documented gaps.

No deviations from MSF principles were noted. Gokwe North does not charge patients for their visits to the PHC, because they get 750 USD per months per clinic to cover maternal and child health through the Health Transition Fund programme supported by donors (started at the end of 2012 for 3 years). Drugs and other medical supplies coming through the Global Fund (Zimbabwe MoHCW) are of good quality. Proximity was maintained through a regular presence of MSF international and national staff at health facility level. Zimbabwe health authorities were updating the guidelines on time according to newest WHO recommendations. Therefore MSF did not have big problems of discrepancies in guidelines (HIV testing protocols discussed in the CoH clinics chapter).

An input from the other health-care partners (National Healthcare Trust, Zimbabwe Health Transition Fund and Global Fund), even though not looked in detail in this report, should have played a contributing role to some of these achievements in the TB/HIV programs in Gokwe North.

2.3.3 Sustainability

Sustainability considerations were embedded in the implementation process from the start, therefore the future looks promising (see the lessons learned from Gweru handover).

In order to fill the gaps in human resources (e.g. 2 doctors, 2 laboratory scientists) MSF provided financial support. However, recruitment of staff was done by the MoHCW and they were put on the MoHCW payroll. This choice supported an initial motivation for new medical personnel to come and 'inhabit' the district but also the continuity of their presence after MSF withdrawal.

⁵⁶ (Handover Checklist Gokwe Project activities 2014)

MSF was providing drug supplies to fill the gaps of ARV and TB drugs and laboratory supplies covered almost exclusively. The gaps of ARV and TB drugs occurred due to poor drug management. This gap was addressed by a tailored training and coaching to boost the DH as well as the PHC with pharmacy management capacity. In the annex (table 2) one can see the total amount of nurses trained on drug management (18) and data management (33). After the training, skills assessment and job coaching the pharmacy responsables feel confident in their future drug ordering capacity. Laboratory supplies are also secured through Global Fund.

As Gokwe North suffers from a bad road network and long distances, an adequately managed car fleet is of immense importance. MSF repaired one can of the MoHCW and donated another car to them. Coaching sessions were done on correct maintenance. Still, the capacity of the district to keep this system up is under question due to its high costs and complicated maintenance systems of Zimbabwe.⁵⁷

2.3.4 Perception of the implementation strategies

In the case of the Gokwe North intervention the implementation process was as much appreciated as the actual achievements. The absolute majority of the respondents from both sides were entirely satisfied with the collaboration of the MoHCW and MSF. The local counterparts felt well informed and consulted, their points being taken into account and implemented. Many respondents mentioned the problematic handover of the Gweru project and how well MSF implemented the lessons learned from that experience in Gokwe North district. All MoHCW⁵⁸ respondents expressed satisfaction in terms of the way of hiring new staff with some incentives from MSF. Only one person from the PME expressed disapproval with this practice (MoHCW payroll instead of MSF contract).

It was appreciated that MSF international and national staff worked hands on with patients when an acute need arose; e.g. national doctor would do a C-section in the absence of an MD, intervention during the infectious diseases outbreaks etc.

The vast experience in HIV/TB clinical and programmatic management that MSF brought to GN was well acknowledged by the health facilities' staff and their coordination; they welcomed this expertise with eager, are willing to learn and absorb.

⁵⁷ (M Moyo, District Medical Officer 2014;)

⁵⁸ Currently the name is: MoHCC, Ministry of Health and Child Care

3 Conclusion and discussion

In earlier years of ARV provision, because of its novelty and a lack of alternative funding sources, a more vertical implementation approach in resource use and decision-making structure with a higher focus on individual patient care was widely used in HIV/TB support programmes of MSF. Currently in the light of the context changes and MSF's internal expertise gain, a decreased complexity of the first-line ART management (such as availability of less toxic and easy-to-adhere regimens, first-line regimens) and availability of long-term funding mechanisms, improving the ART coverage, is increasingly seen as the main challenge to curb the epidemic. This will allow a reduction of morbidity (due to opportunistic infections) and incidence of new HIV/AIDS cases globally.

With such a focus on increased and sustainable access and in the context of available resources and supportive regulatory environment, an integrated approach gains more and more momentum.

The essence of the integrated support programme is that it is designed and implemented to capacitate the existing public health system and staff to care for the patients. Such an approach has sustainability issues embedded from its inception and capacity building is proportionally more important.

Even though MSF has moved from an independent approach to more integrated projects in different countries since quite some time⁵⁹, for OCA the experience in Zimbabwe is one of the first of its kind and therefore it is valuable in terms of the lessons it offers.

Gokwe North project managed to implement the integrated supportive approach, has reached its objectives and handed the activities over to the MoHCW in a timely manner. Success factors for this project were the high degree of communication and positive engagement with the national counterparts as well as the rigorous monitoring and follow-up of the achievement of common goals. MSF staff understood their role as coaches and catalysts for acceleration of supported programmes relying heavily on implementation of the national guidelines. Lobbying was mostly directed to the allocation of human resources and enabling the decentralisation process through task-shifting.

The collaboration process and programme outcomes received high appreciation from the national counterparts and MSF staff. Patients and communities expressed their delight and gratitude for the services they are benefiting from. The project was implemented and handed over in a very thoughtful and organised way, which offers high chances of continuation after MSF's departure. In that respect MSF-OCA has sustainably boosted the capacity of HIV/TB services in a very remote and disadvantaged region.

One of the few possible improvements could be a faster scale-up of the services (including paediatrics and second line) and a linkage with the community-based and PLWHA organisations to support the sensitisation, referral and follow-up activities.

⁵⁹ e.g. in Uganda, OCG in Swaziland, OCB in Lesotho, Mozambique or Gutu district in Zimbabwe etc. – based on internal MSF interviews and evaluation experience of the author.

Based on the experience in Zimbabwe, the following conditions (or most of them) can be defined as necessary for a successfully integrated approach elsewhere:

- Regulatory environment: updated protocols and guidelines, allowance for task-shifting (e.g. ART initiation by nurses) and decentralization at a primary health care level
- Well educated staff employed in the health sector
- Stable political context
- Functional health-care system and basic infrastructure, with an effective coordination in place
- Financial support from donors being secured for drug procurement and other expenses
- MSF staff understanding their role in the integrated project and feeling comfortable as coaches and catalysts of acceleration
- MSF generally adhering to the national protocols and registration systems but lobbying for improved practices and protocols as needed⁶⁰
- Effective collaboration with the national counterparts (with decision-making power) based on transparency, accountability and trustful communication

A reliable input from the other health-care partners (National Healthcare Trust, Zimbabwe Health Transition Fund and Global Fund) should have played a contributing role to some of these achievements in the TB/HIV programs in Gokwe North, enabling MSF to focus on most needy areas.

For example the Mberengwa district of Midlands province would offer favourable conditions to replicate the Gokwe North approach in a shorter time and with higher ART scale-up ambitions using experienced national staff and building on the trustworthy relations with the provincial health authorities.

⁶⁰ E.g. the provincial MD has allowed a nurse-initiated ART at the clinic level as a result of lobbying by MSF.

4 Recommendations

Targeted to the future HIV/TB programmes in high prevalence and resource-limited settings:

1. MSF should use integrated supportive programmes to tackle a new era of HIV/TB epidemic when the conditions are favourable for their implementation, such as: availability of trained human resources in the country, stable context and functional public health care system, updated guidelines and effective national/international counterparts.
2. In case of human resources gaps in an integrated approach MSF should consider financial help (definite in time) but encourage national authorities to hire their own staff and then help train them. This facilitates integration of services and an easier handover process. Accommodation of MSF human resources in a parallel manner should be avoided whenever possible.
3. Implementation of the capacity building activities, a core for an integrated approach, should be regularly monitored by well-defined criteria to assess the health facilities' capacity and individual staff skills. This is especially crucial in the handover phase.
4. A baseline independent assessment of the health care needs and available services is important for the integrated programme design. The support activities should include any component of the overall package based on the assessment outcomes (like necessary improvement of basic infrastructure to ensure infection control, access to better diagnostic services etc.).
5. Supervision and monitoring must be implemented jointly with the national counterparts.
6. Trustful relations with the counterparts must be built through jointly defined goals, regular communication and transparent accountability systems.
7. National protocols and monitoring systems should preferably be used. If a separate MSF system is in place, the handover phase must incorporate the shift to the national systems in terms of required time and resources.
8. Lobbying the national counterparts for required support and changes leading to the intervention goals must be part of an integrated approach.
9. An exit strategy should be defined at the inception of the programme and be thoroughly implemented.
10. A post part evaluation of the sustainability is recommendable to learn lessons for the future.

5 Annex

5.1 Terms of reference

Terms of reference for external evaluation of Gokwe North Project and city of Harare intervention

Commissioned by	MSF OCA
Duration of evaluation	8 weeks, starting from the end of September
Time period that is evaluated	2012 – 2014
ToR elaborated by	OCA Zimbabwe mission coordination, OCA operational cell, and VEU

1. OVERALL OBJECTIVE and PURPOSE

Purpose of the evaluation

The final aim is to determine whether the *light approach* as performed in the Zimbabwe interventions is an approach that can be recommended for use again by MSF-OCA, which contexts it is suitable for and what possible improvements to the strategy could be considered in future implementations as well as evaluating the standard of Quality and the intended goal of the project.

Overall objective

To evaluate the following indicators of effectiveness:

- Overall program performance –
 - Assessment of project goal
 - compared with other HIV program outcomes
- Experienced difficulties during implementation in regards to the provision of intended MSF quality of care standard
- Final outcomes in relation to what was set as targets by the projects
- Compromises made in regards to MSF protocols and standards

2. KEY EVALUATION QUESTIONS

Key evaluation questions

- What are the overall outcomes as compared to initial project purpose and objectives set (including – list indicators – e.g. coverage, adherence, quality of care, death, etc...) How do overall outcomes compare to other vertical MSF HIV programs
- What are the main challenges experienced by the field team (maybe also program managers, technical advisors, etc) in Gokwe and Harare.
- Describe the compromises made in regards to MSF protocols and standards.

- What is the perception of the project by the MOH and other stakeholders?
- What is the perception of the programs by beneficiaries
- What potential impact did the programs have on national HIV program?
- What are the lessons learnt from this strategy (what worked, what didn't, what could be done differently) in regards to training and staff development, resource management, HR, communication,)

3. EXPECTED RESULTS and INTENDED USE OF THE EVALUATION

Evaluation report including lessons learnt and recommendations on future use of "Light strategy" max 30 pages with possible short presentation

- MSF internal use, circulation to counterparts
- Presentation and debates at country and HQ level

4. PRACTICAL IMPLEMENTATION OF THE EVALUATION

- 2 weeks for document review, briefing in HQ
- 3 weeks field visit to both projects
- 3 weeks for draft report

5. TOOLS AND METHODOLOGY PROPOSED (if any)

- Desk review of all available data: Project Proposals, log frames, 4/8/12M reports, trip reports, MMRs and routine collected data as well as interviewing key informants
- Interviews with key informants within and without the MSFH mission

6. DOCUMENTATION FOR READING

As above

7. JOB PROFILE/S of EVALUATOR/S

- with extensive experiences in HIV programs, and evaluation skills
- Fluent in spoken and written English
- Experience in research and networking skills

5.2 List of interviewees

	Name	Function
1	Christian Katzer, MBA	Operations Manager, MSF OCA Berlin desk
2	Norman Sitali, RN. MPH, MIH	Operations Advisor - MSF OCA Berlin desk
3	Musa Hamdan, MD	health advisor , MSF OCA Berlin desk
4	Esther Casas, MD, MSc	HIV/TB advisor, MSF OCA
5	Sidney Wong, MD	medical director OCA
6	Paul Foreman	head of mission (former), OCA-Zimbabwe
7	Jakob Arhem , MD	medical coordinator ,OCA-Zimbabwe
8	Abi kebra Belaye	head of mission, OCA-Zimbabwe
9	Rebecca Harrison	epidemiologist, OCA-Zimbabwe
10	Philomena Jaravaza	assistant head of mission, OCA-Zimbabwe
11	Larissa Nazmeeva	HR and finance coordinator, OCA-Zimbabwe
12	Kim Stambuli	communications officer inter-sectional, Zimbabwe
13	Tendai Kudzunga	training coordinator, OCA-Zimbabwe
14	Caroline Chieza	deputy project coordinator, Epworth, OCA-Zimbabwe
15	Tendai Kwash	referral nurse, Epworth, OCA-Zimbabwe
16	Anna Marabada	team leader, CoH project, OCA-Zimbabwe
17	Masimba	data manager, OCA-Zimbabwe
18	Steffanie	Project coordinator, Epworth, OCA-Zimbabwe
19	Susana Villén Iglesias (MD, MSc)	medical co-ordinator MSF-OCBA, Zimbabwe
20	Fasil Tezera	head of mission, OCB-Zimbabwe
21	Sandra	medical coordinator, OCB-Zimbabwe
22	Nylton Chemhuru, MD,	Midlands province, provincial medical director
23	Brian A Maponga, MD	Midlands province, Maternal & child health officer
24	Tinashe Nyannyawa	Midlands province, provincial manager – Zimbabwe national family planning council
25	Mr. Machakata	Midlands province, provincial monitoring and evaluation officer, acting HIV/TB officer
26	Joan Marembo	Midlands province, provincial nursing officer
27	Mr. Matsunge	Midlands province, provincial health services administrator

28	Mr. Gift Nyama	GN, President's office, Government representative
29	Mr. Farai Niwa	GN, sponsorship and development officer, GoV of Zim
30	Mr. Isaki Chiwara	GN, district administrative council
31	Mr. Matidtsha	GN, finance officer, acting CEO
32	St. Shenai Bwititi	GN, Chirea clinic, sister in charge,
33	Dr. Moyo	GN, District medical officer
34	Mr. Madungwe	MoH succeded to EGPAF
35	Patient 14, F (27 years, widow, 3 kids)	GN, Gumunyo clinic
36	Patient 15, M (60 years, widow, 4 kids)	GN, Gumunyo clinic
37	Patient 16, M (62 years, married, 4 children)	GN, Gumunyo clinic
38	Village health worker 1	GN, Gumunyo clinic, VHW
39	Susan Zishiri,	GN, Gumunyo clinic, primary care nurse
40	St Kaze,	GN, community health nurse (acting District Nurse Officer), Nembudziya district hospital,
41	Mr.	GN, Nembudziya district hospital administrator
42	George Chibukwe	GN, Nembudziya district hospital, Laboratory scientist,
43	Mrs. Chitiwo,	GN, Matron of the Nembudziya district hospital
44	Emilda Mutangirwa	GN, Nembudziya hospital, nurse in the OI clinic
45	Phanuel Magwenzi	GN, Nembudziya hospital, Pharmacy technician
46	Dr. Madanze	GN, MSF project doctor
47	Mr. Matsika	GN, nurse in charge of the Simchembu clinic,
48	Mr. Gift Tirivaviri	GN, Nembudziya district hospital, TB coordinator,
49	Mr. NHIMBE	GN, village head NHIMBE
50	Lovemore Nzvengende,	GN, Vumba clinic, primary care nurse
51	Chief of Chireya	Paramount chief of Gokwe, has 6 head-men
52	Focus group discussion with village health workers: 11 participants	GN, village health workers
53	Group interview with 2 Head-men	GN, Head-men; in charge of 480 and 58 households respectively
54	Group interview with 2 village health workers	GN, village health workers

5.3 Graphs, tables

Table 1: TB in Gokwe north District

	Tuberculosis	Total 2012-R3 2014
PTB+	New Cases	310
	Relapse	26
	Retreatment after failure	2
	Retreatment after default	7
PTB-	New Cases	264
PTB ND	New Cases	77
EPTB	New Cases	172
Other previously treated		45
Total cases		902

Table 2: Training courses conducted for Gokwe Project since inception

TYPE OF TRAINING	NUMBER OF TRAININGS	PARTICIPANTS						TOTALS
		MD	NURSES	PCC	LAB SCIENTISTS	Community health people	PHARM TECS	
SGBV	4		41	13				54
MDRTB	3	1	16	9				26
RDT	2		40	1				41
VILLAGE HEALTH WORKER	2					302		302
DRUG MANAGEMENT	1		18					18
INTEGRATED HIV/AIDS	4		24					24
OI ADULT ART	2		52					52
GENE EXPERT MAINTANANCE	1				5			5
MENTAL HEALTH TRAINING	1		20					20
PAEDIATRIC ART	2		13					13
DATA MANAGEMENT	1		33					33
HIV DRUG RESISTANCE	1		1				1	2
FIRST AID	1					5		5
LAB. TRAINING IN KENYA	1				1			5
LAB MANAGEMENT IN HOLLAND	1				1			1
CR FORM COMPLETION	1		13					13
SLMTA	1				1			1
GRAND TOTAL								615

Table 3: Comparison of the overall ART cohort between adults and children outcomes, Gokwe North, by September 2014

ART patients >15				ART patients <15		
ART >15	4810			ART init	569	
trans-in	2132	44%		decentralized	227	40%
<u>trans-out</u>	<u>1094</u>	23%		<u>trans-out</u>	<u>123</u>	22%
balance	5848			balance	673	
LTFU	1133	19,4%		LTFU	132	19,6%
died	200	3,4%		died	20	3,0%
<u>active</u>	<u>4326</u>	74,0%		<u>active</u>	496	73,7%
other	189	3,2%		other	25	3,7%

Figure 1: PEP and other prevention among the SGBV victims presented in <72 hrs, Gokwe North

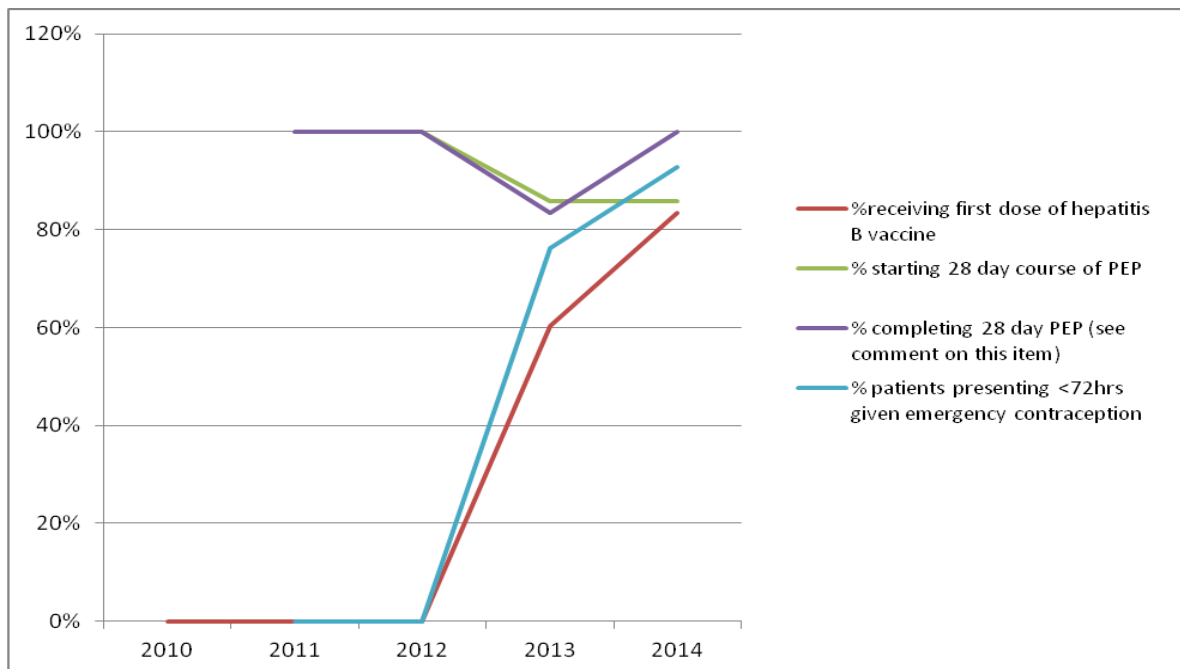
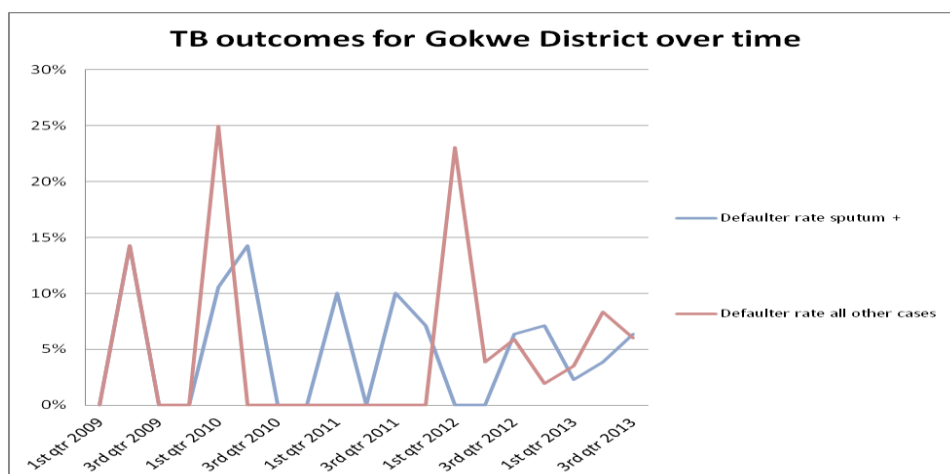


Figure 2: Defaulter rate DS TB treatment, Gokwe North



Tables 4, 5 and 6 : Assumptions for the ARV coverage calculations

Table 4: ART eligibility

ART eligibility scenario	Adults eligible for ART under scenario	Proportion of HIV + population needing ART under scenario
CD4<350 + TB/HIV (Current 2013 scenario)	955.922	76%
CD4<350 + TB/HIV + Option B+	998.622	79%
CD4<350 + TB/HIV + Option B+ + Discordant couples	1.096.513	87%
CD4<350 + TB/HIV + Option B+ + High risk groups	1.139.537	90%
CD4<500 + TB/HIV + Option B+ + High risk groups	1.207.175	96%
CD4<500 + TB/HIV + Option B+	1.066.260	85%
CD4<500 + TB/HIV	1.023.560	81%
High risk groups	140.915	11%
Discordant couples	97.891	8%
350<500	67.638	5%
Option B+	42.700	3%

Table 5: prevalence figures

Assumptions	%
Population growth rate	101%
Adult population	52,80%
Prevalence amongst <15	1,45%
Prevalence amongst 15+	8,10%
Proportion of population <5	17,49%
Proportion of population 5-14	29,71%

Table 6: population figures

Population	Number of people
Hiv population adults and children	1.424.092
HIV + adults 15+	1.259.496
HIV+ 15-49	1.121.942
HIV+ female 15+	743.524
HIV+ 0-14	164.548

5.4 References

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