Vienna Evaluation Unit

MEDECINS SANS FRONTIERES

Evaluation of Homa Bay Handover MSF OCP, Kenya

Marielle Bemelmans, Annie Désilets

January 2016

Acknowledgements

The evaluators would kindly like to thank all the participants in this evaluation who graciously gave their time for interviews and openly shared their thoughts and ideas. Particular thanks go to the Ministry of Health, MSF staff and partners in Homa Bay, the OCP coordination team in Nairobi and at the desk in Paris for their warm welcome, the enthusiasm in their work and their support for this evaluation process.

Disclaimer: *The views expressed in this publication do not necessarily reflect the views of Médecins Sans Frontières or of the Vienna Evaluation Unit.*

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 and anthropological studies and organises training workshops for evaluators.
More information is available at: http://evaluation.msf.at.
Electronic versions of evaluation reports are available on Tukul: http://tukul.msf.org.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

In recent years, MSF has recognised the need to improve its handover process and outcomes. It is no longer satisfactory for the organisation to enter a country, put in place a programme and leave without some degree of accountability for what remains after MSF's departure. This tendency has led the MSF Operational Centre Paris (OCP) to review the handover process of the Homa Bay County Hospital project in Kenya. The main goal of this evaluation is to explore how effective the handover strategy was in contributing to sustainable, comprehensive quality of HIV/TB care in Homa Bay.

Since 1996, MSF OCP has been working in HIV care in Homa Bay County. In 2001, the organisation initiated antiretroviral therapy at Homa Bay Hospital. At that time, the objective was to reduce mortality related to HIV, demonstrate the feasibility of treating a large number of patients in poor resource settings and lobby for increased access to HIV care.

In retrospect, MSF achieved these objectives and in early 2013, in collaboration with the Ministry of Health, MSF initiated a handover strategy with a view to end its engagement at Homa Bay Hospital by December 2015. The strategic objective of the Homa Bay County Hospital handover project was to provide an acceptable level of quality of care for HIV & TB patients independent of MSF.

Overall, the handover stayed on track and the participants bought into the process from the beginning. This facilitated adherence to the handover timeline, and the transfer of MSF staff to the Ministry of Health, which was largely successful. Patients continued to receive HIV care at Clinic B, the HIV clinic in the Homa Bay District Hospital, in particular with an uninterrupted supply of ARVs. The supply of Opportunistic Infections medication and other essential drugs has been more problematic, which led to patients often being referred to a pharmacy outside Homa Bay County Hospital to purchase the prescribed drugs. The Homa Bay County Hospital cohort reports a high number of patients on 2nd line drugs as well as an increasing number of patients failing on treatment, detected through the improved availability of routine viral load testing since mid-2014. The reduction in counsellors and defaulter tracers as well as the malfunctioning *Kenya Electronic Medical Record* (KEMR) system resulted in not being able to identify defaulters timely and probably led to a decrease in quality of care, although it is difficult to confirm a direct link between these factors and a possible worsening of patient outcomes. In particular, children and adolescents are at most risk and measures to address these groups must be taken. Although the handover project did not achieve its objective of transferring out patients and reducing the number of patients followed at Clinic B to 5,000, decongestion of the clinic was still achieved through the implementation of the Six-Month Appointment (SMA) system, allowing stable patients on ART to only have a clinical visit every six months.

The handover dashboard was appreciated as an efficient communication medium for the various stakeholders including patients and staff. The tool also helped the steering committee as it provided clarity on and a perspective of the goals of the handover and helped to keep the entire team focused on the outcomes and activities required to reach those outcomes.

The simplicity of the tool (the green, red faces) is its major asset but it also requires discipline from the team to implement it. However, it was noted that many new expats had difficulty understanding exactly how the tool works and the link between the indicators and the dashboard. This can be a risk for the handover if there is limited clarification. In the case of Homa Bay, one challenge was that the indicators did not measure what is actually needed to ensure a successful handover; it is observed that only 33% of the indicators are well-adapted to the Homa Bay handover. For example, the indicator related to the medical supply has measured the level of MSF support still provided, including non-handover related supplies such as study materials or supplies that the Ministry of Health is unlikely to take over anyhow (i.e. for the TB culture lab). It does not reflect if patients are actually accessing the drugs they need or if the Ministry of Health is assuming an increased level of responsibility in the procurement of drugs and supplies. Focusing on the 'wrong' things may have diverted efforts from focusing on more appropriate issues, in particular the more structural problems encountered in the health system that impacted the effective delivery of quality services and that required more analysis to identifythe real bottlenecks.

Because of the difficulties around the data and, consequently, less clarity about the quality of care, certain groups appearing more at risk (youth) and the unavailability of essential drugs, the handover project has only partially achieved the operational objectives of acceptable quality outcomes in the services, availability of qualified staff independent of MSF, continuity of medical supply independent of MSF, simplification of care, use of standard Ministry of Health protocols and use of Ministry of Health data tools. There are some major hurdles to overcome between now and the planned time frame for the end of MSF activities at Homa Bay Hospital. In fact, although it is not recommended to stay fully engaged, continued MSF involvement may be required in order to accomplish the intended objective of the handover.

LESSONS LEARNED FROM THE HOMA BAY HANDOVER PROJECT		
RELEVANCE	**EFFECTIVENESS**	**CONTINUITY & CONNECTEDNESS**
A long-term handover strategy provides a good opportunity for services to continue once MSF withdraws.	The dashboard tool is generally very useful for identifying challenges, but participants could be more critical to review if indicators still measure 'the right things'.	The development of a genuine partnership with the health authorities in delivering joint interventions is key to increase chances for sustainability.
Early and timely communication of the intended handover at all levels is of high importance and has been appreciated; however, messages became confusing when MSF decided to stay involved in certain areas beyond 2015.	The continuity of certain key staff positions has been critical.	A thorough environment analysis is important when designing the handover strategy to ensure that indicators and targets are realistic and that operational, technical support and advocacy are aligned.
	The handover coinciding with the devolution process had some advantages of better availability of decision-makers at field level but made the handover more demanding for the Ministry of Health.	

RECOMMENDATIONS FOR THE HOMA BAY HANDOVER PROJECT

- ➔ Reflect on the decision to stay in Homa Bay after having invested three years in the handover of the project.
- ➔ Review and adjust the advocacy strategy and immediately increase efforts in key areas such as counsellor recognition, medical and laboratory supply, and capacity building.
- ➔ Approach other organisations before the end of the year to discuss their capacity to sustain continuity of the TB lab, gap fill essential supplies, strengthen the KEMR, support training, support case management of children and adolescents and Kaposi Sarcoma cases.
- ➔ Where it is not possible for partners to take over areas mentioned above, continue to support the management of Kaposi Sarcoma cases, data collection tools (KEMR and EDIT), the gap filling of essential drugs and supplies, and provide support for setting up a revolving fund for the lab.

RECOMMENDATIONS FOR FUTURE HANDOVERS
➔ Allow sufficient time for a sustainable handover of activities.
➔ Develop genuine partnerships, use innovative ideas, such as tripartite partnerships.
➔ Establish relevant and useful indicators and monitor progress by using a dashboard.
➔ Develop communications and advocacy strategies early on.
➔ Accept that the level of quality of care will diminish and establish acceptable limits from the onset.
➔ Develop and implement a capacity building plan that includes training of trainers to ensure continuity of knowledge transfer.
➔ Ensure the continuity of at least one key position throughout the handover period.

ACRONYMS

ART	Antiretroviral Therapy
ARV	Antiretroviral
CBO	Community-Based Organisation
CDC	Center for Disease Control
CoFirH	Coordinator of Finances and Human Resources
CO	Clinical Officer
COP	Country Operational Plan
EAC	Enhanced Adherence Counselling
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EQA	External Quality Assessment
FieldCo	Field Coordinator
FUCHIA	Follow-Up and Care of HIV Infection and AIDS
Hb	Hemoglobin
HBCH	Homa Bay County Hospital
HIV	Human Immunodeficiency Virus
HoM	Head of Mission
IPD	In-Patient Department
I-TECH	International Training and Education Center for Health
KEMR	Kenya Electronic Medical Record
KEMSA	Kenya Medical Supply Authority
MoH	Ministry of Health
MSF	Médecins Sans Frontières
NASCOP	National AIDS and STIs Control Programme
NGO	Non-governmental Organisation
OCP	Operational Centre Paris
OI	Opportunistic Infection
PEPFAR	US President's Emergency Plan for AIDS Relief
PSC	Clinic B/HIV clinic at Homa Bay County Hospital
SC	Steering Committee
SMA	Six-month Appointment
TB	Tuberculosis
TWG	Technical Working Group
VEU	Vienna Evaluation Unit
VL	Viral Load

1. INTRODUCTION

1.1 BACKGROUND

Since 1996, MSF OCP has been working in HIV care in Homa Bay County, Kenya, and initiated ART at Homa Bay Hospital in 2001. At that time, the objective was to reduce mortality related to HIV, demonstrate the feasibility of treating a large number of patients in poor resource settings and lobby for increased access to HIV care.

Early 2013, MSF, in collaboration with the MoH, started the implementation of a handover strategy through participative workshops, which is scheduled to end in December 2015.

The strategic objective was: "By December 2015 acceptable quality of care for HIV & TB patients is available in HBDH independently from MSF".

The operational objectives were:

- Ensure acceptable quality outcomes in the services
- Ensure availability of qualified staff independent of MSF
- Ensure continuity of medical supply independent of MSF
- Simplification of care and use of standard MoH protocols
- Use of MoH data tools

The objective of this evaluation is to take stock of the 2.5 years of handover since its formal start in January 2013, to provide feedback on its **effectiveness, appropriateness, impact, connectedness and continuity of care** by highlighting operational strengths and weaknesses and areas of improvement and to provide recommendations.

The recommendations will be used to improve the final sustainability of the process and enhance the replicability of this handover approach and of the tools applied throughout the process, focusing on the lessons learned.

Landscape at Homa Bay, ©Olga Victorie/MSF

1.2 METHODOLOGY

A standard evaluation methodology was designed to answer the evaluation questions elaborated in the Terms of Reference (see Annex). It included:

- **Document review** of project documents, the handover strategy and reports, M&E of the Homa Bay (HB) project, MoH country policies or documents, epidemiological trends, relevant studies.
- **Quantitative comparative** analysis of key project indicators.
- **Direct observation** of the Homa Bay hospital and related HIV services.
- **Key informant interviews** with a total of 47 MSF and MoH key staff and partners.

Table 1: Key informants

LOCATION/TYPE	NO. OF INTERVIEWS
Paris (Head Office) – MSF staff	9
Nairobi (Coordination) – MSF staff	6
Homa Bay (Field)	
MSF staff	6
Former MSF/current MoH staff	8
MoH staff HBCH	7
MoH staff County	2
DASCO	1
NGO partners (EGPAF)	2
Patients	2
Former MSF expat staff (*by email questionnaire – see Annex 4.4*)	3
Other/handover consultants (*via Skype)*	1

- **Focus group discussion of a support group with 14 patients**

A total of **61 respondents** – a strong mix of stakeholders – were consulted throughout the evaluation process. Please see a complete overview of interviewees in Annex 5.3.

1.3 LIMITATIONS

The evaluators were unable to meet any of the MoH representatives at national level in Nairobi due to an unavailability of stakeholders.

2. FINDINGS

2.1 HANDOVER PROCESS

2.1.1 COMMUNICATIONS

Whenever there is a change in programming, various aspects have to be taken into account to ensure a successful implementation of the changes. One aspect of change management is to ensure accurate, timely and appropriate messaging of the timeline, the objectives and the critical success factors to the different stakeholders. A communication strategy, developed at the onset of the change process, can avoid confusion and rumours and ensure that everyone is aligned in the same direction.

Although there was no official communication strategy developed specifically for the Homa Bay handover, at the onset there were meetings at the clinic, several meetings with all the MSF staff to prepare them for their transfer to the MoH system or to announce their release, meetings with partners on the ground, and messages to the clients, specifically both at Clinic B and in the community. As the handover strategy gained momentum, the steering committee (SC) and technical working groups (TWG) became a platform for exchanges regarding the handover. Today, the difficulty in the communication is related to these stakeholders' perception that MSF is sending mixed messages. Many interviewees reported confusion about the handover because since approximately early 2015, MSF has announced that they will keep working in several areas either as part of the Ndhiwa Project or as a continuation to the Homa Bay project, including continued engagement in the medical wards providing technical support and focusing on complex cases, and because MSF has continued to provide supplies during shortages and opened a new project in the same vicinity. Interviewed patients, MSF and MoH staff wonder whether this process is an actual handover, a reduction in activities or a shift in priorities.

2.1.2 ADVOCACY

As the Homa Bay handover got underway, it quickly became apparent that there were critical gaps in what was necessary to ensure that patients continue to receive HIV/TB care after MSF's departure. These critical gaps (priority areas for advocacy) included frequent stock-outs of essential drugs and supplies, and the status and number of counselors within the MoH human resources system.

Ad hoc advocacy occurred on a continued basis during SC meetings, TWG or in meetings with the MoH on specific situations such as service contracting of laboratory equipment. In the meantime, a plan for advocacy has been developed together with coordination to also specifically target areas at national level in line with the handover objectives and bottlenecks; however, this does not seem to have materialised in a timely fashion. There is also some disconnect of the advocacy initiatives between the coordination and the field. For example, the perception of the field team is that the advocacy agenda that was recently produced was drawn up with little input from them and the priorities may have to be better aligned with the needs and priorities of the field.

2.1.3 MSF/MOH RELATIONSHIP

Previous handover evaluations[1] have shown that local partnerships, as part of the project's exit strategy, are a sustainable and efficient method of ensuring continuity of services in a post-MSF setting. In stable contexts and post-conflict situations, engaging in partnerships, including with the MoH, and making a longer-term commitment to the exit process has become the norm in recent years and has shown some success in achieving the goal of ensuring care for patients independent of MSF.

One of the conditions for such success is the development of sincere partnerships with the MoH. In Homa Bay, the relationship with the MoH evolved and improved with the onset of the handover process. The participation of members of both organisations in the decision-making process of the handover through the SC and the TWG

[1] See evaluation reports: Désilets, A. *Lesotho Handover: Assessment of Handover Strategy of MSF-B HIV/TB Programme.* MSF - Vienna Evaluation Unit Evaluation: 2010b; Hammadi, K. and Désilets A. *Enriched or Confined? MSF Engagement in Local Partnerships.* MSF Vienna Evaluation Unit Evaluation Report: 2012.

may have contributed to the development of this relationship. Members of both MSF and the MoH report that the relationship is on solid ground. Integration at a next level would have meant to be involved in each other's planning and budget cycles, something that is not fully happening yet. The MoH now invites MSF and other partners to consultative meetings in preparation of their county planning and budget. However, participation of MSF has not been regular yet, often due to other priorities, but sometimes also because MSF wanted to avoid adopting too much of a 'meeting culture'.

The Homa Bay handover project chose to use a tool called the 'dashboard' to visualise and monitor progress of the project. MSF has used this tool in other HIV projects during the handover phase.[2] Ideally, and in other projects where a dashboard was introduced, the common objectives, indicators and targets are developed by MSF, the MoH and any other identified pertinent stakeholders. This has the effect of creating, right from the onset, ownership of the process by all parties. In Homa Bay, due to the country's devolution process (the MoH facing an increase in responsibility and workload), the position shuffling within the MoH as well as the felt need for MSF to first agree internally on the handover strategy and then on objectives, MSF developed the handover objectives and indicators alone and presented them to the MoH. This may have had an impact on the feedback from many who perceive that the indicators are unrealistic and incorrect (described in more detail below).

Although EGPAF was invited to the steering committee, it may also have been beneficial for the process outcomes to have considered a tripartite handover strategy between the MoH, EGPAF and MSF. EGPAF may not have been ready at the onset of MSF's handover strategy due to the uncertainty regarding their own future budgets and priorities. But once PEPFAR confirmed their new phase III 'Sustainable control of the epidemic, to shift focus and invest stronger in areas with high prevalence'[3], these issues became clearer and MSF could have played a role in facilitating EGPAF's engagement with the MoH. This partnership could have addressed the areas where major difficulties were foreseen at the onset of the handover (drugs, counsellors), especially since EGPAF is present and has an increasing capacity and desire to respond to the HIV/TB epidemic in Homa Bay.

2.1.4 DASHBOARD

The dashboard is touted as being useful, easy to understand (red face/green face) and a good monitoring tool to identify challenges and areas where improvements are needed. It seems that especially at the beginning of the handover process, the dashboard tool was widely used and exposed at different locations at the hospitals. From around mid/end 2014, once the Fieldco positions for Homa Bay and Ndhiwa were merged, the dashboard results were not shared as regularly, as this new situation increased the responsibilities of the Fieldco, who needed to concentrate on the implementation of the new project. The dashboard allowed the SC to quickly assess the areas that needed attention. One advantage of the dashboard is its flexibility in that there are no strict timelines for achieving the outcomes. However, this advantage can turn into a weakness as the process can be derailed if the objectives of the handover are not prioritised. This is one of the important tasks of the SC and a reason why it is important to ensure consistency and stability of SC members. Furthermore, it was noted that many new international staff had difficulty understanding exactly how the tool works and the link between the indicators and the dashboard. This can be a risk for the handover if there is limited clarification.

However, some of the indicators are seen as unrealistic, not relevant to the strategy and inappropriate in that they do not measure the 'right' things and do not demonstrate progress towards the objectives of the handover. An analysis carried out by the evaluators demonstrates that only 6 out of 18 indicators are useful. Several reasons for this deficiency can be detected through observations and in responses from participants: Despite a growing understanding of the health system and its developments through this handover process, it is still felt that the lack of a thorough environmental assessment at the onset of the handover project resulted in the use of some inaccurate information to develop the indicators (e.g. the inaccurate estimate of the number of patients who would be decentralised, the target of an uninterrupted drug supply through the MoH). There was a lack of critical questioning about the targets, especially since the existing structural issues were not being addressed as part of the handover (supply chain issues, financial issues), and the fact that MSF elaborated the indicators in isolation and presented them to the MoH may have created an unwillingness or a lack of opportunity for them to propose any changes. A careful analysis is provided in chapter 2.2.

[2] For more information, see: Jouquet, Guillaume. *Homa-Bay HIV/TB project. Building and implementing with MSF team. MSF handover strategy*. ppt, January 2013.

[3] PEPFAR, P*EPFAR 3.0 Controlling the epidemic: delivering on the promise of an AIDS-free generation.* Washington: 2014.

Another point of caution is the number of indicators. There is a risk in using too many indicators: it can be difficult to monitor the progress and the participants may lose track of what they are trying to measure by spending too much time collecting, collating and validating data. For these reasons, Guillaume Jouquet, the implementer of the dashboard methodology, recommends to use no more than ten indicators.

Another suggestion is to consider transferring some indicators that have shown good relevance in other HIV project dashboards. Because MSF has already implemented this methodology several times, MSF must have gained significant experience in handovers of long-term HIV projects that can be replicated.

Although the tool allows for flexibility in the implementation, the overall timeline of 'by the end of the handover period' is somewhat too loose. It may not provide an accurate overview of where the handover is at exactly and whether it is on track for success. This set-up could be tightened by setting some general milestones for activities that are considered priorities.

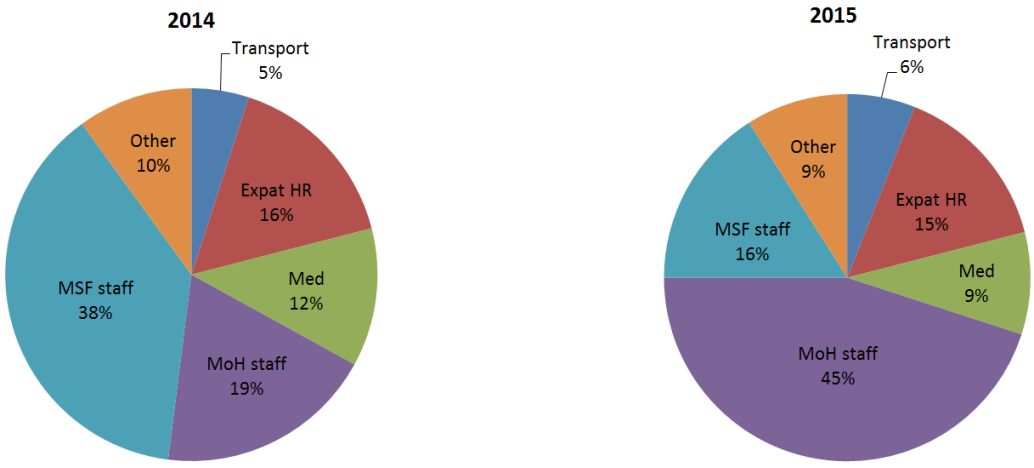
2.1.5 HUMAN RESOURCES (HR)

Other evaluations have shown that having the same people in key positions for the duration of the handover provides stability and continuity, which in turn ensures that the handover stays on track, motivates the people involved in the process and ensures that the objectives remain a priority.[4] In the case of the Homa Bay project, many individuals have been and will remain in the project until the end of the handover, including incumbents in HR, accounting/CoFirH and HoM.

Some concerns were raised, however, when the Fieldco positions for Homa Bay and Ndhiwa were merged, leaving one individual to manage a new project while phasing out Homa Bay. The concern is that, although this approach may have been justified in terms of negotiation strategy, coherence of project approach and volume of work, some observe that the Ndhiwa project receives more consideration, which may be having an impact on the handover process of Homa Bay. The Homa Bay project was managed by the deputy FieldCo, and the MTL managed both Homa Bay and the In-Patient Department (IPD) activities.

One of the successes of the handover is the absorption of the MSF staff into the MoH structure and related to this, less need to concentrate on skills transfer since the staff is well trained and experienced in HIV care already. The communication to the staff was done in a good manner. With the progressive reduction of activities and as ARVs were provided for free by the state, the personnel understood that the MoH could take over the direct management of patients and hence, the reasons for the handover. The explanation also allowed staff to understand that a personnel reduction was necessary for the MoH to be able to ensure sustainability. This change was also reflected in MSF's budget: while in 2014 the majority of MSF's budget was still spent on international and national MSF staff, in 2015, the largest part was spent on subsidies for MoH staff.

Figure 1. MSF budget allocations during the time of handover



[4] Désilets, A. *Evaluation of the Disengagement of Bon Marche Hospital in Bunia, DRC for MSF-OCG.* MSF - Vienna Evaluation Unit Evaluation: 2010

31 out of approximately 70 MSF direct patient management staff were absorbed by the MoH while the contracts for all others were ended. The department with the largest staff cuts was counselling, which saw the staff reduced from 8 to 2, patient defaulter tracing with a reduction from 4 to 0 and data staff with a cut from 8 to 1, although an additional 2 data clerks were supported on a regular basis for the entry or back entry of data for e.g. PMTCT and pharmacy. The number of staff retained was based on the projected objective of reducing the number of patients to 4,000 through decentralisation, as initially planned. Later, this goal was understood to be unrealistic and it was adapted to 5,000 patients in 2014. This target was difficult to reach (patients returned to Clinic B because of the quality of care), which increased the workload of several departments, especially in the areas where there had been the largest reduction of staff. A matter of concern is the possible impact the reduction of counsellors and COs may be having on the increased number of failing and defaulting patients. Different research has shown the link between counselling and adherence[5][6][7][8] and the evaluators found a correlation between these two aspects in Homa Bay too; however, it would require an additional study to prove actual causation between them. The number of failing patients increased at the same time as the routine viral load check and a reduction of counselling services were simultaneously introduced. Either of them could have contributed to the increase of the failing patients.

The position of counsellor as defined in the MSF grid (a person with diploma), does not exist in the MoH HR structure; however, after negotiation between MSF and the MoH, Homa Bay County decided to keep a few counsellors in a (temporarily) adapted position, namely a type of community health extension worker. It has been demonstrated that this position is of critical importance for the adherence of patients. Therefore, for the remainder of the project, it should be a point for strong advocacy with the MoH to integrate this level of position within their workforce. MSF should also work in collaboration with other NGOs (EGPAF) to promote funding and to increase of the number of counsellors.

For now, the rhetoric – particularly of the former MSF staff – is that there is a significant number of professional health workers available in Kenya, but due to restrictions in the civil servant wage bill, which includes the budget for health staff, there is a limited number of positions available. Therefore, despite a large reduction in remuneration (often salaries were halved), those who have been integrated into the MoH workforce are happy to remain in a paid position and receive the benefits of long-term employment as well as allowances within the MoH system. The success of the handover will be closely linked to qualified, experienced and motivated staff remaining in Homa Bay to care for the patients.

2.1.6 TIMING

From top management (HQ/Coordination), the sense is that the timing of the handover – with the delay after the elections in 2013 and the start of the devolution – was good; it allowed for the strengthening of the MSF/MoH partnership and made communication easier. In addition, the handover of Homa Bay was a pre-condition for opening a new project (Ndhiwa) with a focus on incidence reduction. This came at a time of overall reflections about MSF's investment in HIV care within the HIV movement and when a choice was made to shift away from projects with management of large cohorts in settings where the health systems are better prepared and to focus on niche areas and vulnerable groups instead[9].

Although not specifically planned this way, some consider the fact that the implementation of the handover happened at the same time as the devolution as an opportunity, for instance the conditional start of the Ndhiwa project and the acceptance of the MoH to incorporate the human resources in their workforce and to recognise the seniority of MSF staff once absorbed. Having easier access to MoH decision-makers made negotiations easier.

The start of the handover happening at the same time as the country devolution process was very challenging from a field perspective. The devolution implied that most responsibilities were transferred from Nairobi to the counties. However, as health service responsibilities went to the counties, those responsible had to simultaneously try to

[5] Kurniasari M & Turashvili M; *HIV/TB decentralisation in Africa - a literature review*. 2012. Vienna Evaluation Unit

[6] Govindasamy D, Meghij J, Kebede Negussi E, Baggaley R, Ford N, Kranzer K. (2014) Interventions to improve or facilitate linkage to or retention in pre-ART (HIV) care and initiation of ART in low- and middle income settings, a systematic review. *Journal of the International AIDS Society* **17**:19032.

[7] Bärnighausen T et al. (2011) Interventions to increase antiretroviral adherence in sub-Saharan Africa: a systematic review of evaluation studies. *Lancet Infectious diseases*. **11**:942-951

8 MSF (2015) HIV/TB Counselling: Who is doing the job? – Brussels. Available from: http://www.msf.org/sites/msf.org/files/final_web_counsellor_report._one_page.pdf

[9] Internal MSF strategic meetings: Paris meeting 2010 & Johannesburg meeting 2012

understand the intricacies of managing some basic services such as primary health care and take over responsibilities from the MSF activities. In addition, there were many shortages of basic supplies throughout the county prior to the devolution. Reportedly, the MoH responsible at county level was overwhelmed by these changes and unable to engage fully in the initial handover strategy.

Because of the difficulties encountered at field level, it may have been wise for MSF to start off preparing the handover strategy from a more technical side only (such as SMA – which is a best practice in HIV care –, the start-up of Ndhiwa and the absorption of staff into the MoH workforce) and wait a few months until the reality of the challenges posed by the devolution were clearer or at least until the MoH fully grasped their role before transferring responsibilities from MSF to the MoH. This would also have allowed MSF to better understand the new challenges of the devolution and perhaps better adapt the handover strategy (supply, KEMR). In addition, it would have allowed MSF staff to buy into the exit strategy and involve the MoH in the initial discussion of the outcomes and indicators.

2.2 SERVICES/IMPACT

The dashboard was developed by MSF according to the following indicators and targets, which were to reflect progress towards the handover of activities (see Table 2).

Table 2. Overview of dashboard indicators and targets

Key objective areas	Indicators	Target by 2015	Results Q2 2015
Quantitative Med outcomes	1. Active ART pts at PSC	<5000	7749 (Q1 Data)
	2. TB Pts enrolled at Chest Clinic	<80	32
Qualitative Med outcomes	4. % of patients in Retention in care at 12 months	>75%	64%
	5. % of TB patients who completed treatment	>85%	88%
Quantitative Lab outcomes	3. Availability of four essential lab tests	100% of the period	CD4 -75% Haematology 0%, ALT 25% Creatinine 75%
Qualitative lab outcomes	6. Four essential lab tests which passed EQA	All tests passed	3 of 4 tests passed
Qualitative pharm outcomes	7. Drugs order without errors	Complete order placed without error	100%
MSF subsidy for salaries	8. Amount of salaries subsidized by MSF	0%	50% (2,149041 KSH)
Filled positions	9. # of positions filled at PSC 10. # of positions filled at Chest Clinic 11. # of position filled positions at Lab 12. # of positions filled at pharmacy	13 6 18 3	13 5 16 3
Absenteeism	13. % of absenteeism at PSC, Chest Clinic, lab and pharma	<10%	<10%
MSF medical supply	14. Cost of supply to PSC 15. Cost of supply to Chest Clinic 16. Cost of supply to Lab 17. Cost of supply to pharmacy	0 0 0 0	484,264 KSH 265,198 KSH 872,810 KSH 1,625,271 KSH
Data quality	18. % of error in data entry regarding patient's condition, TB, regimen and Lab tests done.	≤5%	5% 0% 5%

The key objective areas were well-chosen and corresponded with critical enablers for the HIV project. However, we found that only 6 out of the 18 indicators (33%) (highlighted in green in Table 2) were useful and relevant, measuring what they were intended to measure: progress in the reduction of MSF involvement as well as an increase of MoH ownership while maintaining quality of care. On the other hand, the progress seen today on 11 indicators shows 'green smileys' (61%), 2 are orange (11%) and only 5 are red (28%). Although these numbers suggest that there is good progress, the indicators have to be reviewed in more detail to see if this is actually the case. Since only 3 out of the 11 'green smiley indicators' are considered relevant, we can assume that the progress is not as positive as one might think at first glance.

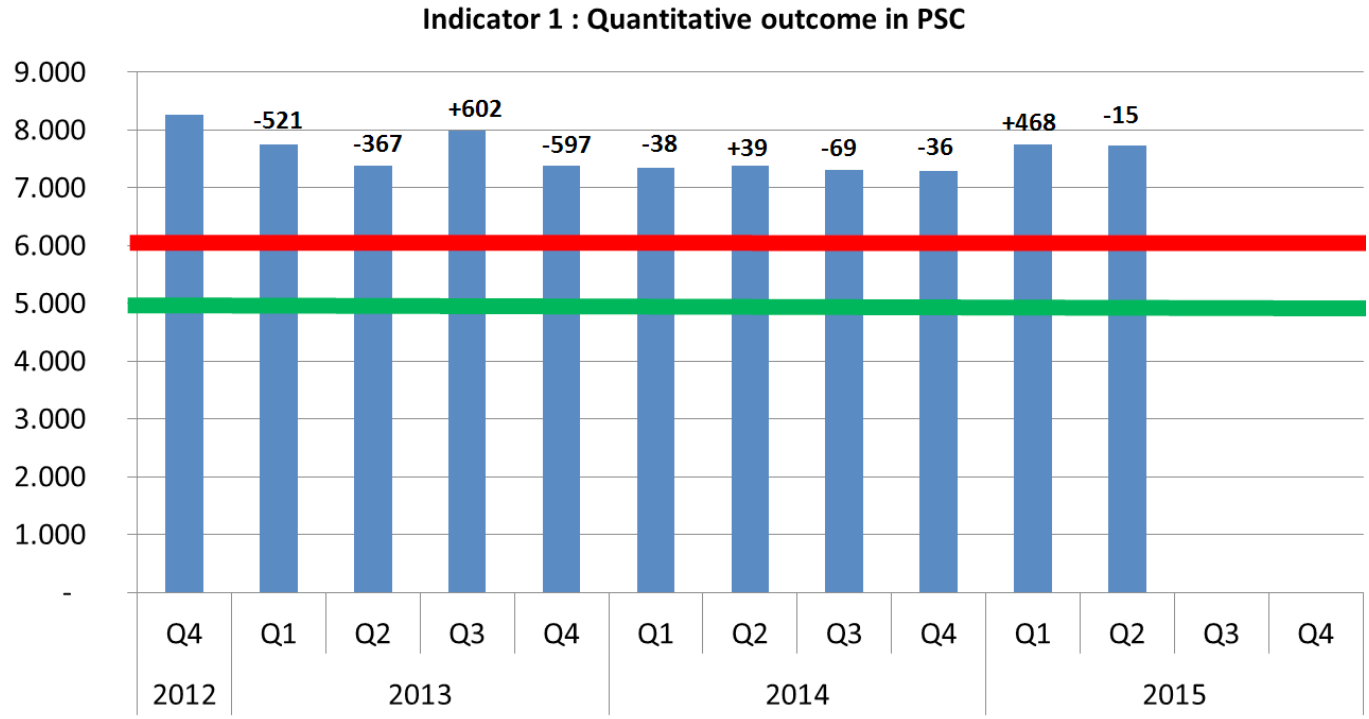
QUANTITATIVE MEDICAL OUTCOMES

1. Active patients in ART cohort Clinic B	target <5,000	Achieved 7,749 (Q2, 2015)

At the end of 2012, Clinic B, the HIV clinic at HBCH, had a cohort of 8,268 patients with an increase of 100 new enrollments per month. It was clear that the clinic needed to be decongested in order for the Homa Bay project to be more 'handover-able'. At the same time, MSF carried out assessments at the health centres in Homa Bay County and came to the conclusion that a similarly high number of approximately 8,000 patients were already followed at the decentralised level managed by the MoH with a reasonable level of patient outcomes. A plan was made to decentralise all stable patients at Clinic B (those who had been on ARVs for at least 6 months without symptoms or side effects) to reduce the cohort to 4,000 patients. This number was adjusted to 5,000 in 2014 when it became clear that the 4,000 target was too ambitious. In order to sensitise the patients to decentralization, MSF engaged in direct communications with patients through clinical officers (CO) and nurses as well as through general messages. General messaging included showing a video promoting the decentralisation in Clinic B, which clinic staff sometimes felt to be too forceful. According to reports from several staff members, new enrollments scaled down, the majority of patients who were transferred out to their nearby clinic never went there or returned to HBCH. During a patient survey in 2013/14 as well as during the evaluation interviews, the reason mentioned most often was the large difference in services between the health centres and the hospital, i.e. less staff, longer waiting lines, drug stock-outs. Some also reported a stronger stigma at the health centre level, but this problem has decreased over the years. Interviewed staff of both MSF and the MoH mentioned the lack of environmental analysis, including asking patients directly about their preference and considerations prior to the transfer out plans. However, MSF had conducted an assessment at surrounding health centres at the start of the handover and the assessed health centres were deemed to be adequate to receive patients from HBCH. No other health centre assessment was done after this, but the Ndhiwa HIV Impact in Population Survey (NHIPS) conducted at the start of the Ndhiwa project reported relatively good outcomes for adult patients followed up in peripheral health facilities.

More alignment with EGPAF's scaling up of staff in health centres could have been done to liaise more closely with health centres ready to receive an increasing number of HIV patients. In Q2 of 2015, the total number of patients followed in Clinic B remained at a high level of 7,734 (Figure 2).

Figure 2. Number of total patient cohort followed in Clinic B throughout the handover period



Active promotion for transferring out of patients reduced in 2014. This happened due to a reinforcement of the attitude that patients should feel free to attend service providers where they like and cannot be forced to be transferred out; nor could patients be denied initiation of ART. So instead of prompting patients to be transferred out, the project focused on introducing SMA for stable patients on ART from the end of 2014 on. This included a 3-monthly ART drug refill and 6-monthly check by a CO or nurse. Today, 2,049 patients are enrolled in the SMA system, i.e. – 26% of the total cohort. This new focus has significantly reduced the workload of the medical staff as today, on any random day, approximately 60–70 patients come in for their SMA drug refill and between 135 and 150 patients are seen by a CO or nurse, translating into approximately 25–30 patients are seen by a CO or nurse, which translates into approximately 25–30 patients per day for each nurse and 20–25 patients for each CO. More patients are expected to be enrolled, considering that ~70% of the total cohort is stable on ART. Beyond HBCH, SMA has also been taken up in other parts of the county and is currently being considered for implementation at national level.

Today, with an increased number of staff, support from NGOs such as EGPAF and a decline in quality at Clinic B because of reduced MSF support (e.g. less regular drug supply), the level of service at the health centres is more comparable to the one at the hospital than before, and it is possible that over time people will decentralise to a health centre closer to their homes. However, continued encouragement for patients at clinician level is needed.

Generally, a better indicator than the number of active ART patients at PSC to reflect decongestion would have been the average number of patients seen in Clinic B per day or per clinician. Using this indicator, we can conclude that the objective to have less congestion in the clinic has been met.

Together with the wrong projection of the number of patients and staff estimates, there were more factors that influenced the workload. With the increased availability of routine viral load (VL) testing, more patients were identified as failing who needed to be seen by the CO, while there had been a reduction from 8 to 3 COs. EGPAF recently (Aug 2015) added 3 COs, making the workload more acceptable (20–25 patients per day).

2. TB Patients enrolled at Chest Clinic	target <80 per quarter	Achieved 32 (Q2, 2015)

This target was met as far fewer than 80 patients are enrolled at the Chest clinic per quarter; however, the target was not chosen well as it does not reflect a success of the programme. There is strong doubt that the number of 32 patients achieved today is a true indication of a quality TB programme, considering that TB continues to be one of the most prevalent causes of morbidity and mortality in the IPD, indicating critical gaps in detection and treatment in the county. There are concerns around TB under-detection in the county. Another factor could be that with the strengthening of the decentralised sites, patients are being better linked to these facilities where improved TB diagnosis takes place, and fewer people are detected at HBCH. National co-infection rates have decreased from 77% in 2012 to 68% in 2014.

QUALITATIVE MEDICAL OUTCOMES

4. % of patients in Retention in care at 12 months	target >75%	Achieved 64% (Q2, 2015)

It has not yet been possible to produce patient cohort analyses with the KEMR system. It only produces two standard reports (report numbers 711 and 731) for submission to the MoH and NASCOP, totalling the number of patients in care. Therefore, MSF's Medical Team Leader (MTL) had to calculate retention in care at 12 months manually for a small number of patients every quarter. These results were generally within the target range.

But there is doubt about the quality of care being reflected through this indicator only. At the earlier stages of ARV programmes, CD4 count was the best proxy indicator available to show the quality of treatment in the active ART cohort. With the availability of routine VL testing since July 2014, the VL measurement would be a better additional marker indicator. The VL is now tested on a routine 6-monthly basis and samples are sent to a CDC-supported lab in Kisumu. Turnaround time is still long and can take from 1–2 months up to over 6 months. The most recent bottleneck occurred when the HBCH lab was out of printer cartridges and was not able to produce the results for Clinic B.

Before the routine VL monitoring was introduced, 850 patients had already been switched to 2nd line treatment, mainly based on clinical and immunological failure. Evidence shows that immunologic and clinical criteria for treatment failure have low sensitivity[10], confirming that treatment failure with VL is of real importance. An introduction of routine viral load allowed to improve accuracy and detect an increased number of patients with treatment failure. From the start of routine VL testing in Homa Bay in July 2014 until June 2015, 320 new patients were identified with a high VL (>1000 copies) and it is not yet known how many of these were or will be switched to 2nd line treatment. Unfortunately, the denominator is unknown due to the difficulties with KEMR. However, assuming that 70–80% of patients have now had at least one routine VL test, the number of high VL together with the 2nd line patients add up to approximately 15–20% of the total cohort, a value in line with other programmes that started monitoring VL on a routine basis.[11]

The number of people on 2nd line treatment seems high in comparison with other large cohorts with long-term MSF support (>7 years) in other settings (Table 3). In all these settings, routine viral load testing has been introduced for a period of between one and three years with the exception of settings in South Africa where it has been in place for approximately 7–10 years. Data on patients on 3rd line treatment is limited or very few patients have been switched so far.

Table 3. % of 2nd line out of total ART cohort in a selection of MSF-supported HIV projects

MSF-supported patient cohort	Total cohort on ART (end 2014)	Total on 2nd line (& 3rd line)
Homa Bay, Kenya	**7,383 (Q2, 2015)**	**833** (2nd line) **+ ~80** (anticipated to be on 2nd line) **+ 28** (3rd line) **941** **(12.8%)**
Kibera, Kenya	5,068	405 (8%)
Chiradzulu, Malawi	31,590 (Q1, 2015)	1,145 (3.6%)
Thyolo, Malawi	40,131	392 (1%)
Murambinda, Zimbabwe	17,505	695 (4%)
KZN, South Africa	10,291	576 (5.6%)
Khayelitsha, South Africa	11,417	815 (7.1%)

National data in Kenya report that 4.1% of all patients on ART are on 2nd line treatment. However, there is probably a high level of under-detection with limited access to VL testing and/or technical expertise in switching patients from 1st to 2nd line in time. The higher proportion of patients on 2nd line treatment in Homa Bay may also be due to better trained and mentored clinical staff in Clinic B and, therefore, a better level of clinical detection of failure, although there may also have been some misclassification during the time of limited availability of VL.

The 2nd line study conducted by MSF in Homa Bay shed more light on resistance. In 2015, 350 out of the 850 people on 2nd line treatment at Clinic B were randomly selected for genotyping. 68 were failing 2nd line because of adherence problems; 25 of those had lost sensitivity and developed resistance to the 2nd line regimen and had to switch to a 3rd line regimen. There was a relatively high percentage of children among the failing patients.

The reduction of counsellors as well as of defaulter tracers since the start of the handover may have affected the quality of care, in particular adherence support. Previously, patients received counselling sessions at the following points in time: pre-ART, 15 days after initiation, at 1 month, 2 months, 3 months and every six months after this. Counselling needs have evolved as at the beginning of the HIV response and in a context of greater stigmatisation, people were less familiar with and needed more education on HIV and its treatment. Today, although the general knowledge amongst the population has increased, other counselling needs have emerged, such as enhanced adherence counselling (EAC) once a patient has a detectable viral load. Disclosure counselling for children is another

[10] Poster: Rutherford GW, Anglemyer AT, Easterbrook PJ, Horvath T, Vitoria M, Penazzato M, Doherty M. Predicting treatment failure in adults and children on antiretroviral therapy: a systematic review of the performance characteristics of the 2010 World Health Organization criteria for virologic failure (2013) Poster at IAS, Malaysia 2013.

[11] Abstract: Nicholas, S., Wapling, J., Rakesh, A., Amoros I., Poulet, E., Schramm, B., Gueguen, M., Szumilin, E. *Description of the Viral Load cascade of ART patients using SAMBA, a Point-of-care Viral Load testing method in Chiradzulu district. NAC*, Malawi: 2015

critical gap. Counsellors indicated that after the staff reduction and with the introduction of routine viral load testing, they increasingly focused on EAC and left general adherence counselling to the nurses/clinicians. Because of time constraints, nurses/clinicians do generally not address this topic during their medical consultations. The most common reasons mentioned by respondents involved in counselling for patients failing on treatment are that patients do not realise the importance of adherence, that they feel better or other general misconceptions. Non-adherence among children is mainly connected to the lack of disclosure of their status. More efforts have to be invested in this group as the majority of patients with a high viral load are children.

5. % of TB patients who completed treatment	target >85%	Achieved 88% (Q2, 2015)

This indicator is on target. The Chest Clinic seems adequately staffed, including a counsellor from EGPAF as well as one from MSF. Their main concern revolves around essential supplies such as N95 masks and other protective gear in case MSF further reduces supply.

QUANTITATIVE LAB OUTCOMES

3. Availability of four essential lab tests	Target 100%	Achieved (Q2, 2015)
CD4		75%
Haematology		0%
ALT		25%
Creatinine		75%

At the beginning of the handover, the CD4-related indicator measured if CD4 was taken in a timely fashion, but with the introduction of the routine viral load check, the indicator changed to 'availability of CD4 tests'. MSF continues to provide buffers for CD4 test reagents, in particular on the FACSCOUNT machines that MSF donated, as well as Creatinine, whereby these two lab tests are officially in 'green'. However, this does not reflect an improved situation within the MoH as this target is being reached only due to the use of MSF buffer. Haematology has not been supported by MSF, apart from Hemocue machines for measuring Hemoglobin (Hb) in the ward and general lab. Indicators that could work better for monitoring the MoH's increased responsibility in providing adequate lab services could have been to look at patients' access to lab tests. Lab registers could have been used to inform such an indicator.

HIV test stock-outs are a real concern, although they are not part of the dashboard. HIV tests are estimated to be out of stock on average 25% of the days during a month. Due to the shift in the MoH protocol from using 'Determine' and 'Unigold' as first and confirmatory test to 'KHB' and 'First Response', MSF can no longer buffer during stock-outs as they do not have the new test kits in stock due to poor performance of the MoH algorithm and because not all tests are prequalified by WHO yet.

MSF fully supports the TB culture lab until the end of 2015; it was negotiated as part of the handover that the MoH would be taking over this lab. However, a TB culture lab is generally not based at county level and with the change to GenXpert, the need for TB culture has also decreased. Urgent continuation of discussions is needed with CDC on either taking over this lab or using it as their branch from Kisumu. During MSF's last discussion with CDC in 2013, the CDC stated they would not take over this lab as long as MSF still had some involvement. Now may be a good time to re-engage the CDC as the funding of PEPFAR evolves and with the MoH-MSF handover process coming to an end, the CDC may have changed their position.

The lab was the most commonly mentioned area of constraint in which the hospital faces continuous stock-outs. Due to evident management reasons, the lab was and is the most difficult part to manage during the handover.

QUALITATIVE LAB OUTCOMES

6. Four essential lab tests which passed EQA	**Target: all tests passed**	**Achieved 3 of 4**

External Quality Assessment (EQA) is improved through an increased contracting out of the services for the lab equipment; however, MSF still supplies certain reagents and pipettes for maintenance. Again, indicators may seem more 'green' as they actually are, and this indicator would have been more relevant if looked at from a shortage perspective rather than from a MSF supply perspective.

QUALITATIVE PHARMACY OUTCOMES

7. Drugs order without errors	**Target: Complete order placed without error**	**Achieved 100%**

The way of checking this indicator leaves a lot of room for subjectivity as the indicator is collected by a quick glance at the Excel sheet of the drug order. Moreover, drug forecasting is currently based on inaccurate drug consumption data due to the difficulties with the KEMR system. A new system called 'EDIT' is under development and is supported by Management Sciences for Health (MSH) and EGPAF.

MSF SUBSIDY FOR SALARIES

8. Amount of salaries subsidized by MSF	**Target 0%**	**Achieved 50% (Q2, 2015)**

This indicator is on target. In 2015, the MoH paid 50% of the 31 agreed positions and agreed to pay 100% from January 2016 on. The majority of participants has been mentioned this development as the key success story of the handover.

FILLED POSITIONS

	Target	Achieved
9. # of positions filled at PSC	**13**	**13**
10. # of positions filled at Chest Clinic	**6**	**5**
11. # of position filled positions at Lab	**18**	**16**
12. # of positions filled at pharmacy	**3**	**3**

The positions monitored include the 31 agreed as well as additional MoH-supported positions. EGPAF has recently made significant contributions by funding additional staff, in particular adding 3 COs and 1 nurse in Clinic B, which reduced the workload and was a welcome addition since the number of medical staff was still based on the target of having only 4,000 patients in Clinic B. Concern is raised about the seniority of staff and about the fact that soon a few of them will retire. Efforts must be made to coach others who could take over certain key roles.

ABSENTEEISM

13. % of absenteeism at PSC, Chest Clinic, lab and pharma	**target <10%**	**Achieved <10% (Q2, 2015)**

This indicator was added in mid-2014 but is deemed difficult to monitor and has been experienced as subjective as well.

In January 2014, a workshop was conducted and the participants decided to remove four indicators from the 2013 dashboard:

- "# MSF staff" because it is green with no risk of changing;
- "Performance evaluation" because it is not objectively measurable;
- "% Nurse review" because it is green with no risk of changing;
- "Computerized MoH data system" because it is green with no risk of changing.

They also decided to add the following three indicators:

- % salary paid by MSF;
- % Absenteeism;
- % of error done in data monitoring.

MSF MEDICAL SUPPLY

	Target	Achieved
14. Cost of supply to PSC/Clinic B	0	484,264 KSH
15. Cost of supply to Chest Clinic	0	265,198 KSH
16. Cost of supply to Lab	0	872,810 KSH
17. Cost of supply to pharmacy	0	1,625,271 KSH

The key change with the handover, as participants indicated in the evaluation, has been the more frequent stock-outs of Opportunistic Infection (OI) drugs and other essential drugs and supplies compared to the period before the handover. MSF still gap fills but on a less regular basis than before. As a result, patients more often have to buy their drugs from the main pharmacy of the HBCH or outside, in case of a complete stock-out. This occurs on a quarterly basis from mid to end of the quarter until the next consignment of drugs arrives. Stock-outs are estimated to happen between 25–50% of the time.

It is unclear how many patients actually do buy essential drugs for treating OIs; some estimate that approximately 20% of patients are unable to purchase the needed drugs and often return with worsening infections. In the past, MSF also provided medication to treat hypertension and diabetes, but they are not available today at Clinic B. Nutrition support also stopped, affecting approximately 10% of patients. The 'ART package' is supplied on a monthly basis through NASCOP, which should be free of charge for patients and includes ARV's and other essential OI drugs, condoms and HIV test kits. 1st line ARVs have been mostly well in stock. Patients had to come back to HBCH to collect their 2nd and 3rd line ARVs on a bi-weekly or monthly basis instead of on a quarterly basis. 3rd line regimen should be supplied by NASCOP soon. There are regular shortages of OI drugs and other supplies of this ART package.

TB drugs have been more regular as they come from a strongly supported national programme. The county buys other drugs (e.g. anti-malarials, antibiotics) directly at suppliers through a bidding process.

Several items were included in the calculation of the dashboard indicator that should not be part of the handover, e.g. for the LAM study, 2nd and 3rd line ARVs that MSF is planning to continue gap filling, donations due to near expiry date and items for the TB culture lab that is highly unlikely to be taken over by the MoH. The indicator does therefore not reflect the MoH's capacity to provide an uninterrupted supply of drugs to patients or if patients actually have access to the drugs they need. A better indicator would have been to monitor the availability of key supplies rather than what MSF supplies.

DATA QUALITY

18. % of error in data entry regarding patients' condition, TB, regimen and Lab tests done	target <5%	Achieved 5% (Q2, 2015)

According to respondents, this indicator is also prone to subjectivity, as only a rapid check is conducted. The real issue in terms of data is the difficulties within the KEMR system. The change from the MSF-supported data programme FUCHIA to KEMR was reportedly conducted too quickly over a period of approximately 10 days. Apparently, there was pressure from the MoH at the time to implement this change quickly and to rely on the KEMR system only. Retrospectively, this may have been a bad decision as KEMR was in a pilot phase and had not yet been rolled out to a site with the magnitude of a patient cohort comparable to the one at HBCH at the start of the handover. The number of staff needed to run the KEMR system was also unclear. It may have been better to have more data clerks staying on to maintain FUCHIA in parallel to the KEMR system and to evaluate, after one year, if KEMR was able to provide accurate data independently. A great concern among the medical staff is that the real outcomes and status of the patients today is unknown and that this fact makes the handover more difficult.

Apart from missing information on accurate patient outcomes, the constraints with KEMR have also affected producing a timely and accurate list of defaulters for tracing and follow-up.

The objective of standard use of MoH protocols was achieved since MSF protocols are no longer used for patient care today and MoH protocols are the standard. An indicator around this objective could have been useful.

2.3 DEVOLUTION

Following the elections in March 2013 and the implementation of the new constitution, devolution of responsibilities to the counties started to take effect from early 2013 onwards. At that time, no one at the MoH either at national or at county level knew exactly what the roles and responsibilities of each party would be. Although the coordination made a great effort to understand the impact of the devolution on the HBCH, there was little to no clarity. People reported during the interviews that, as the devolution occurred and the details became clearer, the process had a large influence on the health services in the county in general as well as at the hospital. Previously, the hospital received its budget directly from the national level, while it currently goes through the county.

The key issues seem to be related to procurement and supply and although most respondents indicated that before devolution started, there was generally a better availability of drugs and lab reagents at the hospital, a more thorough assessment would be needed to check how much this understanding reflects reality. Before, the HBCH received drugs and supplies directly from KEMSA, but now the procurement process is led by the county who is procuring from KEMSA or other suppliers.

Additionally, even the basic management of the hospital showed constraints, as reflected by the example of the lab printer that ran out of cartridges, delaying VL results and affecting adequate patient management at Clinic B, as well as by shortages of patient files and folders for the M&E team or the lack of gloves in the wards.

It was often expressed during interviews that MSF had not properly assessed the devolution process; however, at the beginning there was a significant lack of clarity about the process for everyone, including the MoH.

2.4 SUSTAINABILITY

2.4.1 CONTINUITY OF CARE

It seems likely at this time that there will be continuity of care in Clinic B, in particular in mainstream HIV care. Patients interviewed indicated that the services have continued in a good way, that staff is friendly and patients still prefer coming to HBCH. New initiatives such as SMA were successfully taken up by the MoH. In HBCH as well as in surrounding clinics, support groups started for adults and children. More interventions could still be considered, for example adherence clubs, following the example of the Khayelitsha programme[12], as the number of patients is expected to grow, particularly in light of the upcoming changes in ART initiation threshold moving towards test & treat. Longer waiting lines and the fact that patients now need to pay for OI drugs most of the time, were reported as key constraints. Their main request is to have better availability of drugs free of charge again and make hypertension drugs available again as well. Over time, with the number of patients on 2nd and 3rd line rising, the focus is anticipated to concentrate increasingly on the management of special and more complicated patients at the HBCH. It is important for staff to continue to be updated well with technical knowledge on the management of such cases. It would be a real benefit if the MoH assigned a Medical Officer as today it is still MSF providing key expertise and coaching on complicated cases to the CO. A high level of treatment failure is seen in the IPD at HBCH, indicating challenges in timely detection and patient management at decentralised clinics. More exchange between Clinic B and the IPD could be of benefit.

TB care seems to continue at a similar level of quality as when MSF was fully involved, which is reflected by the strong TB treatment outcomes. This is also due to EGPAF's increased involvement in TB care as well as funding of additional staff at the TB department.

[12] UNAIDS and MSF, *Community-based antiretroviral therapy delivery - experiences of Médecins Sans Frontières*. UNAIDS, Geneva:2015; Bemelmans, M., Baert, S., Goemaere, E., Wilkinson, L., Vandendyck, M., van Cutsem, G. et al., "Community-supported models of care for people on HIV treatment in sub-Saharan Africa", *Trop Med Int Health*, vol. 19, Aug 2014: pp. 968-77

2.4.2 ISSUES AROUND SUPPLY OF DRUGS & LAB REAGENTS

When asked what they expected the situation in Clinic B/HBCH to be like in two to three years, the most common concern voiced by respondents was related to structural problems related to drugs and lab supplies. With regard to staff, there currently seems to be enough qualified personnel in both the pharmacy and the lab.

The fact that patients have to pay for drugs often results in them having less access to needed treatment. Despite free OI drugs being part of the free 'ART package' for HIV patients, in Homa Bay County it seems very common, both in health centres and in hospitals, that patients have to pay on a regular basis due to stock-outs. Although since 2013 the official policy has been to provide essential drugs and antibiotics free of charge at primary healthcare level and to implement cost-sharing at hospital level, patients regularly have to pay out of pocket. Due to stock-outs of the medicines in the medical facilities, they have to purchase these drugs in a pharmacy outside of the hospital.

There are multiple causes for this development:

- Inaccurate forecasting: based on an inaccurate KEMR system.
- Management issues: delay of suppliers, importation issues at harbour, delays in transferring funds from national to county level and from county to suppliers, stock management issues at central medical stores whereby stocks go below a certain minimum level resulting in stock-outs when orders do not arrive on time. Bureaucratic ordering processes e.g. for a lab order, several people need to validate it and generally at county level the budget for the requested order is cut after which the lab manager has to revise it according to the reduced budget.
- Communication issues: There is little or no communication from suppliers or from the county when lab or pharmacy orders are delayed. This affects timely patient and staff notification, which makes it difficult to make alternate interim plans.
- Financial/more structural issues: The county's total annual budget is 5 Bn KsH and approximately 30% (1,4 Bn Ksh) of the county budget is allocated to health. However, from this budget, 85% (~900,000 Ksh) goes to staff salaries (15,000 employees in the county) and 15% remains for financing everything else in the county health sector. Therefore, drugs and lab orders are always reduced by the county pharmacist. In addition, there are debts with suppliers. During the revision of pharmacy and lab budgets, priority is given to items and drugs that patients have to pay for in order to generate some income.
- ARV supply is still managed centrally and 1st line ARVs are less of a concern. Considering funding prospects both through the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and PEPFAR for Kenya, they are sustainable at least for the foreseeable future. The most recent concept note to the GFATM for Kenya's HIV programme was approved and GFATM is also considering investing in certain pilot projects set up around the implementation of the 90-90-90 strategy[13] in high-prevalence areas, including Homa Bay County. 2nd and 3rd line ARVs require more attention, although trends are promising that they will be supplied better through NASCOP. MSF may need to maintain its role in filling the gaps for 2nd and 3rd line ARVs while advocating for improved availability. There is some discussion to also decentralise the ARV supply to county level, which does not seem to be a good plan for the time being, given the critical issues the supply system faces at county level.

The pharmacy is considering a greater level of autonomy related to their pharmacy collection fund but it is unclear today how this may develop. Also, the lab is developing a more autonomous position to generate income directly and use this for the purchase of lab supplies, like a revolving fund. Currently, there are discussions between the pharmacy and the hospital management and there seems to be openness to the idea. MSF is currently considering supporting gap filling and to assist the lab in the further development of this fund until 2017.

In a case like in Homa Bay, where MSF decides to invest in the sustainability of the services to patients, it becomes an ethical responsibility to ensure all avenues are explored and efforts made in order for the objective to be attained. Financially, after investing 18 months, it becomes sensible to make sure that this investment was not made in vain.

Included below are reports from other sections that have implemented strategies to try to address drug shortages and stock-outs. These are recent examples derived and adapted from previously successful experiences (for example, the case of MSF's partnership with Treatment Access Campaign in South Africa). Realizing the situation

[13] 90-90-90 is an ambitious target for HIV treatment. Its goal is that by 2020, 90% of all people living with HIV will know their HIV status; 90% of all people with a diagnosed HIV infection will receive sustained ART; and 90% of all people receiving ART will have viral suppression. See: UNAIDS, 90-90-90 *The ambitious target to help end the AIDS epidemic*. UNAIDS, Geneva: 2014.

is different in every context, perhaps some principles and approaches to analysis on the drug/supply problem and advocacy could inspire MSF-OCP to apply these in the Kenya context.

MSF should consider tackling the drug stock-out issue more structurally, on three levels: operational, technical and advocacy.

A. At operational level, to have a clear strategy in place when to provide gap filling, after a thorough analysis of the causes of the stock-out.
B. At a technical level, both in Nairobi and in Homa Bay, to participate in technical working groups on drugs & supplies, to engage in system issues where it fails and to push for change. Liaise with others, possibly US-funded NGOs or consultancies supporting the supply system, to identify bottlenecks and lobby for focused support.
C. At advocacy level, further assessment of the previous stop-the-stock-out campaign and the NGO/CBOs involved is recommended. MSF should connect with these organisations or other Kenyan civil society groups working on this topic to identify the best ways to address the problem of stock-outs with the public and health authorities. Examples of where MSF has done similar advocacy work in HIV projects in other settings can be found in reports about the Democratic Republic of Congo or South Africa and in an overall analysis of stock-outs in several countries and their impact on service delivery for patients.

Most staff reported that sustainability of services and the MoH's capacity to run the HIV services depends particularly on how the devolution continues to unfold.

2.4.3 STAFF & COUNSELLING

The lack of recognition of the counsellor position within the MoH staff establishment puts this position at risk. It is also unlikely that the MoH will increase the number of counsellors. There is therefore a real concern about how to continue to properly address the following critical counselling needs: (1) counselling as a general preparation for ART as well as follow-up adherence support, (2) EAC in case of detected viral load, (3) disclosure counselling and (4) education and adherence support to asymptomatic people diagnosed with HIV, when moving towards a test & treat approach in line with the upcoming changes of WHO recommendations[14]. Alternative models, such as group counselling or counselling through adherence clubs, could also be considered.

The key concern about staff in general is that certain key senior members will retire soon and it is neither an easy nor a fast process to replace them within the MoH system as retired staff remain on the list for some time and cannot be replaced easily because there is no clear vacancy.

2.4.4 DATA

There are difficulties around the KEMR data collecting system that should be addressed. Since these difficulties also affect MSF in the Ndhiwa programme, it is recommended to advocate for addressing the major constraints and work with I-TECH and EGPAF on how to improve the system, both at national and at local level.

2.4.5 OTHER PARTNERS

Apart from MSF, EGPAF is another key NGO focused on HIV services in Homa Bay County. Generally, there is a friendly relationship between MSF and EGPAF, except for some tensions at the operational level at the hospital or at health centres due to differences in approaches. However, on a strategic level, the two organisations have not coordinated their programmes well. MSF was not aware of EGPAF's annual planning cycle and budget and vice versa. Both organisations feel that the MoH is responsible for the formal coordination of all partners' activities and the first stakeholder meeting was organised only recently with support from MSF. However, if the MoH is not formally coordinating its partners yet, the organisations have a responsibility to liaise with each other since they are working in the same sector in similar locations.

[14] WHO. *Guideline on when to start antiretroviral therapy and pre-exposure prophylaxis*. World Health Organization, Geneva: 2015.

Following PEPFAR's global funding policy to refocus on high-prevalence areas and groups at most risk, Kenya will remain one of their focus countries. Within Kenya, the high-prevalence areas, including Homa Bay County, will be a focus. EGPAF's budget for Homa Bay, funded through CDC, has therefore increased. Their financial year starts on Oct 1st 2015 and their budget allows for an increase of staff: from 65 to 90 COs, an additional 12 counsellors, 12 nutritionists and 12 data clerks. They will soon decide about the placement of these staff in the county. MSF could have played a role in advising on where critical gaps are and influence staff deployment as part of the handover process. In line with the Country Operational Plan (COP) planning process of PEPFAR, EGPAF starts their annual planning between February and April. MSF could have already had an input into this process as part of the handover to ensure that EGPAF focuses on areas where MSF's reduction leads to more critical gaps. MSF should be ready to provide such input again during the next COP planning process in 2016.

The duration of EGPAF's interventions in Homa Bay is unknown since it depends on PEPFAR's funding, but the short-term outlook seems optimistic. EGPAF has indicated that it would also be interested in strengthening the areas of complicated HIV care, 2nd and 3rd line patients, KEMR, and lab support, including the TB culture lab through liaison with CDC. They will less likely be in a position to do gap filling in case of drugs stock-out, though there might be an opening for lab reagents. Strategic discussions between EGPAF and MSF are urgently needed, in particular at coordination level with the EGPAF regional office in Kisumu. Feedback from both MSF and EGPAF staff was that very little strategic discussion took place between the two organisations, despite MSF being invited to the steering committee (which they not always attended).

2.5 CAPACITY BUILDING

Respondents reported that the handover left behind a good level of technically competent staff. There has been a focus on the medical technical level rather than on management. This has been a trend in many handover situations; however, as MSF does have expertise in other areas such as logistics, supply chain management and general hospital management, capacity building in these areas should also be considered. Some respondents suggested that MSF could have lobbied other organisations, such as MSH, to provide more managerial support to the county, in particular related to drug and supply management.

Refresher trainings for all staff should be considered through MoH or MSF/partners as one CO expressed concern about not having received any additional training after having been absorbed into the MoH workforce. The increasing numbers of virologic failing patients and the need for clinicians to keep up their level of knowledge about the management of complicated patients make such refresher trainings a pressing need.

3. CONCLUSIONS

3.1 RELEVANCE

The long-term strategy applied to the handover of Homa Bay provides a good opportunity for services to continue once MSF withdraws. It would be important to start thinking about the handover at an earlier stage in the project and ensure an integrated relationship with the MoH. Developing a genuine partnership with the health authorities in delivering joint interventions is thereby key to increasing the chances for sustainability.

As is often the case in long-term MSF projects, in Homa Bay, the MoH respondents agreed that the MSF standard was too high for the MoH to sustain. Transitioning from a high standard to a lower standard of care – which the MoH is actually able to provide – requires a gradual process, and MSF has to accept that the quality of care will be different.

Reducing MSF support for one project while scaling up in another (Ndhiwa) seems to have enhanced acceptance of the handover and improved team motivation of partners and MSF staff (who were resistant to the handover at the start). However, for some staff and patients who were less involved in the details of the handover, it created some confusion about whether MSF was truly handing over, reducing or re-aligning activities. More regular and detailed communication and dialogue about the 'handover of Clinic B' and the continued commitment of MSF in HB County could have helped to avoid this misunderstanding.

Early communication of the handover to the MoH, to MSF staff and the patients was both clear and timely. This is again critical for the success of the handover. Communication to the staff did diminish after the reduction from two to one Fieldco and once the Nhdiwa project began. This change may have been managed by appointing someone responsible (other than the Fieldco) to oversee the communication and ensure that everyone is kept abreast of the progress and the difficulties. Today, it continues to be important to communicate about MSF activities in Homa Bay beyond 2015.

3.2 EFFECTIVENESS

The dashboard tool is generally very useful for identifying challenges, but participants could be more critical and allow for major overhaul early on in the implementation process to ensure it measures the 'right' things. Although the tool allows for flexibility in its implementation, the overall timeline of 'by the end of the handover period' is somewhat too loose and could be tightened by setting some milestones for activities that are considered priorities.

Patients continued to receive HIV care at Clinic B, in particular with an uninterrupted supply of ARVs. The supply of OI and other essential drugs has been more problematic, which led to patients often being referred to a pharmacy outside HBCH and purchasing the prescribed drugs. The HBCH cohort reports a high number of patients on 2nd line drugs as well as an increasing number of patients failing on treatment, detected due to the improved availability of routine viral load testing since mid-2014. Without further analysis it is difficult to state that there are more failing patients today than there were before since this occurred at the same time when routine viral load became available. **The reduction of counsellors and defaulter tracers as well as the malfunctioning of the KEMR system that is not yet able to identify defaulters in a timely manner has likely led to a decrease in quality of care**, although it is difficult to confirm a direct link between these factors and the possible worsening of patient outcomes. A great concern among the medical staff is that the real outcomes and status of the patients today is unknown and that this fact makes the handover more difficult. **In particular, children and adolescents are at high risk** and measures must be taken to address this group. Although the handover project did not meet its objective of transferring out patients and reducing the number of patients followed at Clinic B to 5,000, decongestion of the clinic was still achieved through the implementation of the SMA, which has also been taken up in other parts of the county and is currently being considered for implementation at the national level.

MSF could have started some interventions such as SMA, **the successful decentralisation of services and the transferring out of patients prior to the handover of the project**, as in other settings these have already proven to be good strategies that help decongest the clinic while bringing services closer to patients' homes[15].

In Homa Bay, **the advocacy strategy was developed late in the process**. This was a missed opportunity for MSF to ensure a better transition to the withdrawal of MSF. Part of the handover objectives should be to involve more partners and lobby with partners for certain services or supplies. Without a focus on improving certain systems/ system support (i.e. drugs/supply), it was too ambitious to set the goal of achieving a 100% supply by the MoH or – as the indicator stipulated – 0 supplies from MSF at the end of the handover period.

In summary, the following areas are foreseen to remain a real concern regarding delivery of quality HIV and TB care in HBCH and where MoH does not seem ready yet to take full responsibility:

- pharmacy (consistent stock of drugs & supplies, including accurate forecasting);
- laboratory (consistent stock of lab reagents and essential lab supplies);
- ensuring up-to-date technical knowledge of clinical staff to enable them to manage more complicated cases, including the increase of 2nd and 3rd line patients;
- focus on children and adolescents as a special group identified as at risk group in treatment failure;
- recognition and increase of the number of counsellors.

3.3 CONTINUITY AND CONNECTEDNESS

The continuity of people in key positions has proven to be a factor of success in handovers[16]; in the case of Homa Bay, there were several positions, including the HoM, which provided stability to the handover process. This is a critical point that should be considered in projects that are at the exit stage and want to hand over activities.

Although not planned this way on purpose, starting the handover at the time of the beginning of the Kenyan devolution programme arguably made the beginning of the handover more strenuous, especially for the MoH, that was still trying to understand the basics of managing a complete health programme. It has been observed in other situations that many changes at once require a greater effort and more resources.[17]

A genuine partnership with the MoH is critical to ensuring continuity of care. The relationship between MSF and the MoH in Homa Bay, although perhaps strained before the start of the handover, became strong during this phase. Not including the MoH when determining the indicators may have been detrimental to choosing the 'right' indicators.

Conducting a thorough environmental assessment is extremely important when designing a handover strategy. Such an assessment should include a mapping of actors, discussions with key stakeholders to better understand constraints and analysing issues that may be problematic in a handover (for example, understanding the supply chain of drugs). In the case of Homa Bay, **the underestimation of the number of patients in the cohort led to a reduction of too many staff**, which may have had a negative effect on the quality of care provided to patients.

When MSF begins to reflect on the handover of activities, it may be important to bring in other partners, when possible. In Homa Bay, the availability of EGPAF could have played an important role in filling some of the gaps left by MSF. The MoH participants expressed how it is unhealthy to be in a 'dependent relationship' for too long and how important it is for the MoH not to rely on one partner only.

Considering MSF's continued presence in Homa Bay County through its Ndhiwa project, the mission has already identified several areas it wants to remain involved in for at least two more years. The rationale for continued activities comprises both the support of Ndhiwa project as well as a continued involvement in areas of critical gaps where it is too early for the MoH and/or its partners to take over complete ownership.

---

[15] WHO, *Guideline on when to start antiretroviral therapy and pre-exposure prophylaxis*. World Health Organization, Geneva: 2015

[16] Désilets, A. *Evaluation of the Disengagement of Bon Marche Hospital in Bunia, DRC for MSF-OCG.* MSF - Vienna Evaluation Unit Evaluation: 2010.

[17] See the recent report on the Chatuley Hospital set-up in Haiti: Désilets, A*. Leaner and more effective - another approach to hospital management in MSF*. MSF - Vienna Evaluation Unit Evaluation: 2015.

4. RECOMMENDATIONS

4.1 FOR THE HOMA BAY HANDOVER PROJECT

Immediately, MSF should implement and adjust their advocacy strategy to tackle the following topics:

- ➔ Recognition of counsellors both at county and national level[18].
- ➔ Addressing stock-outs and availability of drugs (including 3rd line ARVs) by linking with other civil society groups at the county and the national level.
- ➔ Advocate (lobby) with the MoH and EGPAF for capacity building for staff in peripheral sites regarding medical technical skills.

This would benefit the Ndhiwa project, the work in Homa Bay County as well as the hospital as a whole.

For the following specific areas, partners should be identified and lobbied for involvement:

- ➔ TB culture laboratory – urgent discussions with CDC should clarify whether they will take over the TB culture laboratory supplies and integrate them within their lab in Kisumu or use the HBCH TB lab as a branch of their main TB laboratory located in Kisumu.
- ➔ Gap filling for essential supplies that the MoH is unlikely to be able to purchase in the short term, e.g. protective masks for (MDR) TB management – advocacy partner/s to be found.
- ➔ Strengthen the KEMR system – through I-TECH and EGPAF.
- ➔ Support clinical training and updates to CO/nurses – possibly through EGPAF.
- ➔ Support the management of children and adolescents in EAC, through support groups or switch to 2nd or 3rd line – possibly EGPAF.
- ➔ Management of cases with Kaposi Sarcoma – possibly EGPAF.

Depending on MSF's revised strategy in Homa Bay, MSF should consider staying involved in the following areas until a partner is found:

- ➔ Identifying constraints around the KEMR system.
- ➔ Transition of drugs data to 'EDIT', a tool for improved drugs forecasting.
- ➔ Management of cases with Kaposi Sarcoma.
- ➔ Support for the management of children and adolescents in EAC.

[18] MSF. *HIV/TB Counselling: Who is doing the job?.* Brussels: (2015) Available at: http://www.msf.org/sites/msf.org/files/final_web_counsellor_report._one_page.pdf

Together with the MoH, MSF should focus capacity building efforts on mentoring junior staff until the end of the handover as several key senior staff members will retire soon – to ensure a new leadership. Efforts must be made to identify potential replacements and to coach them to fill certain key roles.

MSF OCP should continue to encourage a healthy partnership with the MoH by maintaining the SC, for Ndhiwa.

4.2 FOR FUTURE HANDOVER PROJECTS

- ➔ Allow enough time for a sustainable handover. This includes conducting environmental assessments and mapping all actors in the area to ensure an informed decision-making process. Identify the services that MSF wants to leave to the beneficiaries after its departure and elaborate the timeline around it.
- ➔ Establish clear roles and responsibilities for each partner (as was done between MSF and Homa Bay County through the MoU). Review the MoU periodically to ensure that these commitments are respected.
- ➔ Work in collaboration with the selected partners through steering committees and technical working groups. Any major development affecting the health sector should be discussed in advance and taken into account when planning the handover.
- ➔ Use the dashboard tool as a guide to the handover, but adapt the indicators in time to reflect the evolution of the projects and incorporate intermediary targets on the time-scale. Develop the indicators and targets in collaboration with the partner(s) and stakeholders.
- ➔ Use innovative partnerships such as tripartite agreements.
- ➔ Establish, from the onset, acceptable limits of quality of care that should be sustained.
- ➔ Ensure the continuity of at least one key position throughout the handover period; this works particularly well with a senior national staff member.
- ➔ Develop a strong communication strategy (including advocacy) to ensure stakeholder awareness and understanding.
- ➔ Develop and implement a capacity building plan that should include the training of trainers to ensure continuity of knowledge transfer. Capacity building should not only include medical and paramedical training, but also address management and logistic areas to ensure proper governance, finance, budgeting and human resources skills.

5. ANNEXES

5.1 TEAM OF CONSULTANTS

Marielle Bemelmans – lead consultant
info@bemelmanspublichealth.com, www.bemelmanspublichealth.com

Marielle Bemelmans has an educational background in health and management combined with a Master's degree in Public Health. Since 2000, she has gained extensive experience in developing, managing and evaluating health programmes, in particular through long-term contracts in coordination positions in HIV/AIDS & TB programmes with MSF as well as short-term consultancy work. During her time as Head of Mission for MSF in Malawi, she initiated the handover strategy of the HIV/AIDS project and integration process with the MoH in Thyolo District.

Her key areas of expertise are HIV/AIDS, Human Resources for Health (HRH) and health policy analysis and advocacy. Overseas experience includes Sudan, Malawi, Democratic Republic of Congo, Kenya, Lesotho, Mozambique, Uganda, Senegal, South Africa, Tanzania and Zimbabwe.

Annie Désilets
anniedesilets1@gmail.com

For the last 15 years, Annie has specialised in management and human resources with a focus on efficiency, organisational design, and pay equity. She has worked as a Project Coordinator for MSF since 2006. She currently works as a consultant helping organisations with specific issues such as monitoring and evaluation of projects, developing exit strategies, developing partnership frameworks, and reviewing internal policies and processes. In 2015 she obtained her Master's Degree in International Law and Human Rights from the United Nations-mandated University for Peace.

5.2 TERMS OF REFERENCE

Terms of reference for
EVALUATION OF HOMA BAY HAND OVER, MSF OCP, KENYA

Commissioned by	Pierre MENDIHARAT, Progam Manager, MSF-OCP
Duration of evaluation	1.5–2 months (26 working days)
Starting time of evaluation	Sept/October 2015
Time period that is evaluated	from Q1 2013- to Q2 2015
ToR elaborated by	Pierre MENDIHARAT, Leon SALUMU, Mzia Turashvili

1. CONTEXT

MSF OCP has been working in Homa Bay County since 1996 first in response to ethnic conflict when it realizes the extent of the HIV/TB epidemic and started involving on HIV. In 2001 MSF initiated Anti Retro Viral therapy at Homa Bay hospital being the first public hospital providing free of charge ART in Kenya. At that time, with a 35% estimated prevalence, the objective was 1) to reduce the mortality related to HIV 2) to demonstrate the feasibility of treating large number of patients in poor resource settings and to lobby for increased access to HIV care.

In January 2013, MSF OCP implemented in collaboration with the Minister of Health a hand over strategy through participative workshops organized by an external consultant with the participation of all stakeholders. The process was formalized in January 2013 and is due to end in December 2015.

The strategic objective defined by the consultative process was ***"By December 2015, acceptable quality of care for TB & HIV patients is available in HBDH independently from MSF."***

The strategic objective was divided in 5 operational objectives:
- *Ensure acceptable quality **outcomes** in the services*
- *Ensure availability of qualified **staff** independent of MSF*
- *Ensure continuity of **medical supply** independent of MSF*
- *Simplification of care and use of standards MoH **protocols***
- *Use MOH **data tools***

For each objective 1 to 3 indicators have been set up and regularly measured.

2. OVERALL OBJECTIVE and PURPOSE

OVERALL OBEJCTIVE
The objective of the evaluation is to take stock of the 2,5 years of hand over since its formal start in January 2013 to provide feedback on its effectiveness, appropriateness, impact, connectedness, and continuity of care by highlighting operational strengths and weaknesses and area of improvement, and provide recommendations.

The evaluation will explore how the hand over contribute toward sustainable comprehensive quality of HIV/TB care in Homa Bay independent of MSF support.

For this evaluation the hand over will be primarily looked at as a distinct project by itself rather than just a process.

THE PURPOSE
The recommendations will be used to improve the final sustainability of the process and the replicability of this hand over approach and of the tools used.

The primary focus will be on learned lessons, and the methodology should be designed accordingly.

3. KEY EVALUATION QUESTIONS

Relevance

- How timely was the handover decided and communicated?
- How well were the objectives of the HO identified, prioritized and communicated? Did they meet the needs of MSF target groups?
- Was the HO designed appropriately to achieve its goals, e.g. partners chosen etc? How appropriate were the strategies of its implementation? Were any adaptations required to optimize the approach during the HO process?
- How optimal did the HO work according to the perception of the national authorities? other stakeholders? target population?
- Lessons learned (what worked well and what did not) and suggestions for the similar projects in the future

Effectiveness

- To what extent did the HO achieved the agreed objectives?
- How well the HO monitoring indicators were chosen and applied?
- Were the HO activities carried out as originally planned? Which activities were taken over? Any adaptations needed and implemented?
- What were reasons for achievement or non-achievement of HO objectives?
- To which extent did beneficiaries kept access to project services?
- What difference did the HO project make for the beneficiaries? Staff? National programme?
- Did the HO project have any unforeseen positive or negative impact?
- What can be done in the future to make the hand-over even more effective?

Continuity and connectedness

- Which components were key for the sustainability of the activities (e.g. HR, supply, supervision capacity), and how have they been taken into consideration in the planning and implementation phase?
- What local capacities and resources have been identified
- How does the project connect with the overall health care system?

4. EXPECTED RESULTS and INTENTED USE OF THE EVALUATION

- Final report of no more than 30 pages in English (for MSF-internal use)
- Final report to be shared with the authorities and MoH (external version)
- Presentation of the evaluation work in the MSF-Paris office

Programme manager (and??) will be responsible for considering recommendations and their implementation.

5. PRACTICAL IMPLEMENTATION OF THE EVALUATION

Number of evaluators	1
Timing of the evaluation (working days)	
• For preparation, doc revew	5
• For interviews, HQs	3
• For field visits (including travel)	7
• For writing up report and presentation	11
Total time required	26

6. TOOLS AND METHODOLOGY PROPOSED (if any)

- Review and analysis of project documents
- Interviews with key-team members at HQ and field levels (former staff?)
- Interviews with key national authorities and hospital staff
- Interviews and focus groups with patients/former patients and community representatives
- Observation

7. DOCUMENTATION FOR READING

Examples of documentation;
E.g. Copro, Project documents (narrative and logframe), Situation reports, Trip reports, Medical reports

8. STAKEHOLDERS AND INTERVIEWEES

xx…..

9. JOB PROFILE/S of EVALUATOR/S

Medical and/or epidemiology background
Language requirements: English
Experience in HIV/Aids programing
Evaluation competencies: qualitative and quantitative research skills
Experience in handover

5.3 LIST OF INTERVIEWEES

Operational Centre Paris

Pierre Mendiharat	Desk Coordinator
Leon Salumu	Dep Desk Coordinator
Philippe Blasco	Counselling advisor, Med Dept
Celine Lastrucci	Lab advisor, Med Dept
Adeline Luxey	HR/admin/Finance of desk Kenya
Huan Carlos	Epidemiologist desk Kenya
Greg Elder	Dep Director of Operations
Annette Heinzelmann	Medical Director
Elisabeth Szumilin	HIV Advisor, Med Dept (via email)

Nairobi – Coordination

William Hennequin	Head of Mission
Alexandra Vandenbuick	Medical Coordinator
Steve Wanjala	Dep Medical Coordinator
Mary Ndung'u	Pharmacist
Wariara Mugo	Advocacy Coordinator
Mohammed Alkubati	Finance & HR Coordinator

Homa Bay

Janthimala Price	Field Coordinator (MSF)
Wai Lin	HB MTL (MSF)
Sonia Bouicha	Field Admin (MSF)
Sandra Racheal Muhalya	Pharmacy Focal Mentor (MSF)
May Atieno Onyango	Laboratory Focal Mentor (MSF)
Victor Anyiko	M&E Advisor (MSF)
Evelyn Ododa	Clinical Officer (CO) Clinic B HBCH (former MSF/current MoH)
Sharon Andiva	Pharmacy HBCH (former MSF/current MoH)
Maren Akumu Otieno	SMA register officer (former MSF/current MoH)
Barack Odindo	Lab in charge manager (former MSF/current MoH)
Christine Atieno	Deputy Lab in charge(former MSF/current MoH)
Edwina Oyoo	Counsellor Clinic B HBCH (former MSF/current MoH)
Nancy Ndiege	Nurse Clinic B HBCH (former MSF/current MoH)
Brian Omuchele	M&E Clinic B HBCH (former MSF/current MoH)
John Akwati	Records Manager in charge HBCH (MoH)
Donald Yara	TB HB sub county in charge (MoH)
Andrew	TB nurse (EGPAF)
Charles	CHW TB dept (MoH)

Mr Musundi	Pharmacy in charge (MoH)
Sr Mary	Nurse in charge Clinic B HBCH (MoH)
Dr Francis Ochieng	Medical Superintendant HBCH (MoH)
Ruth Otieno	Matron HBCH (MoH)
Dr Lawrance Oteng	Minister of Health (County MoH)
Mr Martin P. Owino	Chief of Health (County MoH)
Alan xxx	EGPAF Deputy Director
Alice Nyimbaye	DASCO Coordinator
woman ~24 years	Patient Clinic B
boy 13 years	Patient Clinic B
FGD with 14 patients in Support Group	

Total interviews in Homa Bay: 6 MSF, 8 former MSF/current MoH, 7 MoH HBCH, 2 County MoH, 1 DASCO, 2 partners, 3 patients – total: 29

Former MSF staff (through e-mail)

Alphonse Harinayandi	Former FieldCo Homa Bay
Steve Muir	Former logistics Homa Bay
Phoebe Balikagala	Former MTL Homa Bay

Other

Guillaume Jouquet	Handover Consultant (via Skype)

5.4 SAMPLE QUESTIONNAIRE

SAMPLE QUESTIONNAIRE, ADAPTED ACCORDING TO AUDIENCE

Intro

- How and where were you involved in the Homa Bay handover process?

HO process / tools / involvement (Relevance, effectiveness, replicability)

- What is your impression of the HO tool / dashboard – has it been used as a decision-making tool & how?
- How balanced has the responsibility been to monitor progress according to the dashboard (MoH/MSF)?
- What do you find its strengths & weaknesses? What about the SC, TWG, workshops? Was there sufficient analysis when faces remain red? Who did/led the presentations during the SC on TWG feedback? Any suggestions where it could have done different/better?
- Were the handover objectives realistic and appropriate for the needs of the patients/hospital/MoH?
- To what extent have you felt ownership of the handover process (scale 1–10)?
- How do you feel about the indicators chosen, are they indicating progress on reduced MSF and increased MoH responsibility whilst maintaining quality of care? Which were useful/less useful? How easy are the indicators to monitor?
- When did you first hear that MSF would reduce its activities in Clinic B HB?
- Did the handover come at the right time? If not, what would have been better timing?
- Was there enough time allowed for the handover? Timing respected, where adjustments needed in line with changes in the environment?
- Example of flexibility of handover strategy, reacting to the environment?

Environment

- Were the handover objectives, indicators in line with national policies, comparable outcomes?
- Did the supervision set-up for the MoH change with the devolution?
- What were the advocacy strategy & activities along the handover process (both local & national level)? Aligned to certain opportunities in the external environment, i.e. PEPFAR COP process, drug list revisions. Can you name examples? Was this aligned to the dashboard?
- Do you feel MoH had more difficulties to obtain resources from the national level due to longstanding MSF presence in HB?

MoH – MSF partnership & other partners

- How would you describe the relationship between MSF – MoH over the last five years? Did it change during the HO process? MSF's relationship with other partners in Homa Bay?
- What could already have been done during the project period to enhance/make the handover process easier?

Services / Impact / Sustainability

- What has been the key impact of the Homa Bay handover on the patients, services, hospital so far? What changes did you see in your work since the start of the HO? Where are the biggest challenges?
- Staff recruitment: did MSF apply similar selection criteria as MoH – any issues?
- If I come back to Homa Bay Hospital in 2 years, what will it look like? What are your major concerns re the future of HBH?
- Was there any objective around free services? Do patients have equal access to treatment now and before / what has changed?
- To what extent will the MoH / other key handover partners be able to sustain the services after MSF completely reduces their involvement? Where not / where yes?
- Do you feel sufficient training / skills were given? If no, which areas were lacking?
- How about supervision skills? Who is conducting the supervision currently?

Communication

- Were you kept informed of decisions made?
- Was it sufficient, where could it have been improved?

Overall

- What are the key lessons learned from the handover process?
- If you could change anything about the handover process, what would you change?
- What recommendations do you have?
- What would you like to see covered during this evaluation?

5.5 QUESTIONNAIRE FOR FORMER STAFF

MSF-OCP Homa Bay Handover (HO) Evaluation

- How and when were you involved in the HB HO process?
- What is your impression of the HO tool/dashboard?
- What are its strengths & weaknesses?
- Were the HO objectives realistic and appropriate for the needs of the patients/hospital/MoH?
- Did the HO come at the right time? Why/why not?
- Was training/capacity building/skills transfer sufficient? If not, which areas were lacking?
- How well was the handover communicated?
- What are the key lessons learned from the HO process?
- If you could change anything about the HO process, what would you change?
- Do you have any recommendations for a handover in a similar context?

5.6 REFERENCES

Bärnighausen, T. et al. (2011) Interventions to increase antiretroviral adherence in sub-Saharan Africa: a systematic review of evaluation studies. *Lancet Infectious diseases*. 11:942-951.

Bemelmans M., S. Baert, E. Goemaere, L. Wilkinson, M. Vandendyck, G. van Cutsem*, et al.* "Community-supported models of care for people on HIV treatment in sub-Saharan Africa". *Trop Med Int Health,* vol. 19, Aug 2014: pp. 968-77.

Désilets, A. *Evaluation of the Disengagement of Bon Marche Hospital in Bunia, DRC for MSF-OCG.* MSF - Vienna Evaluation Unit Evaluation: 2010.

Désilets, A. *Leaner and more effective - another approach to hospital management in MSF*. MSF - Vienna Evaluation Unit Evaluation: 2015.

Désilets, A., *Lesotho Handover: Assessment of Handover Strategy of MSF-B HIV/TB Programme.* MSF - Vienna Evaluation Unit Evaluation: 2010.

Govindasamy D, Meghij J, Kebede Negussi E, Baggaley R, Ford N, Kranzer K. (2014) Interventions to improve or facilitate linkage to or retention in pre-ART (HIV) care and initiation of ART in low- and middle income settings, a systematic review. *Journal of the International AIDS Society,* 17:19032.

Jouquet, Guillaume. *Homa-Bay HIV/TB project Building and implementing with MSF team MSF handover strategy*. January 2013.

Internal MSF strategic meetings: Paris meeting 2010 & Joburg meeting. 2012.

Hammadi, Karima and Désilets, Annie. *Enriched or Confined? MSF Engagement in Local Partnerships*. MSF Vienna Evaluation Unit Evaluation Report. 2012.

MSF. *HIV/TB Counselling: Who is doing the job?* – Brussels: 2015. Available from: http://www.msf.org/sites/msf.org/files/final_web_counsellor_report._one_page.pdf

Nicholas S., Wapling J., Rakesh A., Amoros I., Poulet E., Schramm B., Gueguen M., Szumilin E. *Description of the Viral Load cascade of ART patients using SAMBA, a Point-of-care Viral Load testing method in Chiradzulu district*, NAC, Malawi: 2015.

PEPFAR. *PEPFAR 3.0 Controlling the epidemic: delivering on the promise of an AIDS-free generation.* Washington: 2014.

Rutherford GW, Anglemyer AT, Easterbrook PJ, Horvath T, Vitoria M, Penazzato M, Doherty M. Predicting treatment failure in adults and children on antiretroviral therapy: a systematic review of the performance characteristics of the 2010 World Health Organization criteria for virologic failure (2013) Poster at IAS, Malaysia 2013.

UNAIDS and MSF. *Community-based antiretroviral therapy delivery - experiences of Médecins Sans Frontières.* UNAIDS, Geneva, Switzerland: 2015

UNAIDS. *90-90-90 The ambitious target to help end the AIDS epidemic.* UNAIDS. Geneva, Switzerland: 2014.

WHO. *Guideline on when to start antiretroviral therapy and pre-exposure prophylaxis.* World Health Organisation, Geneva, Switzerland: 2015.