



MONITORING AND EVALUATION

Final report PM2

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Abbreviations used in the text

ADC	Area Development Committees
AEC	Area Executive Committees
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care (small maternity clinics)
ART	Anti Retroviral Therapy (see under HAART)
ARVs	Anti Retro Virals (drugs)
AZT	Azidotimidin (known also as Zidovudin) antiretroviral drug
BISC	Business Information and Service Centre
CBCC	Community Based Child-care Centre
CBO	Community Based Organisation
CD4	a kind of lymphocyte
CHBC	Community Home-Based Care
CISP	Comitato Internazionale per lo Sviluppo dei Popoli
CMC	Centre Management committee
CO	Clinical Officer (medical degree intermediate between nurse and doctor)
CPD	Continuous Professional Development
CSE	Comunità di Sant'Egidio
CW	Community Worker
DCA	disease control assistant
DEC	District Executive Committee
DREAM	Drug Resource Enhancement against AIDS and Malnutrition
ECDI	Early Childhood Development and Instruction
ECDC	Early Childhood Development Centre
HAART	Highly Active Antiretroviral Therapy (see under ART)
HBC	Home Based Care
HCT	HIV Counselling and Testing (once defined VCT)
HIV	Human Immunodeficiency Virus
HSA	health surveillance assistant
IEC	Information, education and communication material on HIV
IGA	Income Generating Activity
IUSS	Istituto Universitario di Studi Superiori
KS	Kaposi Sarcoma, one of the most fearful complications of HIV-AIDS
M&E	Monitoring and Evaluation
MAGGA/SAM	Malawi Girl Guides Association / Scout Association of Malawi
MCPC	Mother and Child Prevention and Care Programme

MEDI	Malawi Entrepreneurship Development Institute
MFI	Malawi Financing Institution
MKw	Malawian Kwacha
MoH	Ministry of Health
MSF	Médecins Sans Frontières
MwN	Mthengo wa Ntenga
NA	Nurse Assistant
NAPHAM	National Association of people living with HIV in Malawi
OPC	Office of the President and Cabinet
OVC	Orphan and Vulnerable Children
PEA	Primary Education Advisors
PCR	Polymerase Chain Reaction, molecular biology technique utilised in the early diagnosis of HIV-AIDS, particularly in children
PLWHIV	People living with HIV
PM1	Project Malawi first phase 2006-2008
PM2	Project Malawi second phase 2009-2011
PMTCT	Prophylaxis Mother-To-Child-Transmission
PRA	Participatory Rural Appraisal
PSS	Psycho social Support
QECH	Queen Elizabeth Central Hospital
Q2S	Quadro quantitativo sintetico
RRA	Rapid Rural Appraisal
SAM	Scout Association of Malawi
SRH	Sexual and reproductive health
STC	Save the Children
TA	Traditional Authority
VCR	Vincristine, chemotherapeutic agent utilised in the treatment of KS
VCT	Voluntary Counselling and Testing (better defined HCT - see under)
VDC	Village Development Committee
VL	Viral Load, gauge of the virus aggressiveness in an individual
VSLA	Village Savings and Loan Association
WACRAD	World Alive Commission for Relief and Development

1 Introduction

1.1 - Structure of the report

The present document is the final evaluation report for Project Malawi 2. It was edited on the basis of :

- The field visit carried out by the M&E team at the beginning of November 2011.
- The coordinator report.
- The 9th report provided by the partner organizations implementing PM2, made available just only after the field visit. The Department of Nutrition did not provide the report. The reporting period goes from 1st June to 30th September 2011. Q2S formats were not submitted.

The field visit was shaped in order to:

- Evaluate the overall impact of PM2 on the basis of a new methodology, focused on key informants rather than direct beneficiaries and community level project volunteers.
- Provide the M&E team with opportunities to discuss with some of the staff of the partner organizations and meet relevant stakeholders, specifically in the medical field.

The methodology adopted for field visits included:

- Structured meetings organised according to the methodology detailed in part 1.4
- Meetings with the project coordinator and with relevant Authorities variously involved in the fight against HIV-AIDS.
- Meeting with the representatives of partner organizations, whenever possible structured according to the “*three-questions system*”. Interviewed staff was actually requested to give synthetic answers on : 1) which are the main achievements of your organisation in PM2; 2) which are your deepest regrets in PM2, i.e. what you would have liked to do and was not possible to realise; 3) what’s your dream-in-the-drawer for the future.
- Due to the new methodology adopted and to the lack of fuel, hampering the visit of long-distance satellite centres usually performed in the previous visits, in this field visit the inspection of the structures of the project was limited to the three referral DREAM Centres of Mwn, Balaka and Blantyre. Also with these limitations to perform safely the visit – avoiding the risk of being blocked half-way for the lack of fuel – we had to arrange for an emergency storage of fuel in Balaka and to organise carefully the travel, taking into account the passage nearby the boundary with Mozambique where it was possible to buy imported fuel.

This report has been structured in an Introduction, where will be presented an overall evaluation of the Country and the details on the visit and on the methodology adopted; a second chapter devoted to present the results of the meetings with the TAs, the field visits and the interviews with different stakeholders; a third chapter dealing with the analysis of the ninth report presented by the partners; finally a fourth chapter where we will present the conclusions drawn from the analysis of the previous chapters.

1.2 - General overview: the Country in 2011

The political situation

Since winter 2011 Malawi is undergoing a period of political incertitude which originates because of the supposed attempt of the Presidency to gain more power. It is also unclear whether or not the President will step out at the end of his mandate or he will try to stay in power, even if may be not by himself, but by means of some of his closest friends and relatives. There are rumours about the growing power of the President's Brother Arthur-Peter Mutharika, who is also the Foreign Minister. Moreover between summer and fall the President Bingu wa Mutharika has been out of the country for several months due to health reasons, even if he still seems to be in good control of the country. Last July the situation has led to some violent riots with people being killed.

The British Ambassador criticized the President and was expelled from the country. Britain kicked out Malawi's representative in London and suspended aid worth \$550m (£341m) over the next four years. The freeze has left a hole in the budget of a country that has historically relied on aid for 40% of its revenues. The funds from other EU countries are still flowing in, even if in a limited and discrete way, but for sure Malawi is feeling a lack of foreign exchange

The economy

Despite mounting commercial pressure on the currency and repeated calls from the likes of International Monetary Fund for a devaluation, Mutharika has vowed to stand firm. However the black market rate of exchange of the Malawian Kwacha has decreased and during our visit was some 20% higher, in Euro and Dollar terms, than the official rate.

A dispute with tobacco producers' has complicated the exports of this product and has added more strain to the lack of foreign exchange. As it is typical in these condition there is a shortage of fuel, and of gasoline in particular which already affects transportation; we ourselves had to buy gasoline at the black market on the border with Mozambique. When we were leaving the country there was a strike by the civil servants because of the very high increases in the cost of living, estimated around 30%, *vis à vis* the wages increases of 7% in the public sector. There were also complaints about the increasing differences in the salaries between low and high ranking civil servants.

The economic situation is still manageable but it could evolve in many different ways: it could either continue with this creeping devaluation and still manageable inflation, or even fled to a rapid fall in the exchange rate of the Malawian Kwacha: it is very difficult to make any prediction.

The current situation and Project Malawi

For sure the situation is already producing problems in the management of PM activities, some of which require both import of foreign products and also imply transportation costs. These difficulties might increase in the future. However, we have seen that all the partners are adapting to the situation and are implementing the necessary strategies to overcome the major difficulties. For instance these strategies imply buying fuel on the wholesale market and stock it. This reaction is very important because it allows to carry on most of the activities without major disruptions; a fact that for a project of this size and length in time would be terrible. For the time being the implementation of the activities of PM2 are not at high risk, but the reporting, in particular the financial side of it, should consider the rather

exceptional conditions and in particular the fact that the partners have to operate also in a black market situation.

Even if the political situation does not deteriorate this fact might lead to problems in the proper collection and documentation of certain expenses because of the existence of a double price system for many goods. Moreover the lack of foreign exchange and the situation are likely to stay for at least the whole of 2012 and this might lead to rapidly increasing costs for the management of the activities which are already planned in the project.

1.3 Mission report – Visit details

As we did in the previous visits, evaluation team split in two in many occasions, in order to maximize the time available and cover a wider array of activities of PM2. In detail, one evaluator (GBP) took care specifically of CSE-DREAM activities, while other two evaluators (MM + GV) devoted their time fully to perform the assessment in the six TAs where PM2 is present. Transfers were always done together, to reduce the problems of fuel availability.

	GBP	MM + GV
Sun 6/11	<ul style="list-style-type: none"> • 13,30 - Arrival to Lilongwe airport • 15,00 - Meeting with National coordinator Claudio Tonin – overall assessment of the project • 16,00 – transfer to Balaka 	
Mon 7/11	<ul style="list-style-type: none"> • 8,30 meeting with Dr. Owen Chikwaza, DHO Balaka • 10,00 joint meeting with the DHO and Balaka Hospital authorities • 11,00 visit to Balaka DREAM centre – interview with the staff 	<ul style="list-style-type: none"> • 8,00 Meeting in TA Msamala
	<ul style="list-style-type: none"> • 14,00 Meeting with partners at district level • 17,00 Transfer to Blantyre 	
Tue 8/11	<ul style="list-style-type: none"> • 8,00 - meeting with Mr. Peter Chisoni, Blantyre City Council, Assistant Director of Health • 10,00 - Visit to DREAM Centre + labo, Blantyre • 15,00 - Meeting with Dr. Jan van Oosterouth, QECH 	<ul style="list-style-type: none"> • 9,00 - meeting in TA Kapeni • 14,00 -Meeting in TA Somba
	<ul style="list-style-type: none"> • 17,00 - Meeting with partners at district level BT 	
Wed 9/11	<ul style="list-style-type: none"> • 9,00 - Meeting in TA Machinjiri • 13,00 – Transfer to Lilongwe • 18,00 - Meeting with Dr. Mary Shawa, PS OPC 	

Thu 10/11	<ul style="list-style-type: none"> • 9,00 - Visit to MwN Centre • 15,00 - Meeting with DHO Dowa, Dr. Amosi Msekandiana 	<ul style="list-style-type: none"> • 8,30 Meeting in TA Chitukula
	<ul style="list-style-type: none"> • Debriefing with partners (district and national level) 	
Fri 11/11	<ul style="list-style-type: none"> • 8,30 - Meeting with Dr. Frank Chimbandwira, Director HIV Unit • 10,30 - Meeting with Dr, Ruben Mwenda, Deputy Director Health technical support services (Diagnostics) Ministry of Health • 13,30 return to Italy 	<ul style="list-style-type: none"> • GV return to Italy • 8,30 – Meeting in TA Chimutu • 15,00 Debriefing with the partners
	Sat 12/11	<ul style="list-style-type: none"> • MM Return flight to Italy cancelled for lack of fuel in Lilongwe airport
Sun 13/11	<ul style="list-style-type: none"> • MM Successful return flight to Italy 	

1.4 - TA meetings methodology

1.4.1 - Rationale of the method

The methodology adopted for the final evaluation focused on key informants, rather than direct beneficiaries and community level project volunteers.

Key informants are defined as members of a community, broadly intended, who, thanks to their formal or informal leadership position, enjoy a point of view and a level of information higher than other community members over the issues of common interest.

Previous monitoring visits mainly relied on the information provided by

- direct beneficiaries,
- community level project volunteers,
- project staff, from partners organizations.

This proved to be effective in the past and during monitoring to get an understanding of activities and problems and develop operational advises.

For the final evaluation the following points were considered:

- it was necessary to provide a wider view on project Malawi;
- a formal structured survey on beneficiaries would have exceeded the limits of the available resources;
- informal meetings like the ones held during previous monitoring visits are prone to a selection bias, due to the fact that the evaluators had no control over the invitations done by partners;

- a structured methodology was to be preferred, to provide some hard evidence and to allow replication at subsequent steps.

The result of these considerations was the option for an RRA /PRA like methodology, based on key informants.

These methodologies move from the recognition of the existence of a huge body of information, knowledge and capacity of analysis among local actors.

Working with groups, through various techniques thus becomes the way to allow local actors to carry out their own analysis and, most notably, their own synthesis, while the composition of the groups and the so called *triangulation*, ensure that the results are crosschecked and validated.

If at the end of a traditional fieldwork the researcher has collected a number of data to be analyzed, at the end of such exercises the researcher is provided with an output which is already arranged in the form of final tables and diagrams, like the ones that the researcher produces with ex post data handling.

The assumption is that local actors can represent better than any external analyst the situations, the challenges and the constraints experienced by their communities, so that the role of the researcher is somehow redefined to the one of a facilitator.

The final evaluation of Project Malawi II was based on 6 key informants meetings at Traditional Authority level, covering each TA targeted by Project Malawi:

1. Blantyre District: Machinjiri TA
2. Blantyre District: Somba TA
3. Blantyre District: Kapeni TA
4. Balaka District: Msamala TA
5. Lilongwe District: Chitukula TA
6. Lilongwe District: Chimutu TA

It should be noticed that the adopted methodology, focusing on rural areas, only partially covers DREAM and BISC activities which are mostly based in town.

The same applies to MAGGA activities in Limbe centre.

1.4.2 - The participants

For each TA the participation of two categories of actors was required:

- Local authorities representatives,
- Government offices technicians.

The option for these categories was based on the consideration that both local level politicians and officers from the government

- are engaged in community development, since development issues are more or less directly addressed by the missions of their organizations,
- enjoy a privileged position for the observation of development initiatives implemented at community level by various internal and external agencies, since development actors usually involve their organizations for political backing of for technical support,

- have a degree of competence and understanding of development issues and local context which should ensure that their analysis can go beyond the typical quest for direct assistance, also adopting a medium to long term view.

More particularly the invited participants for each TA were:

- One representative from the Area Development Committee (ADC) which means the political committee at the TA level;
- Two or more representatives of the Village Development Committees (VDCs) of some villages targeted by PM2;
- One officer from District Health Office;
- One officer from District Agriculture Office;
- One officer from District Office For Gender, Children and Community Development (social welfare offices);
- Two or more representatives from the Educational Zones of the TA targeted by PM2.

As it can be noticed from the list, Ministries and their District level offices were selected to cover fields of interventions related with the activities of Project Malawi, being many of these offices directly involved by Project Malawi partners in the provision of training courses and inputs.

To keep the costs low and the meetings easy to manage, the VDCs invited did not cover the whole TA, nor even all of the villages targeted by PM2.

The ideal rule adopted for the selection of VDCs in each TA was:

- all the villages where more than one partner work: to enjoy the opportunity of fully assessing the effect of the integrated approach which characterizes Project Malawi;
- One village for each TA where one partner only works alone: to control for the effect of the lack of synergies.

Following this rule and based on the lists of activities made available by the Project Coordinator, the M&E team provided the Project Coordinator a list of participants to be invited (see annex 1), to arrange for the six meetings. The overall result was satisfactory since all the meetings were properly arranged, yet some constraints and misunderstandings should be mentioned because of the limitations that they might pose on the performance of the methodology adopted, namely:

- the villages where more than one partners works were usually kept as requested by the M&E team, with minor exceptions which will be noted during the presentation of the results;
- the idea of control villages (where only one partner works) was misunderstood and these kind of villages were not invited;
- in many cases instead of VDCs members, beneficiaries and community level volunteers were invited;
- all the invitations were made through partners, so that a selection bias could still affect the results.

1.4.3 - The meetings

The present paragraph introduces the methodology used to manage the meetings and the exercises proposed to the participants. After the registration of participants and a brief introduction, the six meetings followed the program shown in the table below, jointly with the meaning associated with each exercise in the view of project evaluation.

	Exercise	Purpose
1	Problems brainstorming	<ul style="list-style-type: none">• Asses project relevance
2	Identification of project components	<ul style="list-style-type: none">• To provide a basis for the later exercises
3	Project components rating	<ul style="list-style-type: none">• Asses project relevance• Asses project effectiveness and impact• Asses project sustainability
4	Benchmarking	<ul style="list-style-type: none">• Asses project efficiency (in terms of how activities are implemented)

The practical functioning of each exercise is briefly described below.

Exercise 1 Problems brainstorming:

- The exercise was carried out in plenary session.
- Participants were asked to brainstorm about the problems of the TA. Problems were defined as constraints to the development of the area and situations preventing the well being of its population.
- Once a list was available pair wise ranking of problems was carried out. This means that each problem was compared with all the other problems one by one and the priority problem was identified for each couple. Priority was defined as associated with problems which prevent the development and wellbeing most hardly and affect most people.
- Problems scoring higher (selected in a highest number of pairwise comparisons) provided the set of criteria used in the following exercise.

Exercise 2 Identification of project components:

- The exercise was carried out in plenary session.
- Participants were asked to focus on the information they have about Project Malawi and to brainstorm about the initiatives/activities of PM.
- Once a list was available, each participant was asked to specify which of the items they already knew before the meeting.
- Only components mentioned by participants were submitted to rating in the following exercise.

Exercise 3 Components rating:

- Participants were divided into 2 groups (technicians from government offices and local authorities).
- The exercise is based on tables where the results of the previous two exercises are cross tabulated. Rows hosted the activities/components identified in exercise 2. Columns hosted the problems selected with exercise 1. An additional column was always included for “sustainability”, as it will be explained below.
- Each group received an initial number of scores, in the form of post-its, calculated as $(1/2 \times \text{number of columns} \times \text{number of rows})$ and allocated them to the cells according to the contribution of each activity/component to address each problem. The sustainability of each activity/component was similarly rated. The initial number of scores is kept low to emphasize the importance of allocating them wisely to cells, but additional scores were provided upon request once the concept was clear.
- Each group presented the work in plenary session and results were discussed.

Exercise 4 Benchmarking:

- The exercise was carried out in plenary session.
- For each component identified in exercise number 2, participants were asked to brain storm about other organizations who perform similar activities in the reference TA.
- Participants were then asked to compare the reference PM component with the one of the other organization identified, in terms of methodology adopted (how things are done).

2 Field visit report

2.1 - TA meetings

2.1.1 - TA Msamala

A problem in TA Msamala meeting was that a number of beneficiaries and community level volunteers were invited by mistake. Anyway, they did not participate in the meeting and only attended a short interview.

Apart from these problem the composition of the group reflected the requests with the following participants:

- 6 representatives of Chiendusiku and Kapalamula VDCs
- 1 Msamala ADC representative
- 3 officers from the 3 ministries (Health, Agr/Vet, Gender -Children ...)
- 4 representatives from the 4 educational zones

n persons who know	Scores (absolute)	5	6	5	4	3	23			
	Scores (normalized)	0,22	0,26	0,22	0,17	0,13	1			
		Original output						Normalized and weighted		
	TECHNICIANS	W&S	communicable diseases	hunger	poverty	resources for education	sustainability	sustainability	Contribution to address problems	Contribution weighted for problems priority
2	CBCC		1	1			1	17%	14%	17%
1	HBC		1				1	17%	7%	9%
1	CHILDREN CORNERS					1	1	17%	7%	5%
1	VSLA			1	1	1	1	17%	21%	18%
2	PEER EDUCATION		1		1	1	1	17%	21%	20%
n.a.	ART		1	1	1			0%	21%	23%
n.a.	PMTCT		1				1	17%	7%	9%
	Total	0%	36%	21%	21%	21%		100%	100%	100%
	<i>LOCAL AUTHORITIES</i>									
3	CBCC			1		4	1	17%	31%	24%
3	HBC		3				1	17%	19%	26%
3	CHILDREN CORNERS					1	1	17%	6%	4%
4	VSLA				2		1	17%	13%	11%
3	PEER EDUCATION		1			2	1	17%	19%	17%
n.a.	PMTCT		2				1	17%	13%	17%
	Total	0%	38%	6%	13%	44%		100%	100%	100%

The analysis of TA Msamala reveals that communicable diseases are the priority problems in the area (26%). In terms of relevance, Project Malawi is perceived as mainly addressing these kind of problems by technicians (36%), while it is more perceived as a Project about education by local authorities (44%).

Most project components which are active in the TA Msamala were mentioned, and consequently rated by participants. The only exceptions are

- BISC, probably due to the fact that there are no BISC clients in the participating villages;
- IGA, probably due to the fact that only 2 IGAs exist in the TA and they were started up only recently.
- support groups.

It can be noticed that all activities but ART were rated positively in terms of sustainability.

In terms of effectiveness, technicians rated higher the following activities:

- VSLA
- PEER EDUCATION
- ART

but if the scores are weighted for the priority given to each of the problems addressed, then the most appreciated activity is ART, due to the importance of the health problems.

Local Authorities rated higher the CBCCs activities, but if the scores are weighted for the priority given to each of the problems addressed, then the most appreciated activity is HBC, due to the importance of the health problems.

The organizations providing similar services in Msamala are:

- VSLAS: Concern Universal (<http://www.concern-universal.org/malawi>);
- HBC: Ministry of Health;
- ART and PMTCT: Ministry of Health.

The main differences noticed by participants between the services provided by Project Malawi and the ones from other organizations are:

- VSLAS: groups of 10 members only instead of 20. Concern trains community facilitators who are then supposed to train the rest of the group, so that the support provided is less direct. Concern also provides support to income generating activities which, according to participants is not done by CISP.
- HBC: Ministry of Health. Participants clarified that the initiative of STC is actually complementary to the one of the Ministry since the original initiative of forming the groups came from the Ministry, which also provides drugs and trainers, but this was done with the support and facilitation of PM and STC.
- ART and PMTCT: PM and CSE services are considered better than the ones of the Ministry because of the provision of nutritional support and better privacy.

2.1.2 - TA Machinjiri

In TA Machinjiri a number of beneficiaries and community level volunteers were invited by mistake. Anyway, they did not participate in the meeting and only attended a short interview.

The composition of the group and the main deviations from the M&E requests are listed below:

- 7 representatives of Likomba, Nkhalamba¹, Masaka, Likoswe VDCs (only Likoswe was in the list with other villages which were not present).
- No ADC representative.
- 3 officers from the 3 ministries (Health, Agr/Vet, Gender -Children ...).
- 2 representatives from the educational zone of South Lunzu, which according to the M&E team program was to be covered under Kapeni TA, while Chilomoni educational Zone, the one associated with Machinjiri meeting was not present.

	Scores (absolute)	9	10	8	6	6	39			
	Scores (normalized)	0,23	0,26	0,21	0,15	0,15	1			
		Original output						Normalized and weighted		
	health facilities	good water	agriculture	lack of drugs	livestock	sustainability	sustainability	Contribution to address problems	Contribution weighted for problems priority	
	<i>TECHNICIANS</i>									
n.a	CBCC	1			2			17%	25%	25%
n.a	HBC				1			17%	8%	7%
n.a	IGA					2	1	17%	17%	14%
n.a	PEER EDUCATION	1	1		2			17%	33%	36%
n.a	DREAM CENTRE	1			1			17%	17%	18%
	Total	25%	8%	0%	50%	17%		100%	100%	100%
	<i>LOCAL AUTHORITIES</i>									
n.a	CBCC		1	2			1	17%	25%	26%
n.a	HBC	2					1	17%	17%	18%
n.a	IGA					2	1	17%	17%	12%
n.a	PEER EDUCATION	1	1	1				17%	25%	27%
n.a	DREAM CENTRE	2						17%	17%	18%
	Total	42%	17%	25%	0%	17%		100%	100%	100%

The analysis of TA Machinjiri reveals that water supply is the priority problem (26%), followed by the lack of health facilities. If lack of drugs and lack of health facilities are jointly considered, then the health area is associated with the problems scoring highest (38%).

¹ Nkhalamba village representatives were also present at the meeting of TA Somba and the village is listed under both TA in the list provided by the Project Coordinator. This should be clarified

The relevance of the project is good, since Project Malawi is perceived as mainly addressing these kind of problems both by technicians (50% lack of drugs) and Local Authorities (42% lack of health facilities).

Some project components which are supposed to be active in the TA Machinjiri were not mentioned, and consequently rated by participants. These are BISC, for the reasons already introduced above, but also VSLA, support groups and children corners. This might mean that these activities were not very successful in this TA.

It can be noticed that some activities were not rated positively in terms of sustainability, by both Local Authorities and Technicians. These are Peer Education and Dream activities.

In terms of effectiveness, both technicians and Local Authorities gave the highest rating to the peer education component, and the result does not change even when the priority given to water and health is considered.

No organization providing similar services in Machinjiri was mentioned.

2.1.3 - TA Somba

A number of beneficiaries and community level volunteers were invited by mistake. They participated in the plenary exercises, while for the group works of exercise 3, they formed a separate group whose result are not analyzed in the present report.

The composition of the group and the main deviations from the M&E requests are listed below:

- 13 representatives of Nkhalhamba, Mingole, Somba, Khaliomba, Malekwa VDCs (only Nkhalhamba and Malekwa were in the list with other villages which were not present)
- No ADC representative
- 3 officers from the 3 ministries (Health, Agr/Vet, Gender -Children ...)
- 4 representatives for 2 educational zones.

The analysis of TA Somba reveals that health and orphanhood are the priority problems (23% each).

In terms of relevance, Project Malawi is perceived as mainly addressing health problems by Technicians (48%) and Local Authorities (26%). Orphanhood is also addressed according to technicians (29%), while it is not among the main concern of Project Malawi according to Local Authorities (18%).

All the project components were mentioned, and consequently rated by participants, with the exceptions of children corners, which are anyway a minor activity, and, more notably, of peer education. Considering the composition of the groups, which included education technicians and local authorities from target villages where MAGGA works, this omission is not positive and can only be explained by the low consideration and understanding of the peer education activities by the participants. DREAM was not mentioned due to the fact that there are no structures in Somba TA.

It can be noticed that all activities were rated positively in terms of sustainability.

In terms of effectiveness, both Technicians and Local Authorities rated highest the CBCCs component, and the result does not change even when the priorities associated to problems are considered.

n persons who know	Scores (absolute)	4	5	4	4	5	22			
	Scores (normalized)	0,18	0,23	0,18	0,18	0,23	1,00			
		Original output						Normalized and weighted		
	water	health	school	hunger	orphan hood	sustainability	sustainability	Contribution to address problems	Contribution weighted for problems priority	
<i>TECHNICIANS</i>										
4	CBCC	1	2	1	1	2	2	22%	33%	32%
2	HBC		2			1	2	22%	14%	15%
1	SUPPORT GROUPS		2			1	2	22%	14%	15%
6	VSLA		1		1	1	1	11%	14%	14%
4	IGA		1		1	1	1	11%	14%	14%
2	VCT		2				1	11%	10%	10%
	Total	5%	48%	5%	14%	29%		100%	100%	100%
	<i>LOCAL AUTHORITIES</i>									
8	CBCC	2	2	2	2	2	1	17%	26%	26%
8	HBC	1	2	2	2	2	1	17%	24%	24%
6	SUPPORT GROUPS	1	1	1	1	1	1	17%	13%	13%
3	VSLA		2	2	1	2	1	17%	18%	19%
4	IGA		2	2	2		1	17%	16%	15%
4	VCT		1				1	17%	3%	3%
	Total	11%	26%	24%	21%	18%		100%	100%	100%

The organizations providing similar services in Somba are:

- VTC: COPRED (Community Partnership for Relief and Development <http://www.hivos.nl/english/community/partner/40008628>) and Development Aid from People To People (<http://www.dapp-malawi.org/>);
- CBCCs: COPRED (Community Partnership for Relief and Development) and formerly GoMalawi (<http://go-malawi.org>)
- IGAs (pass on of livestock and provision of farm inputs): COPRED (Community Partnership for Relief and Development)

The group did not describe any relevant methodological difference between the approaches adopted by Project Malawi partners and the ones of the organizations identified above.

2.1.4 - TA Kapeni

In TA Kapeni 3 beneficiaries and community level volunteers were invited by mistake. They participated in the plenary exercises, while for the groups works of exercise 3, they joined the group of technicians. The composition of the group and the main deviations from the M&E requests are listed below:

- 6 representatives of Manjombe, Chigumula, Kumponda, Kameza, Mtema, Chitungu, Undani VDCs (Manjombe, Chigumula and Undani were in the list with other villages which were not present);

- No ADC representative;
- 2 officers from ministries (Agr/Vet and Gender -Children ...), while health was missing;
- 1 representative from 1 educational zone, out of 2 requested.

N persons who know	Scores (absolute)	6	6	5	4	21			
	Scores (normalized)	0,29	0,29	0,24	0,19	1,00			
		Original output					Normalized and weighted		
		Health facilities	Water	School (facilities)	Vocational skills	sustainability	sustainability	Contribution to address problems	Contribution weighted for problems priority
TECHNICIANS									
2	CBCC	2		1	1	1	17%	14%	14%
1	HBC	1	1			1	17%	7%	8%
0 ²	SUPPORT GROUPS	1		2	1		0%	14%	13%
0	VSLA	2		2	1		0%	18%	17%
1	IGA	2		2	1		0%	18%	17%
1	KAPENI VOCATIONAL TRAINING	1		1	1	1	17%	11%	10%
0	VTC	2				2	33%	7%	8%
0	CLINIC	2	1			1	17%	11%	12%
	Total	46%	7%	29%	18%		100%	100%	100%
	LOCAL AUTHORITIES								
4	CBCC	2	2			1	9%	15%	17%
3	HBC	2				2	18%	8%	9%
2	SUPPORT GROUPS	2			1	2	18%	12%	11%
2	VSLA	2		2	1	1	9%	19%	18%
2	IGA	2		2	2	2	18%	23%	21%
0	KAPENI VOCATIONAL TRAINING						0%	0%	0%
4	VTC	2		1	1	2	18%	15%	15%
2	CLINIC	2				1	9%	8%	9%
	Total	54%	8%	19%	19%		100%	100%	100%

The analysis of TA Kapeni reveals that lack of health facilities and water are the priority problems (29% each).

In terms of relevance, Project Malawi is perceived as mainly addressing health problems by both Technicians (46%) and Local Authorities (54%).

All the project components were mentioned, and consequently rated by participants, with the exception of children corners and, more notably, of peer education.

² According to data collected with exercise 2, none of the technicians was aware of the activity, so that the rating was probably done by the 3 community volunteers who joined the group to cope with the mistakes done with invitations.

Considering the composition of the groups, which included education technicians and local authorities from target villages where MAGGA works, this omission can only be explained by the low consideration and understanding of the peer education activities by the participants.

The livelihood skills training in Kapeni was mentioned and rated but, as it can be noticed from the first column on the left only one technician was aware of its existence and Local Authorities did not even rate it.

It can be noticed that some activities were not rated positively in terms of sustainability by the technicians group. These are support groups, VSLAs and IGAs. Nonetheless, if the first column on the left is considered, it will be possible to see that VSLAs and support groups are activities unknown by technicians, so that probably the community level volunteers were not able to make a technical judgment about sustainability issues, while for IGA the rating could be taken more seriously in consideration.

In terms of effectiveness, both Technicians and Local Authorities rated highest the VSLA and IGA components, and the result does not change even when the priority given to water and health is considered.

The organizations providing similar services in Kapeni are:

- VTC: Mulambe Hospital, National Association of People Living with HIV (NAPHAM), Government Structures, Development Aid from People To People, Matindi Youth Organization (<http://it.wiserearth.org/organization/view/1be90689a67d12eec9db1aa22587f9bb>);
- CBCCs: Sister Anna Tommasi (see 2010 field visit report)
- HBC: Government, Umodzi CBO (Lunzu), Matindi Youth Organization
- CLINICAL ASSISTANCE: Government and private health facilities

Some methodological differences between the approaches adopted by Project Malawi partners and the ones of the organizations identified above were described by the group. These are the provision of food by Project Malawi (with clinical assistance) and, again about clinical activities, the fact that Project Malawi is not experiencing drug shortages which are affecting other facilities.

2.1.5 - TA Chitukula

The composition of the group was consistent with the requests and is provided below:

- 14 representatives of Dzama II, Mlezi, Chiweza, Chikolokoto, Chitukula, VDCs (all of the villages in the list)
- the Chitukula ADC representative
- 3 officers from the 3 ministries (Health, Agr/Vet, Gender -Children ...)
- 3 representatives for 2 educational zones (2 requested).

Scores (absolute)	1	1	1	1	1	1	6			
Scores (normalized)	0,17	0,17	0,17	0,17	0,17	0,17	1,00			

		Original output						Normalized and weighted			
		water	household level poverty	schools and education	health facilities	diseases	community leadership	sustainability	sustainability	Contribution to address problems	Contribution weighted for problems priority
	<i>TECHNICIANS</i>										
4	CBCC		1			1		1	8%	6%	6%
6	HBC		1		1	1		2	15%	9%	9%
3	SUPPORT GROUPS		1			2	1	2	15%	12%	12%
3	BOREHOLES CBCC	1	1			2		1	8%	12%	12%
5	VSLA		2		1	1	1	2	15%	15%	15%
3	IGA		2			1	1	1	8%	12%	12%
7	PEER EDUCATION		2			1	1	2	15%	12%	12%
5	VCT		1		1	1		1	8%	9%	9%
7	TRAINING CBCC CAREGIVERS AND MAN. COMMITTES	1				1	2	1	8%	12%	12%
	Total	6%	33%	0%	9%	33%	18%		100%	100%	100%
	<i>LOCAL AUTHORITIES</i>										
8	CBCC	1		1				1	17%	6%	6%
7	HBC	1	1		1	1	1	1	17%	15%	15%
7	SUPPORT GROUPS				1	1		1	17%	6%	6%
7	BOREHOLES CBCC	1	1	2		1			0%	15%	15%
7	VSLA	1	2	1		1		1	17%	15%	15%
7	IGA		1						0%	3%	3%
6	PEER EDUCATION		1			2	2	2	33%	15%	15%
5	VCT		2		1	2	1		0%	18%	18%
7	TRAINING CBCC CAREGIVERS AND MAN. COMMITTES		1	1			1		0%	9%	9%
	Total	12%	26%	15%	9%	24%	15%		100%	100%	100%

The analysis of TA Chitukula reveals that the priority problems are

- water
- household level poverty
- schools and education
- lack of health facilities
- diseases
- community leadership.

The participants refused to perform the pair wise ranking of these problems. The argument was very good and was accepted. Participants pointed out that, in the first

brainstorming (exercise 1), they already made an effort to focus on key problems, as it was requested, so that it was not possible to select and rank them further.

In terms of relevance, Project Malawi is perceived as mainly addressing household level poverty and diseases.

All the project components, but Children Corners, were mentioned, and consequently rated by participants. DREAM was not mentioned due to the fact that there are no structures in Chitukula TA.

It can be noticed that some activities were not rated positively in terms of sustainability by Local Authorities. These are mostly activities which are actually characterized by the need of external inputs and competences, namely:

- BOREHOLES CBCC (which is not strictly a project activity but STC facilitated the initiative financed by UNICEF)
- VCT
- TRAINING CBCC CAREGIVERS AND MANAGEMENT COMMITTEES
- IGA.

Yet, in the case of IGA, participants explained that sustainability refers to the possibility of continuing an activity after the project end, reflecting its profitability, so that it raises some concerns.

In terms of effectiveness, Technicians rated highest the VSLA component, while Local Authorities rated highest the VCT initiatives.

Yet it should also be noticed that, if the three activities related to CBCCs (CBCC, BOREHOLES CBCC, TRAINING CBCC CAREGIVERS AND MANAGEMENT COMMITTEES) are jointly considered then their total score is above the one of VSLA and VTC for both Technicians and Local Authorities (30% and 29% respectively).

The organizations providing similar services in TA Chitukula are listed below, jointly with the main differences between their methodology and the one adopted by Project Malawi:

- Peer education (sexual and reproductive health): Family planning association (<http://www.fpamalawi.org/>). The differences are that they work in different areas, they do not target only young people and they are more concerned with family planning than with HIV.
- VSLA: Evangelical Lutheran Churches, Land o' Lakes (<http://www.idd.landolakes.com/>). The differences are that money are kept in the villages, not deposited in a bank account. This solution is considered by participants to be more sustainable than the one adopted by PM, due to the difficulties of reaching the bank after the project end.
- CBCCs: Landirani Trust (<http://www.landirani.org/>) and communities alone.
- HBC: CBOs and communities alone.
- IGA: Ministry of Gender

2.1.6 - TA Chimutu

In Chimutu 7 beneficiaries and community level volunteers were invited by mistake. They participated in the plenary exercises, while for the groups works of exercise 3, they formed a separate group whose result are not analyzed in the present report.

The composition of the group and the main deviations from the M&E requests are listed below:

- 5 representatives of Padzuwa, Chimutu, Kafulatira, VDCs (all of the villages in the list);
- the Chimutu TA ADC secretary;
- 3 officers from the 3 ministries (Health and Agr/Vet) while the social welfare office was missing;
- 3 representatives for educational zones, as requested.

n persons who know	Scores (absolute)	8	6	8	7	9	6	44			
	Scores (normalized)	0,18	0,14	0,18	0,16	0,20	0,14	1,00			
		Original output							Normalized and weighted		
		good water	few schools	health facilities	orphans not supported	lack of drugs	hh level poverty	sustainability	sustainability	Contribution to address problems	Contribution weighted for problems priority
3	CBCC		1		1		2	1	25%	33%	31%
3	HBC			1		1			0%	17%	21%
2	CHILDREN CORNERS								0%	0%	0%
3	VSLA				1		2	1	25%	25%	24%
1	IGA				1		2	1	25%	25%	24%
5	PEER EDUCATION							1	25%	0%	0%
4	VCT								0%	0%	0%
	Total	0%	8%	8%	25%	8%	50%		100%	100%	100%
	<i>LOCAL AUTHORITIES</i>										
5	CBCC		1		1			1	20%	13%	12%
4	HBC			2		2			0%	27%	31%
5	CHILDREN CORNERS				1				0%	7%	6%
4	VSLA				2		2	1	20%	27%	24%
5	IGA				1		1	2	40%	13%	12%
5	PEER EDUCATION				1			1	20%	7%	6%
4	VCT			1					0%	7%	7%
	Total	0%	7%	20%	40%	13%	20%		100%	100%	100%

The analysis of TA Chimutu reveals that lack of drugs is the priority problem (20%), followed by the lack of health facilities and water (18% each). If lack of drugs and lack of health facilities are jointly considered, then the health area is associated with a 38% score.

In terms of relevance, Project Malawi is perceived by Technicians as mainly addressing household level poverty (50%) and by Local Authorities as mainly addressing orphanhood related problems (40%). The relevance of Project Malawi to the problems of Chimutu TA is not very high.

All the project components but support groups were mentioned, and consequently rated by participants. DREAM was not mentioned due to the fact that there are no structures in Chimutu TA.

It can be noticed that some activities were not rated positively in terms of sustainability. These are CHBC, the Children Corners and the VCT, notably for both the Technicians and the Local Authorities. Sustainability was here understood in a strong meaning of possibility for the communities to continue the activities alone, also in the absence of government health offices assistance. Yet, this explanation does not apply to Children Corners.

In terms of effectiveness, Technicians rated highest the CBCCs component, while Local Authorities rated highest the CHBC and VSLA components. The result does not change even when the priority given to water and health is considered.

The organizations providing similar services in TA Chimutu are listed below, jointly with the main differences between their methodology and the one adopted by Project Malawi:

- CBCCs: CYDSE (Centre for Youth Development and Social Empowerment, a Malawian NGO). A difference is that they provide monetary incentives to caregivers;
- VSLA: Plan International (<http://plan-international.org/where-we-work/africa/malawi>);
- IGA : CYDSE. A difference is that they only target guardians of orphans, but this is not considered positive by the group;
- HBC: World Vision up to 2009 (<http://www.worldvision.org>). They made the training to caregivers but did not follow up their work , so that Project Malawi is considered to work better;
- VTC: CYDSE and Ministry of Health.

2.1.7 - Synopsis of the TA meetings

The tables below summarizes the weighted scores from the 6 meetings, offering a synoptic view on their results.

- Red (!) was used for activities supposed to be there in the TA but not mentioned and rated by participants
- Yellow was used for activities scoring highest in the TA
- Grey for the second classified
- Orange for the third

Components	CBCC	HBC	CHILDREN CORNERS	SUPPORT GROUPS	VSLA	IGA	PEER EDUCATION	KAPENI TRAINING	VTC	CLINICAL ACTIVITIES
TECHINCANS										
MSAMALA	17%	9%	5%	!	18%	!	20%		!	32%
CHITUKULA	30%	9%	!	12%	15%	12%	12%		9%	
CHIMUTU	31%	21%	0%	!	24%	24%	0%		0%	
MACHINJIRI	25%	7%	!	!	!	14%	36%		!	18%
SOMBA	32%	15%	!	15%	14%	14%	!		10%	
KAPENI	14%	8%	!	13%	17%	17%	!	10%	8%	12%
LOCAL AUTHORITIES										
MSAMALA	24%	26%	4%	!	11%	!	17%		!	17%
CHITUKULA	29%	15%	!	6%	15%	3%	15%		18%	
CHIMUTU	12%	31%	6%	!	24%	12%	6%		7%	
MACHINJIRI	26%	18%	!	!	!	12%	27%		!	18%
SOMBA	26%	24%	!	13%	19%	15%	!		3%	
KAPENI	17%	9%	!	11%	18%	21%	!	0%	15%	9%

2.2 - Partners meetings

During the final evaluation 3 meetings were held, one per each target district plus a session at national level, with the NGO partners of Project Malawi.

The structure of the meeting was the same for all the meetings with the partners asked to mention respectively their main achievement in Project Malawi II, their main failure and their dream for future activities.

The present paragraph introduces the results.

The lists of participants which will be provided below report the qualifications mentioned by the participants themselves. It can be noticed that they often differ from the ones foreseen by the project and the matching is not always straightforward.

2.2.1 - Balaka district level meeting

- Jonas Chisale, MAGGA, Training Coordinator Kapeni
- Goodwin Gondwe, MAGGA, District Coordinator Blantyre
- Chipso Limbuni, MAGGA, District Commissioner Balaka
- Samuel Thanganykia, SAM, District Commissioner Balaka
- Yusuf Kadwala, CISP, HIV/AIDS Facilitator
- Alik Mbewe, STC, District Project Officer
- Emanuel Zenengeya, STC, M&E coordinator
- Tiyamika Tambala, CISP, Business Consultant/ facilitator
- Darlington Thode, CSE- DREAM, Assistant Coordinator

	Achievements	Regrets	Dreams
CSE	<i>Failed to record</i>	Cover more villages (mobile clinics etc.)	Sustainability of dream centres Increase the outreach
CISP	VSLAs	Sustainability of BISC	Start up more VSLAs
STC	CBCCs	Missed opportunities for synergies, due to lack of territorial concentration (reference to CSE and MAGGA)	Covering the age target 0-5
MAGGA	Awareness created	<i>None reported</i>	Livelihood skills training in districts other than Blantyre

2.2.2 - Blantyre district level meeting

- Agnes Nkwanda - IGA Coordinator - CISP
- Wezzie Tenthani - HIV/AIDS Expert - CISP
- Maureen Kamponda - Community of Sant'Egidio - Centre Coordinator
- Patricia Kambewa – Community of Sant'Egidio - Kapeni Centre Coordinator
- Goodwin Gondwe – MAGGA / SAM
- Victor Kadzinje - Save the Children, Blantyre District Coordinator

	Achievements	Regrets	Dreams
CSE	Managed to save the lives of many people. In the hospital they cannot be all properly managed. HIV+ transmission less than 2%	Outreach clinic centres not in all TA (Somba not covered). Stop registering new clients and not able to take care of the husband in the same house.	Increment population served not only in Mandala but also in outreach centres. Increase what done in the field of malnutrition. Increasing awareness and information about HIV in the population.
CISP	Improved capacity of cooperation among partners. Pass-on approach VSLA groups accessing formal financing	Limited involvement with government officers Limited sustainability of IGAs, some IGA not able to sustain themselves.	Improving sustainability of IGA ³ Improving cooperation with governmental partners

³ According to CISP staff this should be done through non product-base IGA (pass on approach gives to the IGA group a service based meaning, since they do not produce animals, meet, milk for the market but provide a livestock breeding service at village level). Under this new concept the profitability is expected to be achieved at the household level while for the group it is enough to recover the costs necessary to ensure the sustainability of the service.

STC	Networking collaboration with other stakeholders Capacity building at local structure.	Retention of caregivers and volunteers drop out – issue of volunteerism lack of motivation Role of implementers, should be more facilitators than implementers	Implement all activities through the CBOs
MAGGA	Awareness increased in the target groups (reduced absenteeism and increasing performances), Dropped out back to school. Good integration with partners.	Retention of peer educators also due to the culture of buying participation (different standards for allowances and reimbursements also within the group of PM partners)	Move from peer education to patrol system. Increase partnership with stakeholders.

2.2.3 - Lilongwe district level meeting

- Madalitso Maunga, MAGGA, Community Facilitator
- Olivier Kabambe, CISP, IGAs/VSLAs expert
- Wongani Chimbali, CISP, HIV/AIDS expert
- Donnex Bengo, STC, Project Officer
- Annie Dambe, CSE DREAM, Assistant Coordinator

	Achievement	Regrets	Dream
CSE	100% children saved (PMTCT) low mortality rate less malnourished children.	set a clinic in Chitukula	like to expand the care among the people . Home visits once a week to be increased to visit all children.
CISP	Improved orientation to ownership made VSLA and IGA more sustainable	CISP haven't collaborated much with MAGGA – different locations haven't helped to do so.	max effort on sustainability and strengthening relations with MAGGA
STC	community mobilization.	not improved the structures of Chimutu CBCCs (not budgeted)	strengthen commitment of CBO to phase out
MAGGA	Considering not only school authorities but now also the local authorities.	peer educators drop out: the methodology failed	children themselves to more empowered: Patrol system

2.2.4 - National level meeting

- Francisco Zuze, CSE DREAM, Project Manager
- Nancy Michidzankufa, MAGGA, Director of Programmes
- Ruth Magela, MAGGA, Executive Director
- Emanuel Zenengeya, STC, M&E coordinator
- Matthew Pickard, STC, Country Director
- Moses Ngalo, CISP, Project Assistant
- Federica Servilli, CISP, Country Director

	Achievements	Regrets	Dreams
CSE	PMTCT (children negative at 18 months more than 98%) Government adopting the triple therapy, at the beginning it was refused, using DREAM data as backing.	Stop in registering new clients	various governmental partners and ministries making use of DREAM best practices, through activities addressed to have them using DREAM guidelines.
CISP	VSLAs, which also make IGAs stronger	not involved enough the Ministry of trade and industry which is key to BISC sustainability, involvement of government at national level missing or weak.	improved visibility and to be adopted as a model (CISP was approached by big institutions admiring what we are doing as partners in PM3)
STC	Support to community guardians All ECD programs of STC enjoying cross-fertilization from Project Malawi.	Lack of initiatives targeting the 0-3 age group Lack of collaboration (between partners?) to discuss how to manage volunteer gap between phases (institutional memory lost with the change of staff).	sustainability of the activities . Empower the village level structures (VDC and CBO) to sustain their activities.
MAGGA	capacity building consultancy improved and identified the weak areas and opportunity to strengthen the structure.	not systematic data collection. Lack of activities empowering the beneficiaries straight (not through PEs)	more empowerment of children and young people to increase sustainability of activities.

2.3– DREAM centres meetings

2.3.1 - Balaka DREAM centre staff meeting

- *Darlington Thode, clinical officer*
- *Mark, clinical officer*

The Centre is working regularly with some 90 new patients enrolled each month, and some 30 to 40 mothers each month included in the PMTCT protocol; the main problem they are now facing is a breakdown in the CD4 machine.

Relations with Balaka District Hospital are rated as very good; now the main problem facing their activities is the lack of fuel, hampering on one side the possibilities to reach satellite centres, on the other to receive regularly drugs from the Govt. Being the actual stock of drugs available in the store sufficient for just one week, it could become real the possibility of not being able to deliver drugs in the near future. The same problem applies also to test kits availability.

According to their views, synergies with other PM2 partners are very nice, with an exchange of clients between them. *“If we aren’t able to reach the people, the people will reach us”* : served population is perceiving PM2 as a single entity, the same project shared by many partners working together.

Of particular interest is their observation *“We saw the difference in working alone and working together with other people, that is beneficial in terms of recruiting patients and getting education”*. A significant help in this exercise of working together has been given by the PM2 office in Balaka, although now there is no coordinator and therefore is not easy as before to work together.

The approach adopted by PM2 to deal with the problem of HIV+ is considered the right one, with many workers approaching many aspects of patients’ life. An issue still unresolved is the one of properly approaching adolescents: resources should be found to organize activities in the Centre aimed to achieve this goal.

2.3.2– Blantyre DREAM centre and laboratory staff meeting

- *Mr. Lowole Matambo, DREAM administrator*

From the administrative point of view the main problems faced in the last period have been:

- the cost of reagents for the laboratory, very expensive and as such not always fully affordable (if possible help from other donors is sought for, for example in the sense of receiving free samples of reagents);
- the supplement of food, that is a very expensive challenge to maintain, requesting to squeeze the number of beneficiaries and the contents of the food packages. Some drugs also have to be bought; they are delivered lately but they never run out of stock;
- the cost of cars maintenance (two cars available, one for centre and outreach activities and the second for the administrative work in the office or for the centre);
- the soaring cost of fuel, just today increased to 380 MKw / liter for petrol and 360 MKw /liter for diesel from 290 and 270 respectively. Black market prices are in the order of 700 MKw / liter for petrol and 600 MKw / liter for diesel.

This entails an increase in the cost of life, evaluated in some 10% in the last three months.

- *Mr Bruce Tambwali, centre coordinator*
- *Mrs Maureen Kamponda, centre coordinator*

1) Achievements

- To have reached quite a number of clients, specifically in PMTCT, thus saving a lot of children, and having produced the best results ever in Malawi. The Govt itself said that that PM can be now taken as an example, considering the PMTCT results obtained with the tritherapy to all pregnant HIV+ women. This protocol is what DREAM adopted in the last years, with a transmission rate at 18 months less than 2%, “...*the best memorable result produced in Malawi*”.
- To have provided data on malnourished children to a delegation of World Bank with MoH officials during a visit to the centre the 4th November, to be used as a baseline to design their project.
- To have a laboratory offering first class performances (among them the PCR to diagnose HIV+ in babies) and lab facilities are made available also to QECH, due to the fact that their VL equipment is out of order and they aren't able to cope with all their patients (up to a maximum of 40 determinations offered for free), as well as to MSF Thyolo, MSF Chiradzulu and Blantyre Adventist Hospital. In the lab are also trained students sent by the College of Medicine.

2) Regrets

- Inadequate coverage of TA Somba, served much less than TA Machinjiri and Kapeni, because of distance.
- Reduction in enrolling new patients, accepting a maximum of some 60 new patients per month, and with more than a hundred a day refused because of lack of availability. The sad choice is done on clinical basis and on these criteria: first very sick people; priority lane given to patients referred by the partners of PM2; then QECH and other hospitals referrals; then on first arrived first served basis. For pregnant women needing PMTCT no limits apply, and priority is also given to their husbands if positive not to have children orphans at the beginning.

3) Dreams

- To have the project going on in order to be able to serve many more people
- To expand the project in other TAs and in other districts, and to ensure treatment to the people now worried by articles in the newspaper speaking about shortage of drugs.
- To help families where there are discordant couples .
- To increase awareness in the public about HIV-AIDS, because the feeling that everybody knows about HIV but this is not completely true

- To go on working hand in hand with other partners in the same villages served by other partners
- To have an impact concerning malnutrition.

▪ *Richard Luhanga laboratory responsible*

1) Achievements

- To have trained an adequate number of staff, all trained to perform all kind of tests in a rotation system that proved to be very effective
- To have in place a good quality control system

2) Regrets

- Not to have performed enough resistance tests (over 150 samples processed in Italy but less than twenty done locally, including a few coming from Mozambique).
- To have failed to join the system of accreditation of WHO and MoH because failing to attend one meeting and therefore rejected. Go back July next year.

3) Dreams

- To be accredited by the MoH
- To have two members of staff for each dept. (1-Reception and preparation area; 2-Biochemistry; 3-Hematology; 4-Molecular biology).
- To have backup instruments for CD4 and biochemistry.

▪ *Dina Tembo responsible of nutritional program*

1) Achievements

- Number of malnourished children steadily decreasing because of prolonged breast feeding policy. Now the children followed for nutritional problems are stable at 45. Food packages are distributed as before but the costs are raising. About 20% of patients receive a food integration, following a decision taken on clinical and social grounds by the doctors or the coordinators.

2) Regrets

- Still a lot of cases of diarrhea meaning that the issue of hygiene needs to be again and again stressed to the mothers. Complicated cases are referred to QECH but otherwise are treated at home.

3) Dreams

- To see even more reducing numbers of severe malnutrition cases, although it's difficult to change mothers' mentality, considering malnutrition as a normal thing .

2.3.3 - Mthengo wa Ntenga DREAM centre staff meeting

- Annie Dambe, Assistant Coordinator
- Davious Chimwaza, Lab Technician
- Annie Kanyemba, Nurse
- Martin Maulidi, Clinical Officer
- Francis Zuze, Administrator

1) Achievements

- To have 100% of children born from HIV+ mothers free of infection.
- To work together with other partners, particularly in TA Chitukula, where people served are understanding what PM2 is doing, differentiating what every partner does. This kind of cooperation will go on also after PM2 will be over, because clients came from different groups and these groups will go on.
- Most of the activities scrutinized met expectations of patients with the most modern technology; the best achievement registered is that number of deaths in PM2 patients, as well as in malnourished children, is decreasing.
- To Increment in scaling up of the treatment, because the population is seeing DREAM as a centre of excellence
- To be able to sustain ongoing activities, also when doing them with other partners as in Mtendere and Dedza, and enjoying trust from stakeholders and partners.

2) Regrets

- Not to be able to open new centres to reach more people and to achieve more integration with other facilities such as the Govt. ones, and this because DREAM offers services that Govt. is unable to offer.
- Not to have yet been able to build up a centre in Chitukula, because of absenteeism of the involved public, long distances to cover with lack of fuel and lack of funds to devote to the Centre.
- Mtendere centre gave a huge workload, thus maximizing the performances, but with a lot of clients coming from Mozambique attracted by the good name of the Centre not able to be accepted. There is only a single day when laboratory samples are dispatched from Mtendere, therefore involving a huge work to do; the possibility of sending more samples in two different days could significantly improve the service and the work could be better distributed, but this problem is compounded by the lack of fuel. The same applies also for Dzoole centre, working twice a week, but overloaded by people coming from Kayembe and wanting to go to Dzoole rather than in Govt. centres because the service is deemed better.

3) Dreams

- Like to see expansion of care in terms of quantity: more people being enrolled (now roughly some 15 to 20 new patients and some 5 to 10 PMTCT mothers per month; no more people can be enrolled because of lack of space and funds).
- To have another extension in term of working relationship with other partners to assure sustainability.
- Not to run out of stock because of lack of reagents or drugs, as today happens more and more: as per now, no reagents for biochemistry, and suppliers in Lilongwe do not have them because of forex issue.
- To integrate with Govt. centres like is done in Dzoole. Capacity building to work together in terms of training and materials, as the University of North Carolina investors are doing in Kamuzu Hospital or John Hopkins in QECH, working together with the Govt. hospitals, where many players are working in the same project as a single team and in such a way putting together the scanty available resources.
- To have some back up machines of the same standard of the one available in laboratory. It's actually a nonsense to have a manual machine to back up an automatic one, having a much higher capacity (automatic CD4 machine: 180 samples per hour; manual. 20 samples per hour).
- To add a new building for the partners to work together, such as the one in Kapire. Their approach is actually different from that of other partners getting money from the Govt. also as far as allowances management is concerned. This idea – setting issues of allowances and working philosophy - should be realized in PM3, aiming to link together better DREAM and Govt. hospitals.

2.4 - Interviews

Dr. Mary Shawa, Principal Secretary, Office of the President and Cabinet on HIV/AIDS and Nutrition

“I’ve seen the project changing from being individualistic to be a group”. This has been the first statement of Dr. Shawa, urging to further develop a new project to have a still better product. Her only worry is *“... what we have not been able to prepare adequately is the training manual”*, where to specify who is who in the project, what the partners do, which is the task of every single organization, in order to serve as an example for other organizations wishing to work together as PM2 has done. Actually, *“...in Lilongwe they have been able to act as a team ... and also other projects rush to see what PM does just to learn from them”*. There are still partners working on their own but most of the activities are done together.

A problem left open is the one of harmonizing the service delivery and training; e.g., in a documentary about nutrition produced by DREAM it is still referred to 3 food groups and not the 6 groups now defined by the Nutrition Dept., and this is even more worrying if we consider that in the next PM nutrition is not there. Actually, there is another way to go round this problem: to find out another partner working with nutrition, thus solving the problem.

The draft of the training manual is a very positive accomplishment, just needing to be finalized and printed; next stage is developing a monitoring tool in order to check the

different people delivering the same service. Malawi govt. considers PM as one of the most innovative HIV undertaking because it has been able not only to motivate the people to undergo HIV testing, but also to handle the positive ones and the orphans, in this project assisted in many ways by different partners.

Second point, Malawi Govt. doesn't have any state of the art molecular biology laboratory able to extend the knowledge on HIV in the Country, while DREAM has been able to reach more than 15.000 people with some 50.000 people reached through the network. Pregnant women have been assisted in a very innovative way to reduce malnutrition and to help reducing virus transmission. Going on as well with breastfeeding and having maternal mortality in the cohort assisted at 0,03% and infant transmission at 1,5% it is something very important. On the other hand the project contributed to adopt WHO guidelines bringing the starting endpoint of therapy to 350 CD4, and on top of that improving capacity building for laboratory technicians and community workers to take care of their own progresses within the communities. It has also been appreciated the fact that laboratories have formed a network between various maternity centres.

DREAM laboratory is the only one doing resistance analysis and able to detect seral status of individuals within 6 weeks from infection using PCR systems, and the project is able to track the mothers after delivery of the baby. Malawi Govt. is emulating this example of tracking mechanism.

Another best practice is the use of activists, very unique in Malawian panorama, letting them to feel and gain the confidence of the public.

About MAGGA activities it's significant that through them youth are more than ready to do the VCT testing, as testified in the Limbe centre full of youth all the time because it's felt as an especial service to them. *"You can't close it, it's ours !"*

STC set up people on how to take care of children. Properly caring about issues of development and interactions with friends, and following children up to school, they grow up children that are performing in the school better than other children, with less drop outs compared with those that have not been trained in such a socialization.

"To be honest this is a very good project": to accomplish it there is the need to produce a manual to monitor what has been done and to prepare other people to follow this example, an operational guide to document this experience, where all partners have been trained in one single approach. *"When you are grown in a family you are not divided in many parts, therefore the mutual comprehension is very critical".*

Dr. Frank Chimbandwira, Director HIV Unit, MoH, Lilongwe

DREAM has a lot of interaction with the HIV unit, and much involvement is devoted to check how the project is evolving. Interactions involve on one side the supply of drugs and reagents when available, on the other one the notification of working data as never done before. Still more effective are interactions in priority areas like research: in this field the WHO proposal – letter of intent sent to HIV Unit, inviting institutions conducting research in PMTCT, is quite encouraging. Relationship are improving on and on, and they appreciate DREAM openness of mind and readiness to involve the Unit. *"We wish to support them because of that unique advantage in patients monitoring through laboratory services that are strongest than any other institution in the Country".* HIV Unit will go on supporting DREAM with reagents and laboratory services, although now there are limitations (lack of forex → reagents lack) and some few issues with Global Fund that is reluctant to release funds to buy reagents. The extension of the program to PM3 is a good news because HIV will not stop for ages to come, and partners supporting the fight will be always welcome.

Dr. Ruben Mwenda, Deputy Director Health technical support services (Diagnostics), Ministry of Health

A positive note is the ongoing cooperation in the process of developing a memorandum of understanding between DREAM and MoH for supplies of laboratory determinations. Collaboration and communication is ongoing, with DREAM participating in the MoH meetings and taking part in the elaboration of the Govt. five-years laboratory strategic plan, *“and we appreciate it so much”*.

Mzimba laboratory is not yet in full operation and has not yet been handed over, because of some weak equipment in the CD4 machine, having problems with an used and not operational autoanalyzer.

In summary they are thankful to DREAM initiatives and hope that more will follow, being always ready to support DREAM to help patients and people in need of HIV care. No criticism is put forward, just long term capacity building has not yet been seen and sustainability on the long run has yet to be improved. A possible suggestion could be to implement Masters PhD's courses within the institution, to breed some high level laboratory experts.

Dr. Owen Chikwaza District Health Officer Balaka

His overall evaluation on DREAM activities in the district is at the highest mark. He considers the Balaka DREAM centre as an ideal facility for treatment, such as all the Govt. ART clinics in the district should be like this, actually only just a “dream”. This because, according to his words, *“the quality of care is well beyond the public facilities”*. Cooperation between his office and DREAM is defined as *“excellent, we are working hand in hand”*. Also the existing differences between protocols are *“on the positive side”*, with the Govt. approaching those of DREAM if not for the lack of funding. His wish is to have more facilities available, in the sense of more satellite centres attached to Balaka DREAM centre.

Dr. Amos Msekandiana, District Health Officer Dowa

The DHO has been very recently moved from Blantyre to Dowa, hence he has no much acquaintance with the service rendered by DREAM in Mthengo wa Ntenga, but he knows well Mandala DREAM centre.

Up to now in any case no problems have been reported in the service agreement in MwN: management is proper and there are no problems open. *“They are working very well, price are quite reasonable, the management is good and they are doing a good job”*. The public gave high appraisal of the service rendered and the training of the staff, very good in comparison with other services given in the Country or in some other mission hospitals. Up to now he has not yet checked in details on the ground the PMTCT management.

Blantyre Mandala centre is one of the great models to be taken against HIV discrimination: no more stigma is felt among patients, that are managed very well. The partnership between DREAM and Blantyre DHO is very good, and when there he allowed the staff to be used in Chileka maternity to improve services in that area. A further improvement could be an help in building new infrastructures in Blantyre area, in carrying out updating courses and topping up to the staff undergoing further studies.

Mr. Peter Chisoni, Blantyre City Council, Assistant Director of Health

According to Mr. Chisoni the overall impact of PM2 on Blantyre city is “quite a lot” although it turns out to be difficult to appreciate what every single partner is actually doing. In detail, they are aware of the activities of STC and CSE-DREAM.

About STC in the health sector the perception is that their main role is to take care of realizing and funding activities in areas where the Govt. has no funds to allot; his appreciation is that in handling their projects their impact is very high, and that “...they not just make noise but show their actions”.

About CSE-DREAM activities the main issue is that they haven’t done too much in collaboration with the City Council. In general, NGO should know how to collaborate with local authorities not only because this is requested by donors. Only some of them collaborate from the beginning, realizing late the need of cooperating with the City Council that can give some guidance specifically in the sense that the Council, having an overview of all activities in place, can help the various organizations on the field to meet the different demands and to coordinate different actions. Working more closely in interaction, proposing new projects and injecting more ideas can complement what the Council is already doing.

Speaking more in detail about CSE-DREAM activities, his comment is that these are not as many as the Council would like to have together in place, but nevertheless they heard a lot of positive appreciations about DREAM. by the population served. Although cooperation is not so developed the Council is nevertheless able to fully realize and deeply appreciate what they have done. The wish for the future is to improve cooperation and communication: there is a strong need to share more information for the sake of beneficiaries themselves.

Prof. Jan Van Oosterouth - Vice President Dept. of Medicine – Blantyre Medical College - Consultant HIV Unit

Generally DREAM is well known for the good quality and the decent level of patient comfort, mostly if compared with public facilities. Actually, patients going to most of the Blantyre hospitals must face huge queues just to be visited for a couple of minutes by the clinician, if at all they are lucky enough to meet him, while DREAM patients can enjoy a good comprehensive and comfortable HAART care together with food support that most clinics cannot afford. Their protocols are at 97% similar to the national ones, thus having a fairly uniform therapeutic approach using national guidelines. One exception is the way of delivering PMTCT, where DREAM has been in the forefront leading the way to the national policy that now is even a step further in front to DREAM, considering that national programs now foresee universal eligibility for ART, to be prolonged through breast feeding and going on lifelong. Among the many reasons to adopt this policy over and above is what DREAM used to do.

Second point concerns monitoring HAART, with DREAM adopting a very extensive monitoring where most Hospitals have an extremely limited one. DREAM adopts CD4 and VL tests to decide when to start, according to national guidelines although a bit modified. These guidelines now switched to VL monitoring every two years, somewhat following DREAM example, although this move is not much realistic considering that for example in QECH there are just three machines for VL, one broken, one not for general use (John Hopkins research program) and one at not affordable prices (Wellcome Trust private setting). While the new guidelines provide for VL instead of CD4 monitoring, public hospitals are struggling to introduce this guidelines hampered by logistic and financial problems. DREAM laboratory turned out to be very helpful over the years to confirm and to provide for free VL determinations: QECH is

actually not relying only in DREAM for its VL testing, but nevertheless it is obliged to do so.

Third point is represented by the resistance testing, where DREAM acts as the only reference laboratory available in the Country, now unfortunately working only as research program. It is certainly good to have resistance tests done, on condition that DREAM would communicate with HIV unit to share the results and the studies.

Just a little point of critique is about clinical documentation given to DREAM patients, fully detailed in their files but not registered in the patients' health passport. This is of paramount importance if the patient must seek care elsewhere, otherwise there would be no details on treatment given for other doctors. This move could really add value to DREAM program.

3 Analysis of the progress reports

3.1 - Comunità di S.Egidio

CSE – DREAM produced two reports, the standard 9th fourth-month report discussed in this chapter and a comprehensive one dealing with the overall results and impact of CSE-DREAM in PM2 ⁽³⁾, analysed and discussed in chapter 4.1.

The 9th report details activities performed in the reference four-month period (1 June – 30 September 2011), is written partly in Italian and partly in English, and includes an annex 4, extending on 6 pages structured according to the project scheme, annex 5 (Gantt), annex 6 (indicators), the integrated financial plan together with an explanatory document, and the following mission reports :

- **Ulderico Maggi**, Coordinator, July 2011, reporting on Balaka clinical centre
- **Massimo Leone**, Medical Doctor, July 2011, detailing coordination and clinical activities and teaching given in Balaka and Kapire
- **Stefano Orlando**, Coordinator, 24 July – 11 August, detailing supervision activities in Blantyre office
- **Maria D’Angelo** and **Francesca Balestra**, Coordinators, August 2011, reporting on Blantyre, Chileka and Machinjiri activities
- **Annie Kaniemba**, Nurse, August 2011, reporting on Mtendere activities
- **Maurizio, Federica, Laura**, Coordinators, 14 August / 3 September 2011, reporting on Mthengo wa Ntenga activities
- **Piero Mosca**, Medical Doctor, August 2011, detailing clinical activities and teaching given in Balaka, Kapire, Namandanje, Blantyre, Mthengo wa Ntenga
- **Annalisa Schiavon**, Coordinator, August-September 2011, giving a report of a mission of volunteers in the DREAM Centre in Blantyre.

Of particular interest is that in many of these reports comes out clearly what can be considered the most distinctive feature of DREAM work, i.e. the transmission - through the personal involvement of the expatriates in mission - of a peculiar “style” of relationship with the patients. *“We have to teach how to work...”*; *“...we worked with them [the local staff] trying to show how to do the job”*; *“... to do this job you need also a tutor and not only a theory”*. It goes without saying that this is the best legacy the DREAM staff can leave to the Malawian staff, beyond all considerations on sustainability reported thereafter.

One sign of this involvement can be got from the report from the nurse Annie Kaniemba reporting on the “dreams” of the youngsters in treatment in Mtendere centre, two of them wishing to be doctors: this goes well beyond just distributing drugs.

On the clinical point of view is relevant the work done by the two medical doctors in mission during this period, and dealing the first (Massimo Leone) with the problem of children affected by severe malnutrition, usually associated with diarrhea, the second (Piero Mosca) aiming to give the clinical officers a more sound knowledge on a series of clinical diagnoses going from neurological to pulmonary to cardiac and renal pathologies.

Is this exactly the sort of clinical attention to the single patient, beyond the generic adherence to the protocol, we emphasised since our first reports. As a counter evidence

of this observation can be quoted the main criticism moved by one of the doctors to the staff in MwN, where the CO “...follow rigidly the protocols ... in a bureaucratic way... there is a scarce interest in tailoring the care to the needs ... clinicians are involved in a routine where there is no passion neither for science nor for patients”.

Moreover, if we consider that both medical doctors as well as the coordinator Maggi underline the heavy impact of infant malnutrition in the area of Balaka, it could be considered the opportunity of a synergy between the DREAM centre and the brand new dept. of Pediatrics of the Balaka Community Hospital located in the same compound.

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Following observations will be related to the narrative contents of annex 4 and indicators reported in annex 6, jointly analysed in order to follow the schema utilised in the report.

Item 1.1 and **Item 1.2** give technical details on the report.

Item 1.3 Supplementary funding, deals with contributions offered by other donors to the project. As in the previous reports this paragraph is the photocopy of the similar ones already presented, dealing with the contributions collected in 2011 for a total of 508.000 euro and equalling the 25,4% of the yearly budget of the project. For this reason we refer to what already stated in our previous report (8th), specifically as far as long term sustainability is concerned.

Item 1.4 Expected results, emphasizes how the project evolved in the last period, with a trend we represented graphically in the following tables and figures, completing those presented in the 8th report. It is also quoted the start of Mzimba laboratory, now only partially active because of lack of some equipment, as stated in the interview with Dr. Mwenda and Dr. Shawa previously reported in par. 2.4.

Item 1.5 of the report details the **activities performed** according to the Gantt structure.

Result 1.1 Health Centres strengthening

1.1.1 Blantyre Laboratory drug resistance test

No new determinations have been done in the reference period. A new research protocol has been approved, scheduled to be implemented during PM3.

1.1.2 Strengthening of the home-based care services

The paragraph focuses mainly on what already stated discussing the mission reports, i.e. the typical feature of CSE DREAM approach style: care devoted to the patient, responsibility, decision making. It must be recognised that this is actually of paramount importance while intervening in the medical field in Africa, a patient-oriented capacity building whose importance goes well beyond the mere procurement of structures and drugs.

1.1.3 Strengthening liaison between Health Centres and their satellite centres

Details on activity are given about the satellite centres of Kapeni and Mtendere. The former is working nicely particularly as far as cooperation with other partners is concerned, as stated also in Annalisa Schiavon's report where it is significantly stated that *"the cohabitation between different realities makes more complete each one's intervention"*; about the latter it is emphasised the good relationships with the new management. On the contrary no data are given about the situation in Masuku – Mulibwanji Hospital, reported as critical in our last field visit and apparently worsened since then, as stated also in the National coordinator report.

About the maternities linked with the centres, of the 11 in activity [Mthengo wa Ntenga, Dzoole, Mtendere, Balaka, Namandanje, Machinjiri (BT), Chileka (BT) Chirimba (BT), and the last three where only info about the project are given, Mponela (Dowa district), Kankao and Chindausika (Balaka district)] details are given about those of Machinjiri and Chileka. The main problem in Machinjiri is lack of space, and the same problem is present also in the partner centre owned by World Alive; notwithstanding these limitations the work is increasing in an appealing environment, as stated in the coordinator's report. Yet more interesting is the report about Chileka, a maternity centre working in cooperation with a ART centre run by the Govt. and overwhelmed by patients. The report underlines the good cooperation with the staff of the centre, to such an extent that the experience started in Chileka is judged as a possible new model of synergistic cooperation the public and the "private". In this model CSE-DREAM has got the task of training the staff and providing the laboratory facilities, the Govt. the provision of the staff: in such a way it could be possible to offer the two highest assets of CSE-DREAM, the laboratory and the "style", of which something has already been said before, as well as to guarantee the sustainability of the project also with a "lighter" direct commitment of CSE-DREAM.

Result 1.2 Start and strengthening of satellite centres

Result 2. Strengthening of assistance programs towards adults and children affected by HIV/AIDS

No further details are given about these results.

Result 3. Spreading of the prevention activities scheduled in the MTCT programme – Prevention and Care Mother & child

3.1 HIV testing campaigns and women counselling

Activities go on as scheduled, with an increase related to the higher number of maternities involved.

3.2 Realisation of PMTCT protocols.

Impact results on this topic are discussed in chapter 4.1.

Item 1.6 is devoted to the **coordination with local partners**.

What stated in this paragraph is highlighting the level of “oneness” reached between PM partners, testifying an enormous step forward since the beginnings of PM1. The partnership within the members of the project reached so high a level that, as clearly stated in the report, *“the idea of working together is important not only to the partners of PM but also to the Government”*. Actually the Govt. officials now are considering PM as a single entity and not as a tangle of four different organizations; again, as happened in Chileka taken as an example of possible cooperation public / private, the model offered by the partnership of actors in PM2 has been proposed as an example *“to encourage other organizations to emulate this approach”*. The various examples of activities done together with other PM2 partners testifies how this attitude is actually put in practice and not merely sought for. Of particular interest in this connection are the joint activities ongoing in TA Chitukula, that could represent an extremely interesting model of sustainable joint project, replicable also in other TAs.

On top of the coordination with other PM2 partners it is noteworthy the cooperation offered to the Govt. activities in terms of know-how and research of new strategies against HIV-AIDS (new PMTCT protocols – praised also by the First Lady -, national guidelines on sample transportation, activists involvement, nutrition policies, laboratory plan, and so on). It is actually the top characteristic of CSE-DREAM activity in Malawi, quality and not quantity, in a joint venture with the national policies that must be praised.

Item 1.7 deals with **risk analysis**.

The risks quoted in the report have as a key words *“lack of fuel”* and *“political tension”*, endangering clinical activities that could not only be “slowed down” – as optimistically stated – but positively hampered in the not so long run. Actually, as already detailed in par. 1.2., the Country is facing a political crisis whose consequences are not yet clear, but nevertheless worrisome. We actually had the opportunity of witnessing directly the logistic problems caused by the lack of fuel, being forced to reduce our movements and to cut the visit plan previously adopted; still more worrying are the rumours picked up during the visit about the explanation offered by the President to this situation: *“Under my rule Malawian economy grew up so much that everybody was enabled to buy a car, therefore there is shortage of filling stations and the need of waiting in queue to get some fuel”*. It could be a rather humoristic joke, if it would not be in reality an ominous one.

Conclusions reported in Item 8 focus on the impact of CSE-DREAM best practices on the national policy about PMTCT, highlighted also by the First Lady in her UN assembly speech.

3.2 - MAGGA / SAM

Result A - Increased number of young men and women (10-25 years) accessing and utilizing Sexual and Reproductive Health including HIV Testing and Counselling (HTC) Services by 2011

Activity A.3. Offer HCT Services to young people:

A total of 166 young people accessed the HTC services at Limbe resource centre during the period. Kits were provided by CSE. Shortage of condoms was registered again.

The chart below shows the number of tests offered in each period during PM2 and their cumulated values, revealing a important gap between the target of 3000 and the achieved number.

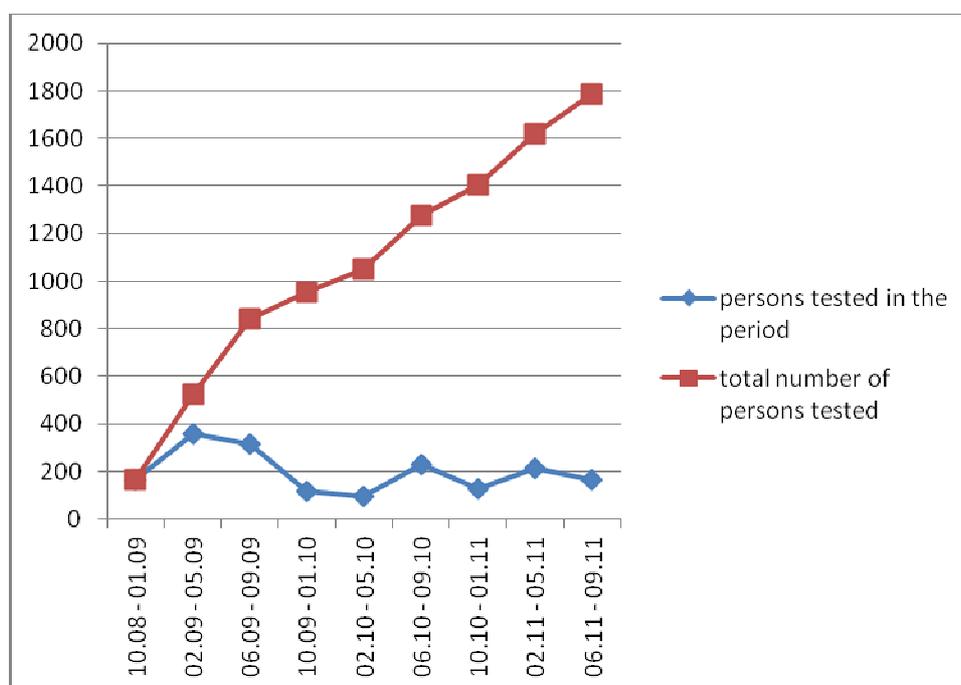


Fig. 3.1. - Number of tests offered in each period during PM2 and cumulated values

All the indicators for result A but the one related to the number of tests offered are above the expected values.

As already noticed, the indicator about the number of tests is the only one filled using data directly recorded, while all the remaining indicators for this result are based on projections of an interviewed sample, whose construction remains unclear.

Result B - Increased Coverage of Life skills Education for young people, in- and- out-of-school by 2011

It was noticed in the previous report that the total number of units/schools declared by MAGGA as reached was 175 when the target was 150. This seemed to be not appropriate to the M&E team, since the unavailability of trained peer educators and the difficulties encountered in providing an acceptable monitoring to the peer education activities by MAGGA staff make it clear that investment should be made on quality and not on quantity.

The answer of MAGGA did not clarify the reason of this increase.

B.3 Conduct peer education sessions

MAGGA report states that Peer Education “was mainly conducted by patrol leaders with the assistance of Guide and Scout leaders and the few remaining peer educators”. It is not clear how the patrol system was set up, how the patrols were selected, which is their number.

B.4 Establish girl guide units and scout troops in ECDCs

The report from MAGGA states that Girl Guiding and Scouting activities were on-going in 40 CBCCs (13 Blantyre, 14 Balaka and 13 in Lilongwe).

It is not clear how and if the drop out of peer educators affected the CBCCs, who is carrying out these activities and how these centres will be covered under the new approach, based on the patrol system.

Indicators for this result are positive but fails to fully capture the qualitative dimension.

Result C - Increased number of orphaned and other vulnerable young people socially and economically empowered through vocational/entrepreneurship skills by 2011

C.2 Train young people in livelihood skills

The training was completed at the beginning of August without experiencing further drop out. The Association has trained a total of 79 young people in PM 2.

MAGGA report also describes some initiatives that were taken to help the graduated to start their working activities.

C.4 Support trained orphans with livelihood starter packs

MAGGA states that starter pack for the last intake of trainees will be purchased after the end of the project, following the last instalment from donors. This sounds strange because costs incurred after the end of the implementation period are not usually eligible.

Indicator 1 “90 orphans and other vulnerable young people reporting having been economically empowered through vocational skills training”, is below the target (79/90).

Result D - Strengthened capacity to implement, coordinate, monitor and evaluate SRH/HIV and AIDS response in impact districts by 2011

D.4. Quarterly (ex Monthly) review meetings

Quarterly review meetings at district level were conducted in all the three project districts in the month of May 2011 and then again in June.

D.5 Monitoring and supervision visits

The Executive Directors and Chief Commissioners for MAGGA and SAM conducted Monitoring and Supervision visits where they also distributed the procured bicycle tyres.

Zones based review meetings and visits to schools were conducted as shown in the table.

	N of schools visited	N of zones visited
Blantyre	2/77	3/7
Balaka	8/46	2/4
Lilongwe	2/52	2/5

The situation is now the following:

- In Blantyre there are at least 41 schools which were never visited in the last 16 months
- In Lilongwe there are 21 schools which were never visited in the last 16 months
- In Balaka there are at least 9 schools which were never visited in the last 16 months

The worst situation is in Blantyre.

Indicators were poorly computed and difficult to be interpreted but it can be noticed that

- answering the questions raised by the 8th M&E report MAGGA specified that the number of persons reached with school authorities re-orientation was 1108, which is above the expectations.
- the number of monitoring visits remains very low

3.3 - Save the Children

Even if it is clear that there is a lot of work behind STC reports and they always try to provide answers to issues raised in the M&E reports, this effort is not very effective.

Reports and clarifications sometimes look like referring to budgets and activity plans which are not the same which were submitted and approved.

Many inconsistencies can be found between one annex and another.

This was the case for the issue about the positive living / HBC training or for the bicycles devoted to CHCB volunteers or CBCC mentors.

This might be due to some gaps in the communication between the staff implementing the project in Malawi and the Italian headquarter, which are also likely to affect the overall management and governance of the project, at least in terms of efficiency.

Save the Children reports that devaluation of the Malawi Kwacha and some savings from construction line led to excess budget which enabled the project to accomplish to implement some unforeseen activities, namely, according to STC report:

- 1 community mobilization session involving 40 participants (40 males and 10 females) “in new area in Lilongwe”. It is not clear what “new area” means;
- 2 children’s retreats organized;
- refresher sessions for 20 CHBC volunteers;
- and 1 positive living training session involving 27 people (22 females and 5 males). This was reported as unforeseen but it was foreseen, even in the absence of excess budget;
- purchasing of CBCC construction materials to rehabilitate two additional CBCCs in Balaka district (Kapalamula and Tchaidon).

Result A. Increased access to PSS and CHBC for OVC and the chronically ill

A3 Conduct Children’s retreats

According to the budget for the third year, resources are available for 7 retreats of 70 children each, for a total of 490.

Even if 8 retreats were held with the participation of 542 children, and the activity was considered concluded, the project conducted 2 retreats in Lilongwe in the last reporting period with 172 children (90 boys and 82 girls).

Annex 4 does not provide information about children clubs but an increase in attendance is shown by the progress of the related indicator in Annex 6.

A4 Training on Community Home Based Care

The project had already trained all caregivers as was planned, nonetheless in Lilongwe district a refresher workshop was conducted for CHBC volunteers (20 volunteers were trained but not counted by STC in the corresponding indicator annex 6, because probably they were the same persons already counted when they received the first training).

A.5 Provide material support for CHBC

STC tried to provide clarifications about bicycles provided in the previous period to CHBC volunteers but the situation is not yet clear. 36 bicycles (12 in Lilongwe, 10 in Balaka and 14 in Blantyre), instead of 18 foreseen, were provided to CHBC volunteers for supervision of patients, while it is not clear if CBCCs mentors received any bicycle (18 foreseen).

In Lilongwe and Balaka Districts, the district Health Offices, through health centres, supplied drugs for community home based care, but in Blantyre District there was general shortage of supplies during the reporting period.

A.6 Positive Living training for PLWHA support groups

During the reporting period the project trained 27 people in positive living and these were drawn from support groups in Balaka. According to the report this was not foreseen and was done thank to excess budget made available by the devaluation of the Malawi Kwacha calculated during the last month of the project and by some savings from construction line items.

Nonetheless more than 14.000 € were allocated to this activity in the third year budget and training was foreseen, even if STC never quantified the expected number of trainees. As a consequence the corresponding indicator cannot be computed.

Indicators related to result A are quite positive, but Blantyre District is often below the targets in all fields: PSS (including training and children corners), HBC.

Result B: Improved quality of ECD services that protect and promote children's development

B.1 Conduct training for CBCC caregivers and Management Committees

Main activity during the reporting period was training of centre management committee members from 5 CBCCs in Blantyre where numbers were lower than other CBCCs. 30 Centre Management Committees members were trained (5 males, 25 females).

B.2 Provide material support to CBCC

According to the report construction activities for 13 CBCCs in Lilongwe and Balaka were completed (8 CBCCs in Lilongwe and 5 CBCCs in Balaka).

However, 2 more CBCCs of Kapalamula and Tchaidoni in Balaka have been supported with construction materials procured using funds gained due to devaluation of Malawi kwacha and under expenditure on constructions. Renovations at these 2 CBCCs are currently underway.

The report from STC also provide some detail about the harvests from CBCC gardens, already reported in the previous report.

	A	B	C	D (D=C/B)	E	F F=B/E	G	H H=B/G	I I=H/75gr
district	N. of CBCCs provided with farm inputs	Actual harvest (kg)	Expected harvest (kg)	Ratio expected to actual	Number of acres	Yeld (kg/a)	number of children	kg pdc	number of meals (75 gr)
Lilongwe	15	11650	na	na	na	na	1232	9,45616	126,082
Balaka	11	2830	6000	0,4717	8,1	740,740	865	3,27167	43,6224
Blantyre	32	5950	7600	0,7829	19,25	394,805	1861	3,19720	42,6294
total	58								

The table below summarizes the data provided by STC and makes some computations on them. The number of meals resulting shows that this activity of supporting CBCC gardens have a real potential and, even under the suboptimal conditions that will be described below, proved to be important to feed a number of children.

The report from STC also provides the following additional information about the last reporting period:

- In Lilongwe all CBCCs were able to feed children regularly
- In Balaka the main problem was that the district experienced sporadic dry spells and erratic rains in the months of January, February and March which were critical months for maize production. Only 4 CBCCs manage to feed children regularly, apparently with contribution from households.
- In Blantyre, only Kapeni was hit by spells of inadequate rains but anyway only 11 CBCC are able to feed children regularly mainly due to poor management.

It can be noticed that 58 CBCC out of 62 were provided with inputs, while only 18 were foreseen.

Most of the indicators related with result B are below the targets:

- Number of people trained (Caregivers and Centre Management Committees members)
- CBCC attendance and total enrolment
- N of CBCCs regularly providing food and meeting the government standards.

It should anyway be noticed that this is mostly due to the poor performances of the third year, when particularly difficult conditions were experienced (fuel shortage, poor harvests) and whose targets were ambitious.

Result C: Strengthened community capacity to support children affected by HIV and AIDS

C1 Community mobilization trainings and sensitization

The project trained 40 more community members (30 male and 10 female) in community mobilization in Lilongwe District.

In addition to this, Blantyre, conducted 6 community mobilization meetings.

C2 Support Community networking and exchange

The project supported a total of 17 networking meetings; 4 in Blantyre, 7 in Balaka and 6 in Lilongwe. In Lilongwe, Chiwedza VDC was isolated to have performed very well. It has managed to mobilize resources, proper coordination of structures, modern and permanent CBCC infrastructure and to obtain a registration certificate as CBO with department of social welfare.

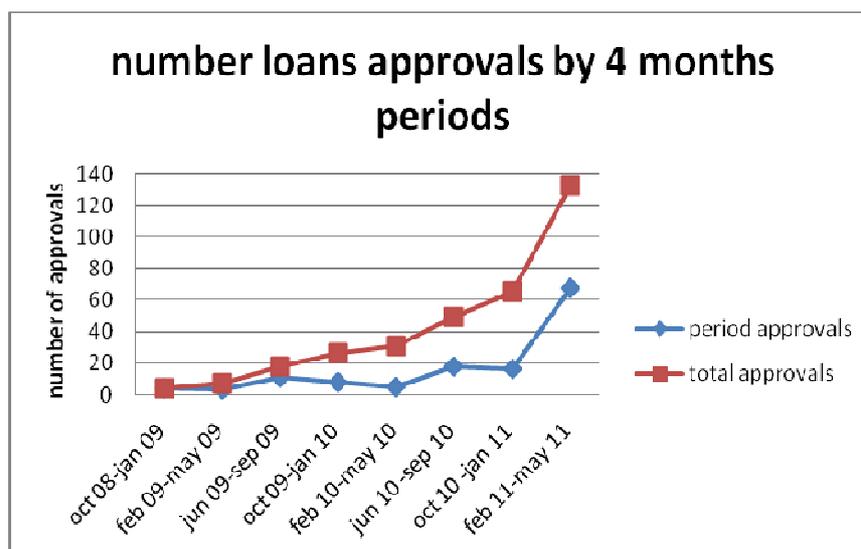
Indicators for this result are positive, with the exemption of the number of community leaders trained in Blantyre which is very low and below expectations.

3.4 - CISP

Result A. Through the BISC, assisted at least 400 entrepreneurs to develop their businesses in a sustainable way and at least 120 entrepreneurs with loan access from MFIs.

A.2 Support entrepreneurs to access loan facilities and monitor their performance

In Lilongwe 4 loan applications have been presented to MFIs in the period and remain pending, whilst the total number of approved loans remains the same.



CISP clarified that confusion about repayment rates resulted from the joint consideration of PM1 and PM2 data, with the relevant figure for PM2 remaining around 95%.

A.3 Establish collaborations and implement a plan for Blantyre BISC sustainability

For the purpose of identifying a BISC sustainability strategy one more consultant was contracted: *Ex-Change*. CISP reports that the conclusions of the consultant were in line with BISC's own thought process with two routes to sustainability:

- one is to seek further donor funding to continue operating,
- the other is to seek support from a large private sector player such as banks or MFI so that it can operate as an independent service provider.

CISP also reports about another consultancy and another business plan: "BIF (Dfid funded Business Innovation Facility) have offered BISC a consultant for a period of 3 months to help design a business plan for BISC".

As it can be notice from the present report and from the previous ones there were a number of consultancies under this activity and, apparently, few practical steps undertaken.

A practical initiative which can be registered is the presentation by CISP of a “short proposal” to Indefund about the possibility of paying for BISC’s services (payments from Indefund to BISC). BISC was waiting for some feedback by the end of November 2011.

BIF also introduced BISC to DFID for possible financing.

Finally CISP reports about an internal brainstorming meeting held in the period in Lilongwe where the “team decided who would represent BISC on its board for the establishment of BISC as a company limited by guarantee”.

This is the only information available about the decision of registering BISC as a company limited by guarantee and raises 2 comments:

- the meaning of representing BISC in BISC board is questionable, probably the person selected will represent CISP;
- will any representative from organizations other than CISP sit in the board?

Indicators for this result are positive, being the problems with the delay of loans fully solved.

Result B. Through the IGA centre, assisted at least 1500 vulnerable households and youth to start & develop Income generating Activities and initiate informal micro finance with at least 70 VSLAs (Village Savings and Loan Associations).

B.1 Identify vulnerable households to benefit from IGAs and B.2 Build the capacity of the selected beneficiaries, support them to start an IGA and monitor their participation

CISP reports that in the last period of PM2, in Blantyre 4 new IGAs were identified, while Lilongwe and Balaka concentrated on the IGAs already identified. In total, there are 72 IGAs which have been implemented in PM2 distributed across the districts, out of which 8 IGAs were initiated in PM1 and carried over to PM2.

The district split is as follows:

- Blantyre 48;
- Lilongwe 22;
- Balaka 2.

According to CISP, so far 9 IGAs have become non-operational after operating for more than 2 years. Among the benefits gained by the groups, according to CISP, there is not only the access to capital and the profits that should follow but also the “sense of hope and empowerment” that the beneficiaries gain from organising and running their own business through the various capacities CISP provides.

CISP provides a table showing the activities that reached 18 IGAs in the reporting period, all of them are about pigs and goats. They all have received group dynamics, business management and technical training. All of them but one in Balaka, also received the livestock already and 7 received construction materials for the IGA building.

These might mean that 11 IGAs did not complete the full cycle of support foreseen, but it is not clearly specified by CISP.

B.3 Train and build capacities of the VSLA members, monitor their participation and create a social capital amongst the vulnerable communities

Since the beginning of Project Malawi II, 93 VSLAs have been established. This figure is provided in annex 4 and confirmed in annex 6.

Other figures are less consistent. Contradictory statements and figures about the number of new VSLAs from different annexes are copied below:

- Annex 4: Blantyre identified 3 VSLAs in this reporting period while Lilongwe and Balaka continued to reinforce capacity to the already established groups
- Annex 4: 6 VSLAs being set up in the reporting period; 2 in Blantyre, 2 in Lilongwe and 2 in Balaka
- Annex 6: value realized for this period 2 in Blantyre, 4 in Lilongwe 2 in Balaka.

The district split of the total is also unclear, as it is possible to see in the table:

	Annex 4	Annex 6
Blantyre	44	43
Lilongwe	35	36
Balaka	14	14
total	93	93

The VSLA-IGA approach has seen 36 VSLAs operating IGAs. (Blantyre 12; Balaka 2; Lilongwe 22).

This figure of 36 is very high and can be commented. The methodology of “graduating” VSLAs into IGAs made IGAs stronger and increased their probability of success. This is important because IGAs were the weaker tool adopted to address the economic empowerment of vulnerable households. Yet this methodology also limited the total number of beneficiaries reached since the same groups are targeted and counted twice, under VSLAs and under IGAs.

12 new loans have been accessed and one of these loans was accessed by an IGA. This is something new in the methodology adopted because up to now, loans were guaranteed by the VSLA group but used at the individual level by group members, while probably, the loans accessed by IGA groups are devoted to the IGA business, which is an interesting and promising news for the sustainability and replicability of IGA initiatives.

The explanations provided by CISP about the reason for the low number of loans by VSLA are not very clear since in their answer to the 8th report they state that people did not borrow money for their businesses because they were engaged with fields and agriculture in the previous 2 periods, while in the last report they state that people were still not borrowing because “*they are accumulating savings with expectations to share out during the cultivation period (November- May) so as to acquire adequate farm inputs*”.

The indicators for this result are poorly computed and sometimes inconsistent. Nonetheless they are good for VSLAs and slightly below the targets for IGAs.

The number of monitoring visits is anyway too low to both kind of groups, probably as result of fuel shortage.

Result C. Facilitated awareness sessions for the business and the vulnerable rural communities on HIV and AIDS epidemic and nutrition, and promoted voluntary HIV testing and referral to the Dream Centres.

C.3 Organize awareness sessions on HIV/AIDS, nutrition and family planning for the direct and indirect IGA beneficiaries.

Like in the previous report, CISP mentions “awareness forums” for Save the Children but without clarifying what these forums are.

According to annex 4, Blantyre undertook 9 sessions for VSLAs (7) and IGAs (2) in the reporting period, while nothing was done in the other districts. Anyway, two sessions in Lilongwe are also computed in annex 6 and a 11 sessions are reported in the synergy paragraph of annex 4.

Apart from this confusion, indicators reveal that result C was not fully achieved:

- “Project staff take part in at least 3 training meeting on HIV/AIDS and nutrition each year”: this is below the target, with no initiatives in the third year;
- “At least one meeting per year on HIV/AIDS and nutrition organised for the IGAs-VSLAs groups”: the target was recalculated, since the indicator should be intended in terms of 1 meeting for each group. The actual achievement is very poor;
- “*Number of DREAM clients participating in Business Management training courses*”: no target was proposed by CISP for this indicator.

4 PM2 overall evaluation

4.1 Clinical activities of PM2 in the national scenario

To give an overall evaluation of the impact of PM2 clinical activities in the national scenario we'll conduct a comparative analysis of the Govt. *Quarterly HIV Programme Report* ⁽¹⁾ together with the document "Project Malawi - Secondo triennio - 2008-2011 - Impatto del programma DREAM sulla salute delle persone sieropositive in Malawi - Gennaio 2011" ⁽³⁾.

One of the most relevant accomplishments of PM2 – and particularly of the partner more deeply involved in clinical activities, CSE-DREAM – has been the deep integration in the national health system, not only through the OPC, as the case in PM1, but also and particularly through the MoH and its HIV Unit, the bodies specifically entitled to coordinate the fight against HIV-AIDS at national level.

The mutual benefit of this close interaction has been witnessed by the adoption by the MoH of clinical protocols introduced by CSE-DREAM, namely those on PMTCT and on laboratory monitoring. It is somewhat curious that those are exactly the protocols more troublesome in terms of relationship with the MoH during PM1: in PM2 the situation has changed to a point that CSE-DREAM has been asked to take part and to organise CPD events on behalf of the MoH, and to serve as a training centre by the National Medical College itself, a less than negligible sign of high reputation. Among the more relevant innovations introduced in Malawi as a consequence of the encouraging results obtained by CSE-DREAM protocols is the increase of cut-off value of CD4 to start therapy from 250 up to 350 cells/mm³, thus increasing the chances of success in keeping the infection under control; the introduction of viral load in the panel of laboratory determinations, thus obtaining a higher diagnostic accuracy in monitoring the course of infection; the adoption of the antiretroviral tritherapy in pregnant women from early pregnancy until weaning, thus obtaining the lowest vertical transmission rates ever recorded in the Country.

As a first consideration in an analysis of the impact in the national scenario it must be noticed that when Project Malawi first started in 2005-06 there were in the Country 83 centres delivering ART: in this situation the impact of CSE-DREAM centres could have been significant simply from a quantitative point of view. Today the number of centres registered at the HIV Unit of the MoH raised to 449 (Fig. 4.1.1), therefore reducing the relative quantitative impact of PM2. Actually, a refrain of all our reports about the clinical activities performed within PM2 is that their impact on the national scenario is more on the side of quality than quantity, although the 15.666 patients under assistance at 1/11/2011 mean that as a matter of fact one out of 20 patients affected by AIDS in Malawi is cared of in CSE-DREAM premises, a meaningful data also from the merely quantitative point of view.

Testing and Counseling

Nationwide there is a total of **778** static and **614** outreach HTC sites and locations, of which **20** (9 Centres and 11 maternities) belong to PM2. The total number of people tested and counseled all over the nation in one year (July 2010-June 2011) is **1.773.267**, of whom 45.117 (9%) HIV positive; in PM2 premises in almost the same span of time (June 2010 – May 2011) **10.696**, of whom 5302 (49,5%) HIV positive. The difference shows that the people accessing PM2 facilities is already clinically screened to avoid too many negative tests, taking also into account the recurrent problem of lack of reagents.

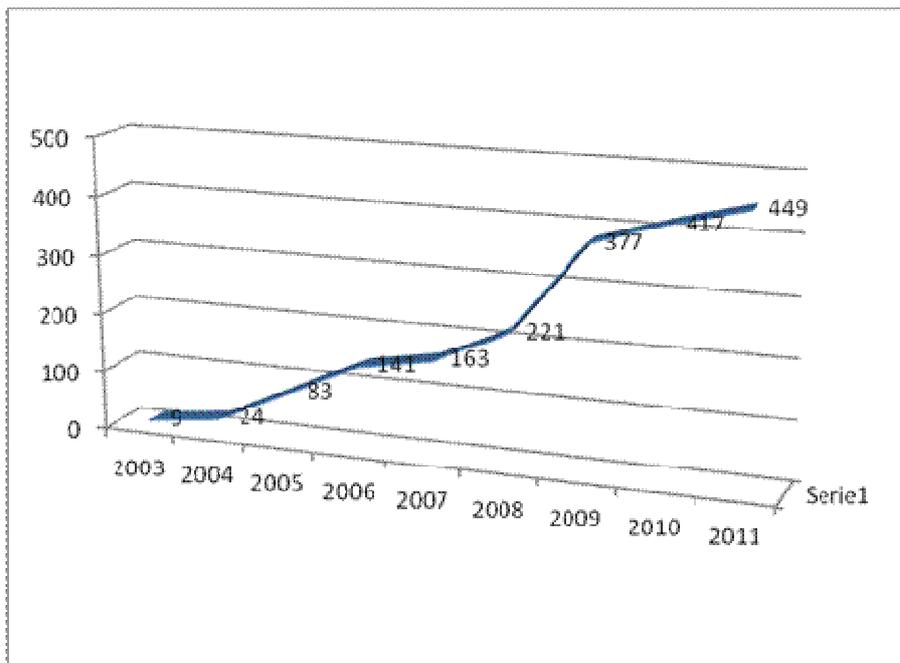


Fig. 4.1.1 – Increase in centres delivering ART in Malawi

Antiretroviral Therapy - Community care and Home care

By the end of June 2011, there were in Malawi **449** ART clinics (**303** static clinics and **146** outreach / mobile clinics). Out of the **382,953** patients ever initiated on ART, **276,987 (72%)** were retained alive on ART, **44,390 (12%)** had died, **60,555 (16%)** were lost to follow-up (defaulted) and **1,424 (<1%)** were known to have stopped ART.

Of the 303 static clinics, 9 belong to PM: here **17,579** patients ever initiated ART (4,5% on a national basis) and **15,282** are living and in care (86% of the total, 5,5% on a national basis).

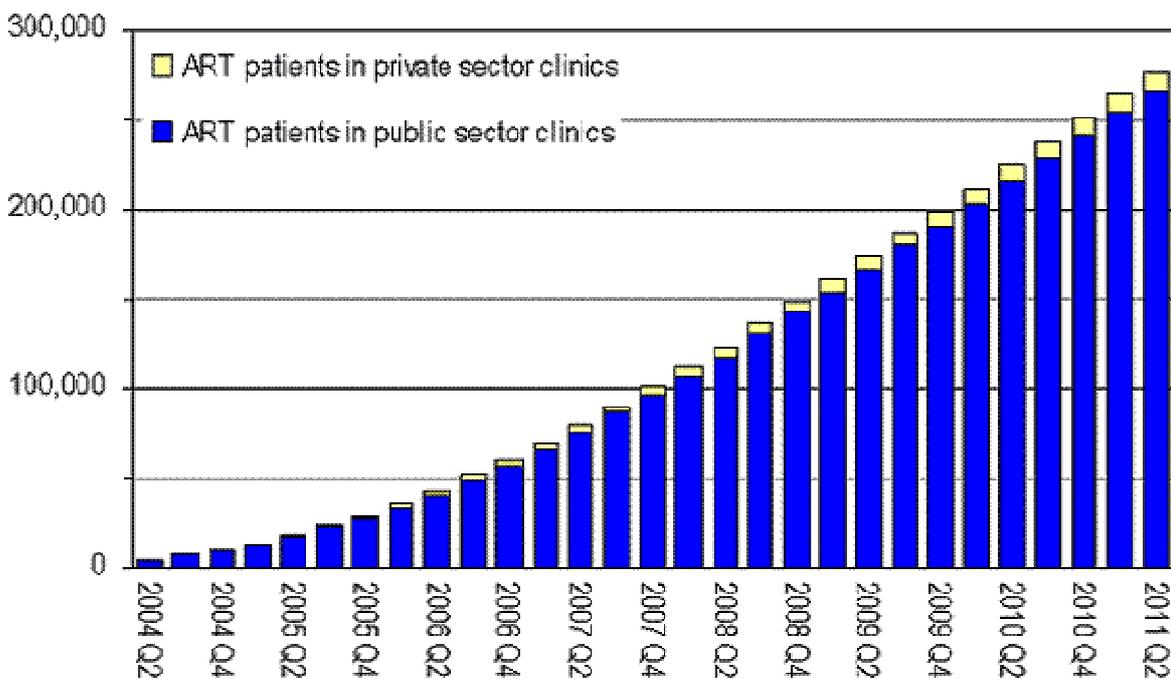


Fig. 4.1.2 – Patients alive and in ART in Malawi

Although the number of patients starting ART in Malawi has steadily increased in time, as shown in fig. 4.1.2, it must be noticed that, as clearly stated in the quarterly report of the MoH, the **276,987** patients alive and on ART in Malawi represent just the **67%** coverage of the estimated population in need of ART (Fig. 4.1.3); in other words, there is still one third of Malawians affected by AIDS and needing therapy waiting to be enrolled in a therapeutic program.

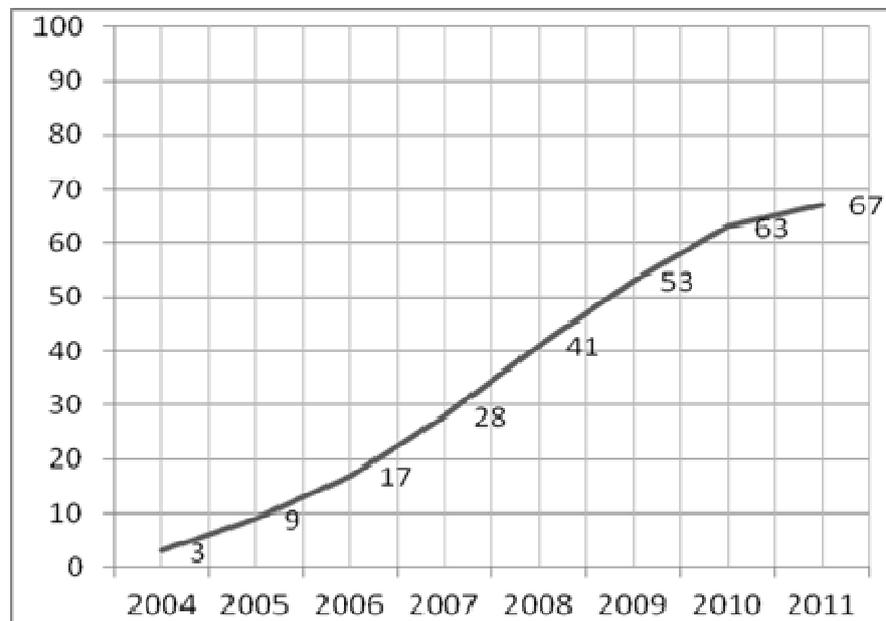


Fig. 4.1.3 – Coverage of the estimated population needing ART

This somewhat disappointing percentage is a challenge for every organization fighting HIV-AIDS in Malawi, moreover in the light of possible future withdrawal of support from the Global Fund due to the political unrest in the Country; according to his Director Chimbandwira, the HIV unit is devising a plan of action to respond to these difficulty. In this very scenario has to be considered the shrinkage in patients' recruitment that CSE-DREAM approach, privileging quality towards quantity, has determined. The quest for a high quality of care delivery has obviously its cost, somehow forcing to freeze new recruitments and to go on with the actual numbers. Actually, notwithstanding the financial constraints, during PM2 the recruitment has never stopped, and in the last 2 years of the program the total number of patients living, in care and on HAART increased of the 22,4%, from 8.964 to 11.466. On the other hand, on a national basis in the same two years span the total number of patients alive, in care and on HAART increased from 190.000 to 277.000, equivalent to an increase rate of 45%, double of that registered in PM2 centres. It is surely a data to be considered in planning the future clinical activities of the project.

Early mortality has declined considerably nationwide. In 2006, 11% of new patients died within the first 3 months after ART initiation, while five years later, in 2011, this number has declined to 4% all over Malawi ⁽¹⁾. A similar trend has been recorded in PM2 centres (see fig. 4.1.4., from fig. 4 ⁽³⁾); it is worth of interest to observe how in this experience the drop in mortality has been from 7% to 4%, while at national level the drop had an initial figure much higher (11% to 4%). Possibly the persistent rate of mortality of 4% represents a sort of "barrier" related to a delayed ART initiation, when the patient is already in advanced WHO clinical stage 4 and therefore in critical conditions, already beyond cure. At national level the proportion of patients starting ART in WHO clinical stage 4 decreased from 25% in 2005 to about 10% in 2011, thus possibly explaining the related decrease in early mortality.

Actually, the cause for inclusion in HAART is still one of the greater discriminating factor between national and PM2 experiences, and here again can be felt the importance that laboratory facilities available to CSE-DREAM and not to the Govt. has on the national scenario. At national level HAART is started on the basis of low CD4 count, when the patient hasn't yet evident clinical signs of AIDS (WHO stages 1 or 2), in the 33% of the cases, on the basis of definite or advanced clinical signs (WHO stages 3 and 4) in the 67% of the cases; in CSE-DREAM experience these data are respectively 75,2% and 24,8%, thus clearly emphasising how much earlier the therapy can be started, when the patient is still in rather good clinical conditions and not when the infection has already made clear its devastating effects.

To further reduce early mortality at national level it will therefore be of paramount importance an earlier start of therapy, as detailed in the new national guidelines adopted also on the basis of the positive PM2 experience, and in this process the impact of CSE-DREAM laboratories – Blantyre laboratory is already supporting 7 health districts for PCR qualitative diagnostic in children - will be more and more significant.

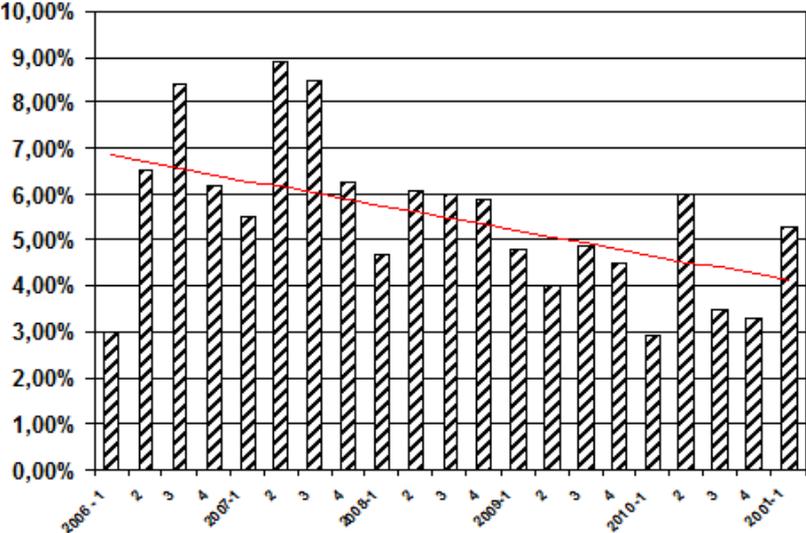


Fig. 4.1.4. Trend in adult early mortality in PM2 from 2006 to 2011

In the discussion about **overall mortality** is worth of interest what stated about defaulting patients, in particular when hypothesized that defaulting patients are actually patients whose death has not been communicated to the centre. Also taking into account this wise observation the overall mortality is contained in a figure around the 14%, rather satisfactory once considered that it's half of the national one, in the range of 28% ⁽¹⁾ (see also fig. 12-16 ⁽³⁾)

Again about defaulting patients, it has to be taken in due account the fact that – as easily predictable – the highest ratio of defaulters is recorded in the peripheral centres such as Masuku, Namandanje or Mtendere. It's an observation urging to struggle for the realization of new peripheral centres, possibly following the format of the “Chitukula initiative” discussed at par. 4.6.

Taking into account data about infant mortality it is worrying to observe what graphically expressed in fig. 21 of the report ⁽³⁾, reproduced in fig. 4.1.5., about the slightly increasing trend in early infant mortality. This phenomenon has been judged worth of further studies by the report itself ⁽³⁾, specifically as far as differences in different centres' performances are concerned. A possible answer is identified in an inadequate formation and training of clinical staff in dealing with children, while in

adult cases the level of care is homogeneously good throughout the different Centres. Actually, this difference of clinical behaviour among adults and children is of paramount importance and absolutely well known by all paediatricians, whose beloved aphorism is “*a child is not an adult in miniature*”. Thus, also a good clinical officer well trained in caring of adults’ problems can be misled by the symptoms presented by an infant in critical conditions, thus leading to an inappropriate urgent management. The need of having children cared of by a staff specifically trained in paediatrics could induce to consider the possibility of tighter relationships between CSE-DREAM centres and neighbouring paediatric units, such for example the one to be shortly opened in Balaka, in a synergistic action aimed to offer these small patients the best of the care available also in critical situations, not allowing by definition a long-distance consultation and support from Italy such as done in difficult adult cases.

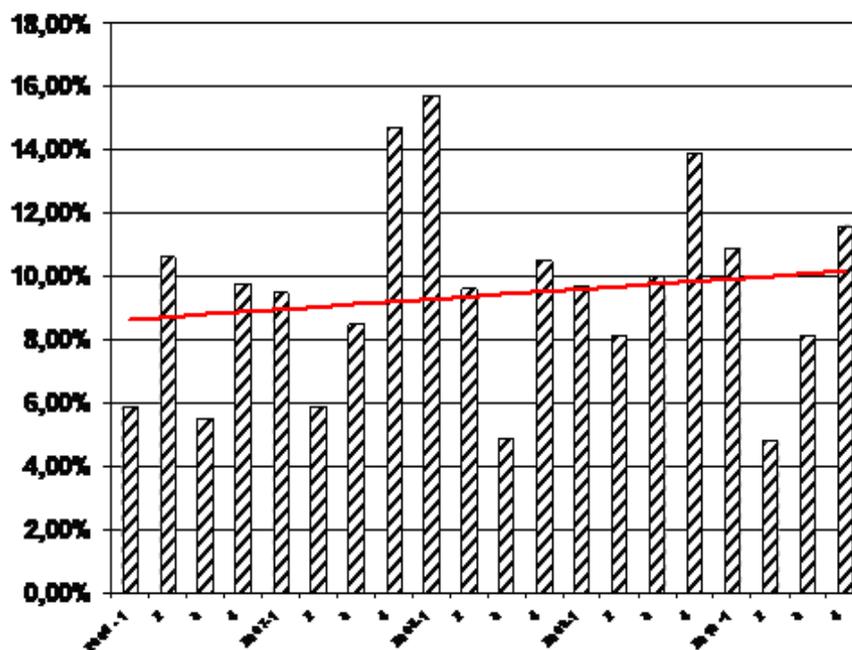


Fig. 4.1.5. Trend in children early mortality in PM2 from 2006 to 2011

Prevention of Mother to Child Transmission

Between April and June 2011, **486** facilities all over Malawi were providing PMTCT at ANC and/or maternity, of which **17** (9 centres and 8 maternities) belong to PM2. **7,524** (85%) of 8,525 women attending ANC who were known to be HIV positive received ARVs; **5,804 (94%)** of 6,172 infants born to known HIV infected mothers at maternity received ARV prophylaxis. Actually, about half all HIV positive pregnant women in Malawi are estimated to have a CD4 count <350 cells/mm³ and are therefore eligible for ART.

7,258 (85%) of HIV infected women attending ANC received maternal ARVs: of these, **2,642 (36%)** were given a single tablet of nevirapine to take home and **2,984 (41%)** were started on AZT combination regimen. A total of **5,602 (84%)** of HIV infected women attending maternity received ARVs during labour. Out of these, **3,363 (60%)** received the labour dose of AZT combination regimen, **551 (10%)** received single dose nevirapine and **1,688 (30%)** were on ART. **5,230 (79%)** women were already taking ARVs during pregnancy: **3,279 (63%)** of these were on AZT combination regimen and **1,951 (37%)** were on ART (lifelong triple therapy). **2,340 (71%)** of women on AZT and **1,721 (88%)** of women on ART had received the respective regimen for over 4 weeks during pregnancy. Roughly in the same period the mothers newly admitted in the

PMTCT protocol of CSE-DREAM were 112; therefore, on first approximation, we can conclude that nationwide the 6,5% of mothers receiving a proper PMTCT protocol during pregnancy is assisted by CSE-DREAM (112 out of 1721).

About this subject, it has to be emphasised that the regimens including a single dose nevirapine are ineffective: the national report itself underlines that “AZT and ART should be taken for more than 4 weeks during pregnancy to ensure optimal effectiveness”. The CSE-DREAM protocol on PMTCT is actually covering well more than 4 weeks during pregnancy, being started at the 25th week of pregnancy and continued six months after delivery. The encouraging results obtained by this protocol are one of the factors inducing the MoH to adopt since June 2010 a change in PMTCT, ART and infant feeding policy, the so-called “Option B-plus”. New national integrated PMTCT/ART guidelines and training curricula were developed and implementation started in June 2011: it is noteworthy that these new guidelines, proposed by the WHO, have been accepted by the Malawi Govt. also on the basis of the example given by CSE-DREAM experience, presenting the lowest level of mother-to-child transmission ever registered in the Country.

The beneficial effect of the PMTCT protocol adopted by CSE-DREAM can be appreciated not only in the reduction of vertical transmission of HIV+ mother to child, but also in the sensible reduction in the rates of maternal mortality, abortivity, prematurity and still births.

This report is not the appropriate place to comment in further detail the sophisticated statistical multivariate analyses presented in the CSE-DREAM final document ⁽³⁾, offering intriguing data for discussion about proportional relative risks presented by different variables in the complex clinical scenario of a patient affected by HIV/AIDS. These analyses are nevertheless a gorgeous example of what PM2 can offer to the scientific community in terms of local data processing, leading to scientifically grounded conclusions able to benefit the whole Malawian community.

Laboratory activities

Malawian Govt. recently adopted WHO guidelines for the laboratory monitoring of patients HIV+ and/or in HAART: unfortunately, to put in practice these guidelines it would be needed a much higher number of laboratories. The last quarterly report (Q2-2011) does not give further details on the Viral load determination equipment available in the Country, that in our last report we estimated in a total of 6. half of which belonging to PM2 (CSE-DREAM: Mzimba, Mthengo, Blantyre / Other hospitals: Mzuzu MSF, Lilongwe-Kamuzu Hospital, Blantyre-QECH). Actually the machine in Mzimba is not yet fully operative because of some problems, both technical and “political”, related to the procurement of reagents by the MoH.

Details are given on CD4 determinations nationwide, and also on this side the situation at Govt. level is worsening: out of the 303 static facilities delivering ART, 58 had CD4 count machines installed and 50 of these produced any results during Q2 2011, with a decrease of 3 operational equipment from the previous quarter (break down of equipment and/or interrupted supply of reagents). The total quarterly output of CD4 results declined by 11,315 (from 44,223 in Q1 to 32,908 in Q2). In the same period, the CD4 testing machines in DREAM laboratories (representing the 8% of the total available in the country, 4 out of 50) produced some new 4.000 determinations, equal to the 12,5% of the total nationwide. In this scenario the expertise offered by CSE-DREAM in the field of laboratory will be more and more important at national level, as clearly showed by the inclusion of Blantyre laboratory in the teaching network of the Blantyre College of Medicine, by the inclusion of CSE-DREAM experts in the elaboration of the Govt. five-years laboratory strategic plan, and finally by the open statement of the Director of HIV unit Dr. Chimbandwira: “... [CSE-DREAM] *laboratory services are strongest than any other institution in the Country*”.

A further topic of cooperation between CSE-DREAM laboratories and the MoH is represented by the **viral resistance tests**. At the end of PM2 patients moved to second line therapy where 106, representing the 0,9% of the total: this percentage is similar to what observed in other similar projects (of 48,338 adults followed on antiretroviral therapy by Médecins Sans Frontières in various African Countries ⁽⁴⁾, 370 switched to a second-line regimen after a median of 20 months, for a switch rate equal to 4.8/1000 person-years), although surely underestimated. A report on HAART projects in Cambodia refers to 3,9% of resistances ⁽⁵⁾, and the possible real figure is in the range of 5% ⁽³⁾.

Being the one in Blantyre the only laboratory in the country able to perform the test, and being the increasing number of resistances to standard antiretroviral drugs one of the most difficult and impending issues in ART delivery, it goes without saying that the possibilities offered on this topic are of paramount importance for Malawi, both in terms of direct clinical implications and in term of further research, possibly to be done jointly with QECH. Again, as clearly underlined by Dr. Mwenda of the MoH, *“...if the choice [of further funding] should be between food and laboratory, we strongly support the latter. We can find many organizations taking care of food integration, but no one has DREAM expertise in laboratory work !”*.

A last observation somewhat related with laboratory activities concerns **opportunistic infections** and **toxicity** to the treatment. CSE-DREAM report quotes a wrong estimate of the actual incidence of cases of tuberculosis (underestimated, because of lack of proper diagnostic workup) and of malaria (overestimated, because mostly this diagnosis is made on exclusively clinical grounds, and sometimes only on anamnestic data). Dealing with the actual incidence of toxicity of antiretroviral drugs, it is demonstrated on the basis of laboratory data that its incidence is largely overestimated, in adults as well as in children and in pregnant mothers. Again, this result is highly relevant for the HAART delivery all over the Country and not only in PM2 premises. This said, one can wonder why the laboratory could not be utilised to avoid the problems of wrong estimate in tuberculosis and malaria incidence, that can be both diagnosed with laboratory tests. As a matter of fact, this statement is not fully true for tuberculosis, that in many case needs a complex diagnostic assessment including not only laboratory tests but also chest X-ray and a more comprehensive diagnostic workup, difficult and expensive to implement in CSE-DREAM centres. It would therefore be advisable, to avoid in PM3 to misdiagnose tuberculosis, to liaise with hospitals neighbouring CSE-DREAM centres and able to perform the needed studies. For example, a protocol envisaging an exchange of expertises between a CSE-DREAM centre (offering its laboratory capabilities) and a Hospital (offering its TB-diagnostic capabilities) could represent a highly appreciable example of further synergy between Project Malawi and MoH.

4.2- Evaluation of PM2 clinical activities

At the end of PM2 the clinical structures managed by CSE-DREAM are 23: 3 referral centres, 6 satellite centres, 3 laboratories and 11 maternities (see Tab. 4.2.1)

Tab. 4.2.1. – Distribution and activity of CSE-DREAM structures

Region	Centre name	type	building	property	activity	Laboratory
Nord	Mzimba	Laboratory	Newly built	Mzimba Hospital	Partially operative	--
Centre – referral to Mthengo	Mtengo wa Nthenga	Referral Centre	Newly built	Project Malawi	Fully operative	MT
	Mtengo wa Nthenga	Laboratory	Refurbished building	Project Malawi	Fully operative	MT
	Mtengo wa Nthenga	Maternity	Hosted in hospital	Carmelite Sisters	Fully operative	MT
	Dzoole	Satellite Centre	Refurbished building	Project Malawi	Fully operative	MT
	Dzoole	Maternity	Refurbished building	Project Malawi	Fully operative	MT
	Mponela	Maternity	Hosted in a HC	Malawi Govt.	Information centre	MT
	Mtendere	Satellite Centre	Hosted in a HC	Teresian Sisters	Fully operative	MT
	Mtendere	Maternity	Hosted in a HC	Teresian Sisters	Fully operative	MT
Centre – Referral to Balaka	Balaka	Referral Centre	Newly built	Project Malawi	Fully operative	BA+BL
	Balaka	Laboratory	Newly built	Project Malawi	Fully operative	BA+BL
	Balaka	Maternity	Newly built	Comfort Clinic	Fully operative	BA+BL
	Kankao	Maternity	Hosted in a HC		Information centre	BA
	Chindausika	Maternity	Hosted in a HC	Malawi Govt.	Information centre	BA
	Kapire	Satellite Centre	Newly built	Loan for use to PM	Fully operative	BA
	Namandanje	Satellite Centre	Newly built	Montfort Fathers	Fully operative	BA
	Namandanje	Maternity	Newly built	Montfort Fathers	Fully operative	BA
	Mulibwanji - Masuku	Satellite Centre	Hosted in a mission hosp.	Montfort Fathers	Partially operative	BL
Sud – referral to Blantyre	Blantyre	Referral Centre	Newly built	Project Malawi	Fully operative	BL
	Blantyre	Laboratory	Newly built	Project Malawi	Fully operative	BL
	Kapeni	Satellite Centre	Newly built	Project Malawi	Fully operative	BL
	Machinjiri	Maternity	Hosted in HC	Blantyre CC World Alive	Fully operative	BL
	Chileka	Maternity	Hosted in HC	Blantyre City Council	Fully operative	BL
	Chirimba	Maternity	Hosted in HC	Blantyre City Council	Fully operative	BL

The trend of clinical activities and recruitment of new patients in PM2 has been rather inconstant, due to the reasons analyzed in our previous reports. The exponential development recorded in the first year induced to freeze new recruitments in the second year, to be newly increased in the first half of the third year and then stabilized on the attained levels. As already done in the last report we'll try to give a more accurate picture of this trend, based on the actual data given in annexes 6 of the nine four-months report describing the activities of PM2, calculating the Δ (algebraic differential variation) of the most significant indicators, presented in tab. 4.2.2.

Tab. 4.2.2. – Differential values for the most relevant indicators for each of the 4-months periods of PM2

indicators	4-months period								
	1-I	1-II	1-III	2-I	2-II	2-III	3-I	3-II	3-III
Haemocrome	7.888	14.245	18.160	13.219	8.026	12.926	12.592	20.318	17.138
biochemical	8.819	11.585	13.884	10.121	6.543	10.952	9.872	16.835	15.830
CD4	12.990	11.919	11.004	10.507	6.700	9.538	8.300	15.285	4.988
Viral Load	8.864	6.259	13.484	7.188	4.726	6.475	4.129	7.077	4.717
increase new VCT	3.219	2.907	5.717	2.536	2.074	2.314	3.743	3.543	3.410
HIV positive-total	2.588	2.194	1.505	645	729	673	2.322	1.642	1.338
% HIV positive vs total VCT	80,40	75,47	26,32	25,43	35,15	29,08	62,04	46,34	39,24
Patients living and in care	0	0	0	355	414	343	-70	949	726
Total patients accessed HAART	1.335	1.522	2.007	632	715	653	1.914	1.343	1.148
Total patients living, in care and in HAART	0	0	0	234	437	357	81	687	706
Pregnant woman assisted	0	0	0	1.658	1.238	1.552	1.148	1.442	447
Mothers started HAART	993	277	446	399	396	424	368	738	112

Laboratory activity trends depicted in fig. 4.2.1. shows a decrease in the 2nd 4-mo period of the 2nd year, and yet a greater one at the end of the last period.

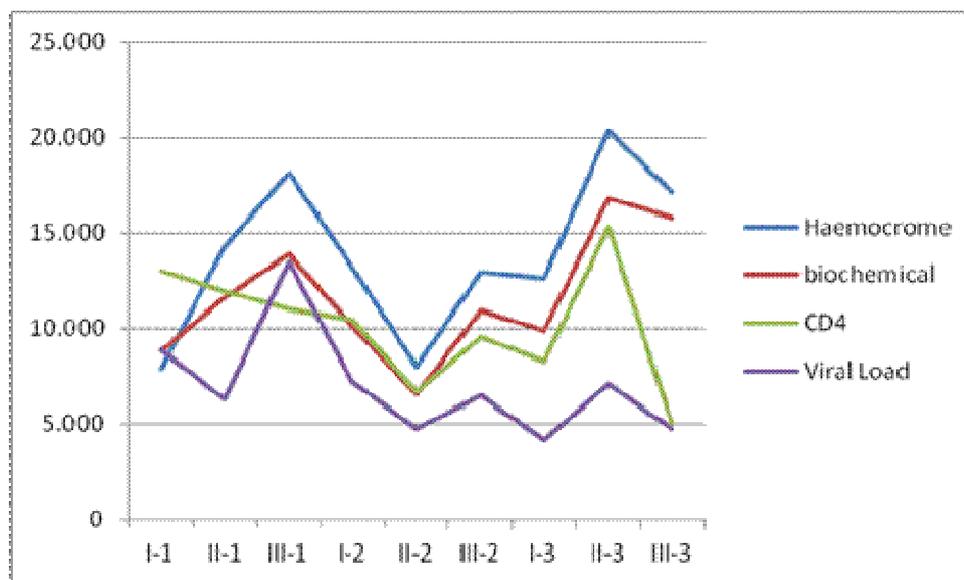


Fig. 4.2.1 – Laboratory indicators trend

Fig. 4.2.2. express clearly the three different periods of PM2 in recruiting new HCT contacts, well emphasizing the unexpected “flood” of contacts at the end of the first year, with the consequent equal and reverse reaction in the second year, and the stabilization reached during the third year. With a number of new contacts almost equal to those registered at the beginning of PM2 (3400 vs 3200).

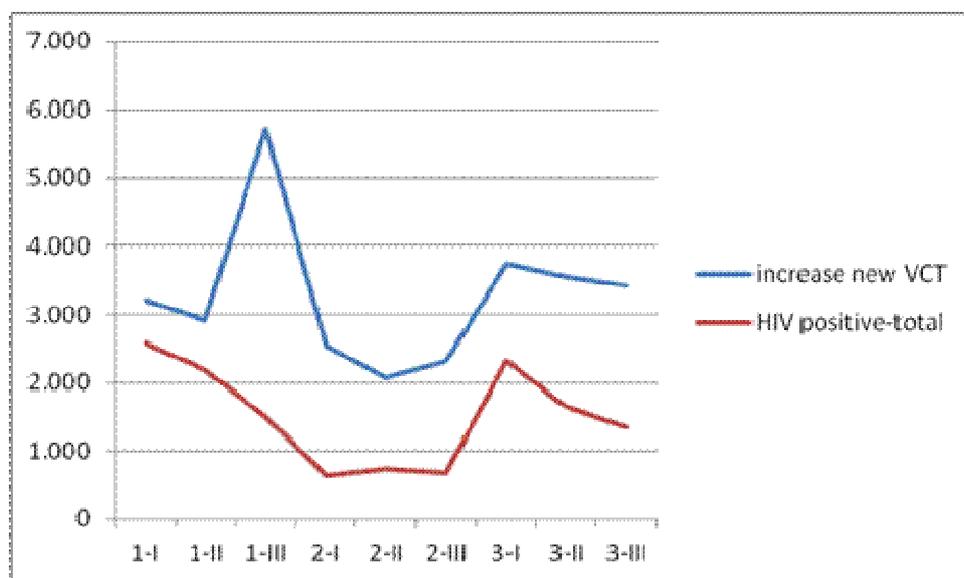


Fig. 4.2.2. – New VCT contacts trend and # of HIV positive

As already mentioned in our previous report, an intriguing problem coming out from fig. 4.2.2., further emphasised in fig. 4.2.3., is the huge difference in the ratio between number of people asking for VCT and number of HIV positive cases, going from 80,4% at the beginning of 1st year to 25,4 % at the beginning of 2nd year to the 39,4% at the

end of the third year. Still more intriguing is the difference between these data and the same at national level, where the ratio between people tested and people turning out to be HIV+ doesn't reach 10% (see par. 4.1.). This difference is possibly related to a more careful selection of HCT candidates by CSE-DREAM rather than govt. centres, but surely deserves to be further studied.

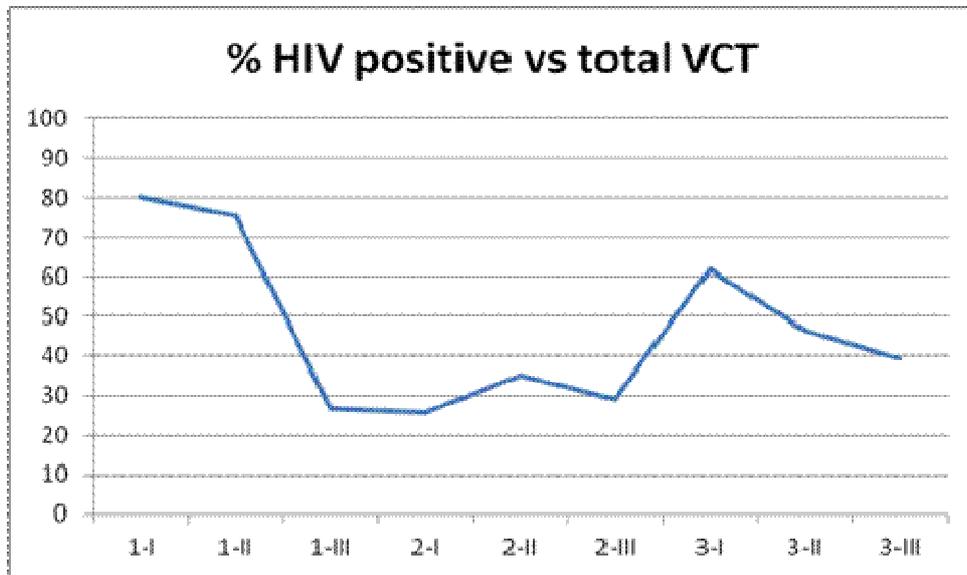


Fig. 4.2.3. – Percentage of people accessing VCT and turning out to be HIV positive

Fig. 4.2.3. well demonstrates the two rebound effects in recruiting new patients accessing HAART, the first at the beginning of second year where the sudden increase recorded at the end of the first year was followed by an equally sudden drop (632 vs 2005), and after a year of stagnation a new rebound effect – now in the opposite direction – brought new patients from 653 to 1914. It is worth of interest the observation that the conclusion of PM2 brought a sort of a rest in these swinging fluctuations, with the final datum, 1148 patients, not so distant from the initial one, 1335.

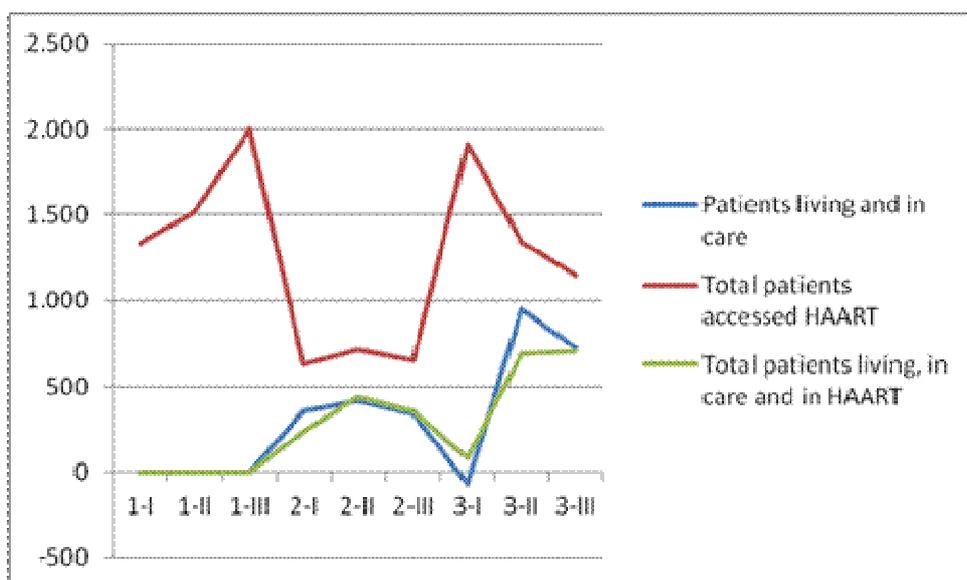


Fig. 4.2.4 – Trends in HAART recruitment in time

Fig. 4.2.5. illustrates PMTCT performances in the second and third year of PM2 (data unavailable for the first year); number of new mothers recruited in the program is rather stable until the very last 4-months period, were a collapse from 1442 to 447 new cases – if not caused by a data input mistake – is matter of concern.

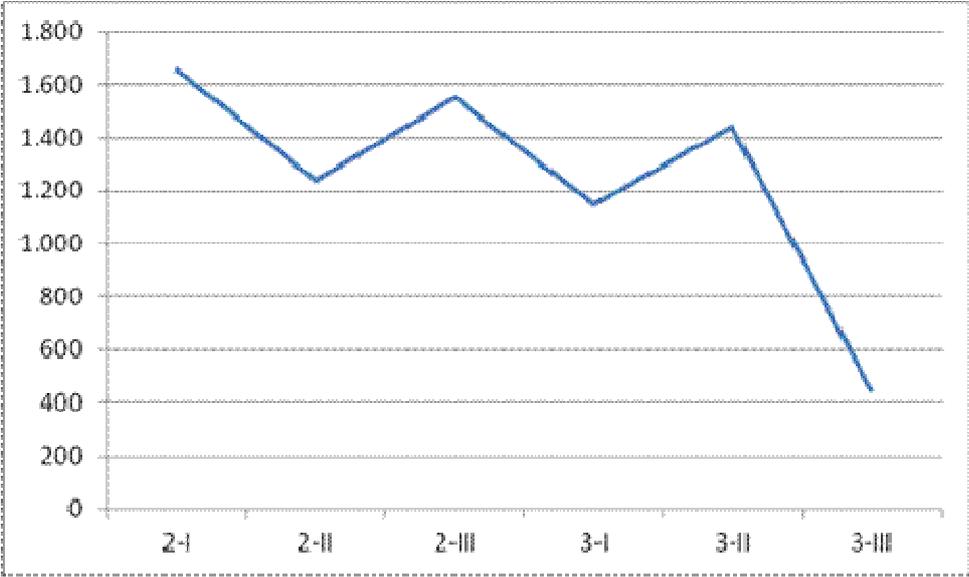


Fig. 4.2.5 - Pregnant woman assisted and recruited for each period (data not available for the 1st year of PM2)

An evident shrinkage in new recruitment of mothers needing HAART is again evident in fig.4.2.6. After a stabilization at some 400 new patients per period during almost all PM2, an increase registered in the second 4-months period of the last year has been followed by a rebound effect reducing the number from 700 to 112.

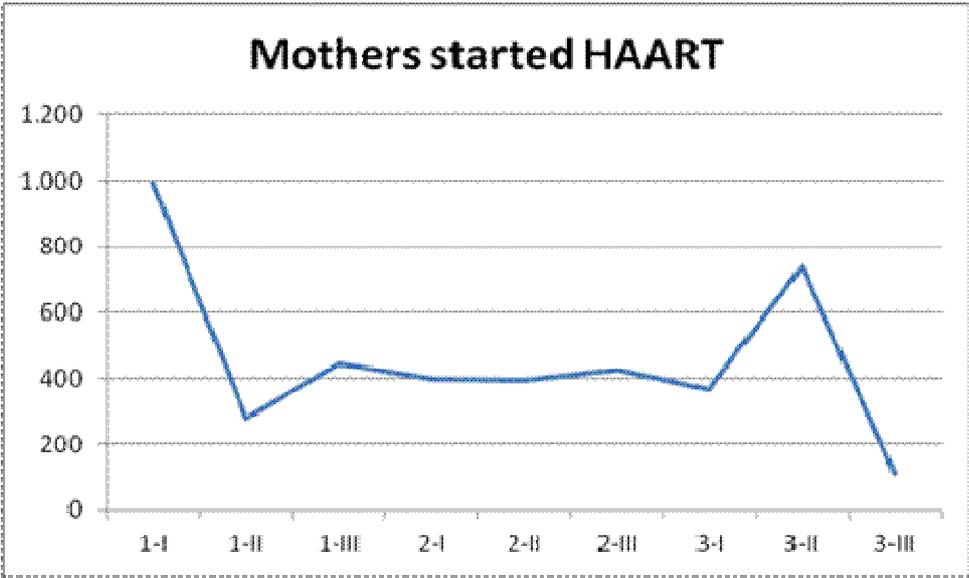


Fig. 4.2.6 – Mothers starting HAART for each 4-mo period

The figure 4.2.6. well illustrates the problem that clinical commitment of Project Malawi needs to face, i.e. the piling up of a high number of patients already in care, hampering the recruitment of new patients; and this also despite a good level of “efficiency” in the use of funds (increasing number of patients under care for a steady budget → reduction of per capita expenditure). This “piling up effect” can be easily appreciated from the following figures, reproducing the same values expressed in figg. 4.2.1. – 4.2.6. now as a cumulative data and not subdivided per each 4-months period.

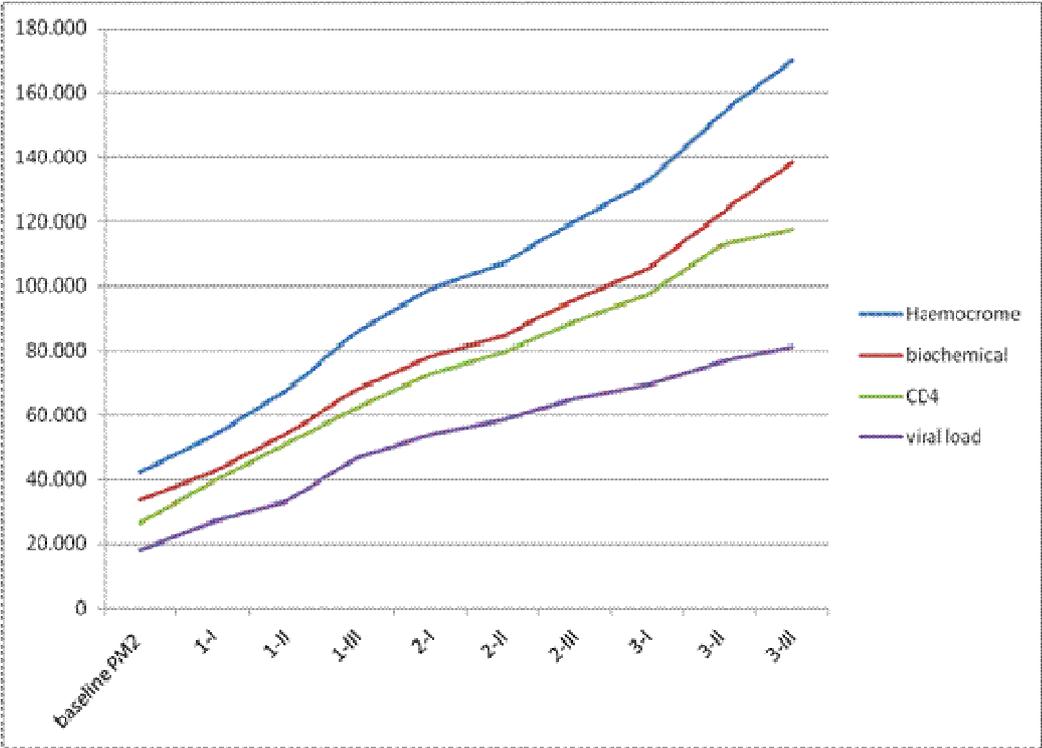


Fig. 4.2.7 – Laboratory indicators – cumulative data

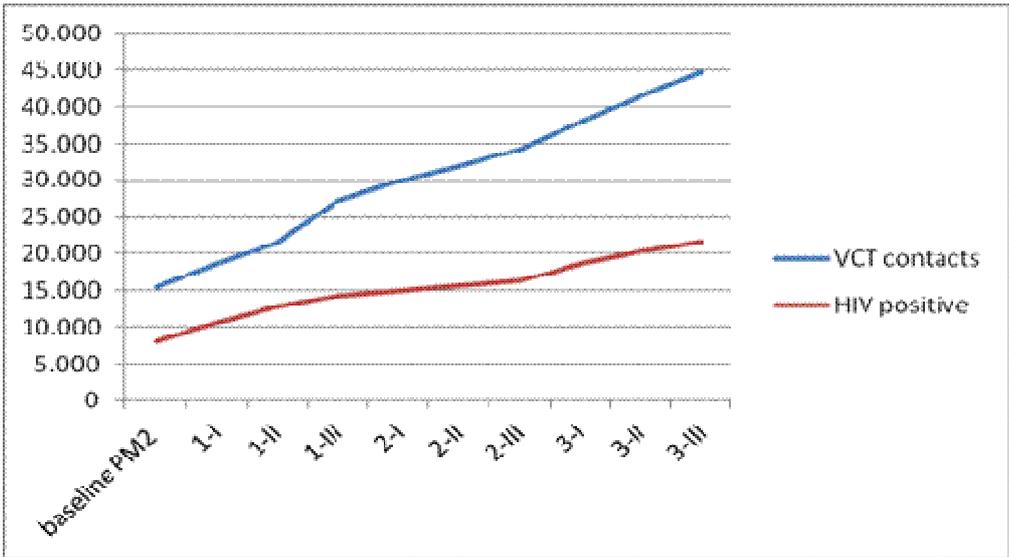


Fig. 4.2.8 – New VCT contacts trend and # of HIV positive – cumulative data

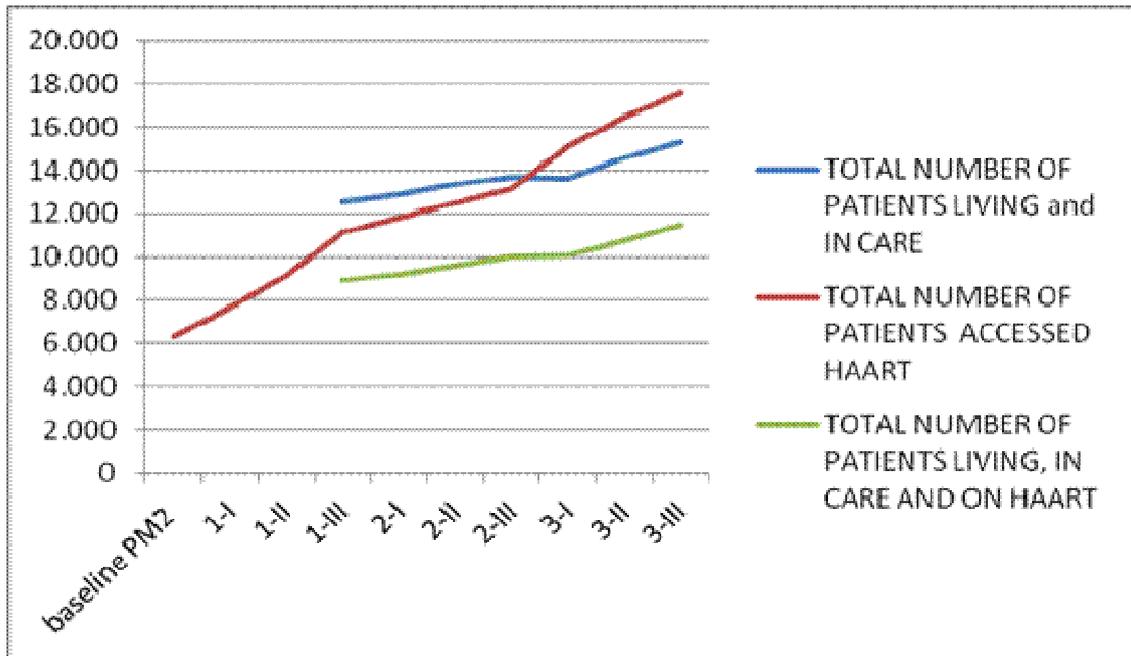


Fig. 4.2.9 – HAART recruitment – cumulative data

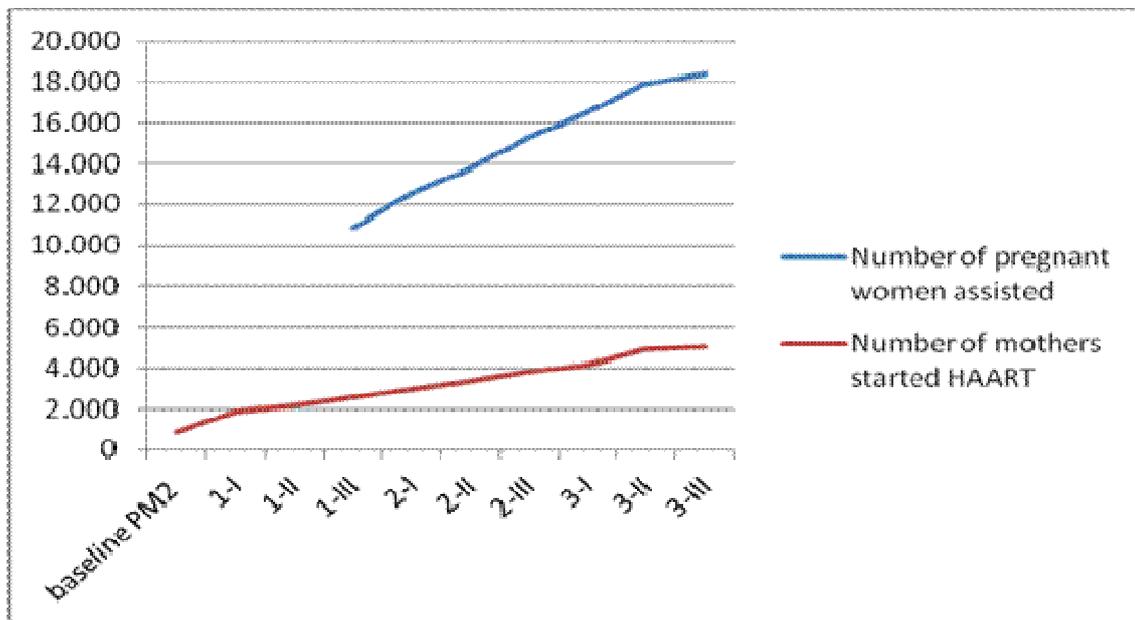


Fig. 4.2.10 – PMTCT recruitment – cumulative data

As far as attainment of final goals foreseen in the project document of PM2, we have already mentioned in previous reports the difficulties related to the changes in the expected results done during PM2 (see the 8th report, fig. 1.8). Taking into account the latest version of the expected results, it is possible to summarize graphically the degree of achievement realized in PM2 (Fig. 4.2.11), expressed as a percentage of obtained results vs the expected ones.

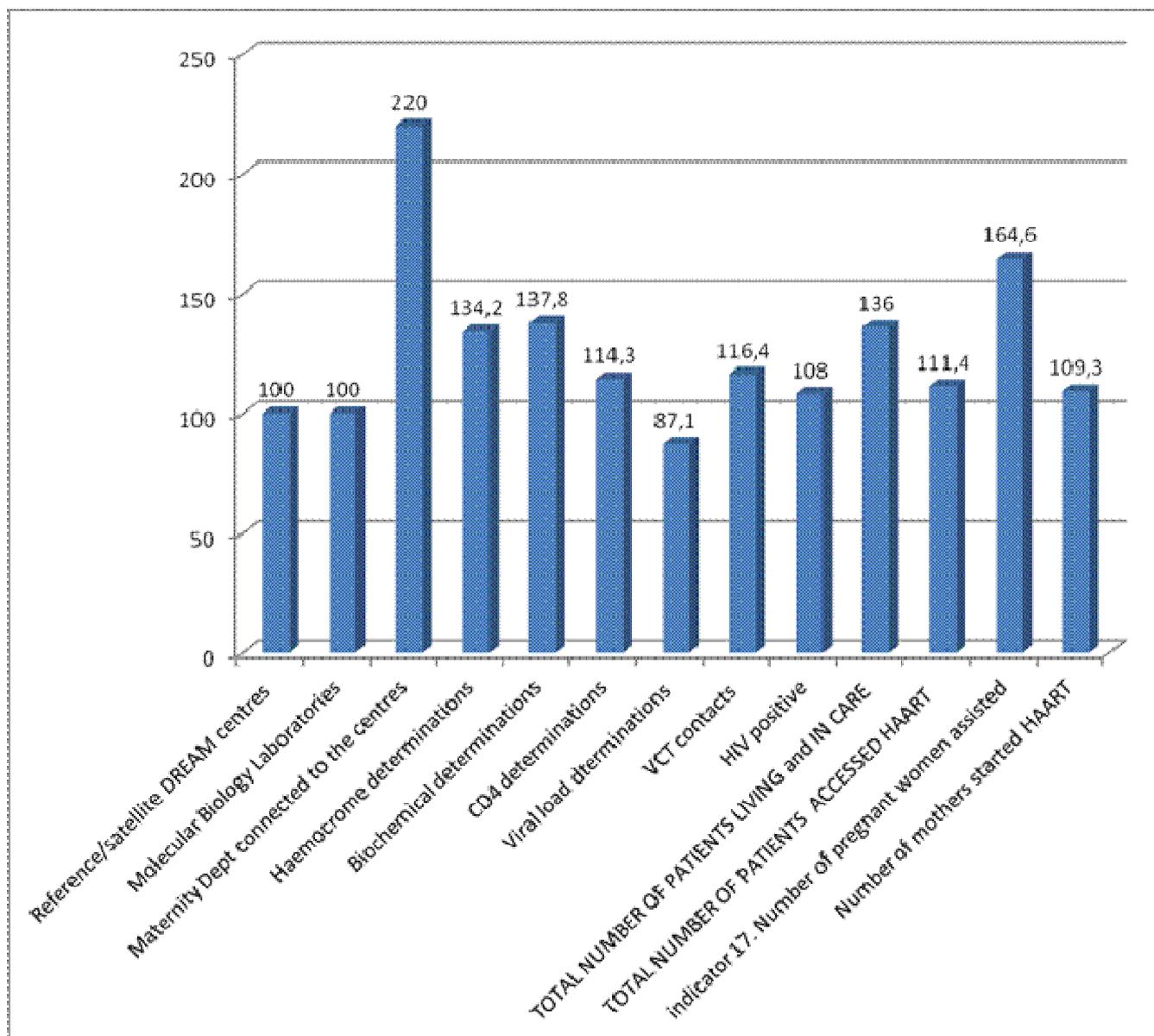


Fig. 4.2.11. Percentage of obtained vs expected results

It is clear how all the expected goals have been reached if not largely exceeded, with the exception of viral load determinations slightly short of 100%. Noteworthy is the 220% of new maternities connected to the centres, expected in the number of 5 and realized in 11 instances.

4.3 - Evolution of PM2 non clinical activities

During PM2, the socioeconomic environment at the national level was characterized by trends of deteriorating economic situation and increasing vulnerability and uncertainty for both urban and rural households. Beneficiaries have been experiencing increasing prices, recurrent crop failures and the general loss of social cohesion and traditional values at community level which results from weakened families and widespread orphanhood due to HIV. PM2 addressed these situations working with communities, various groups and households adopting methodologies which were improved and better integrated during the years. Out of some 440.000

persons who, according to the last census, live in the 6 target TAs of the 3 District, PM2 managed to directly reach more or less 1 out of 5 households. Even if further improvements could be introduced, PM already offers a valuable example of integrated action, targeting all relevant target groups and covering the most important dimensions of poverty and vulnerabilities associated with HIV/AIDS.

The charts here below present the values of the indicators for the 3 partners more involved in non clinical activities, while for more complete reference the excel annexes are recommended (see annexes). It should also be noticed that this is only a part of the report based evaluation, namely the one based on indicators, while more comprehensive synthesis can be found in the table provided in paragraph 4.5 Summative Evaluation, which also includes results from partners discussion and TA level meetings.

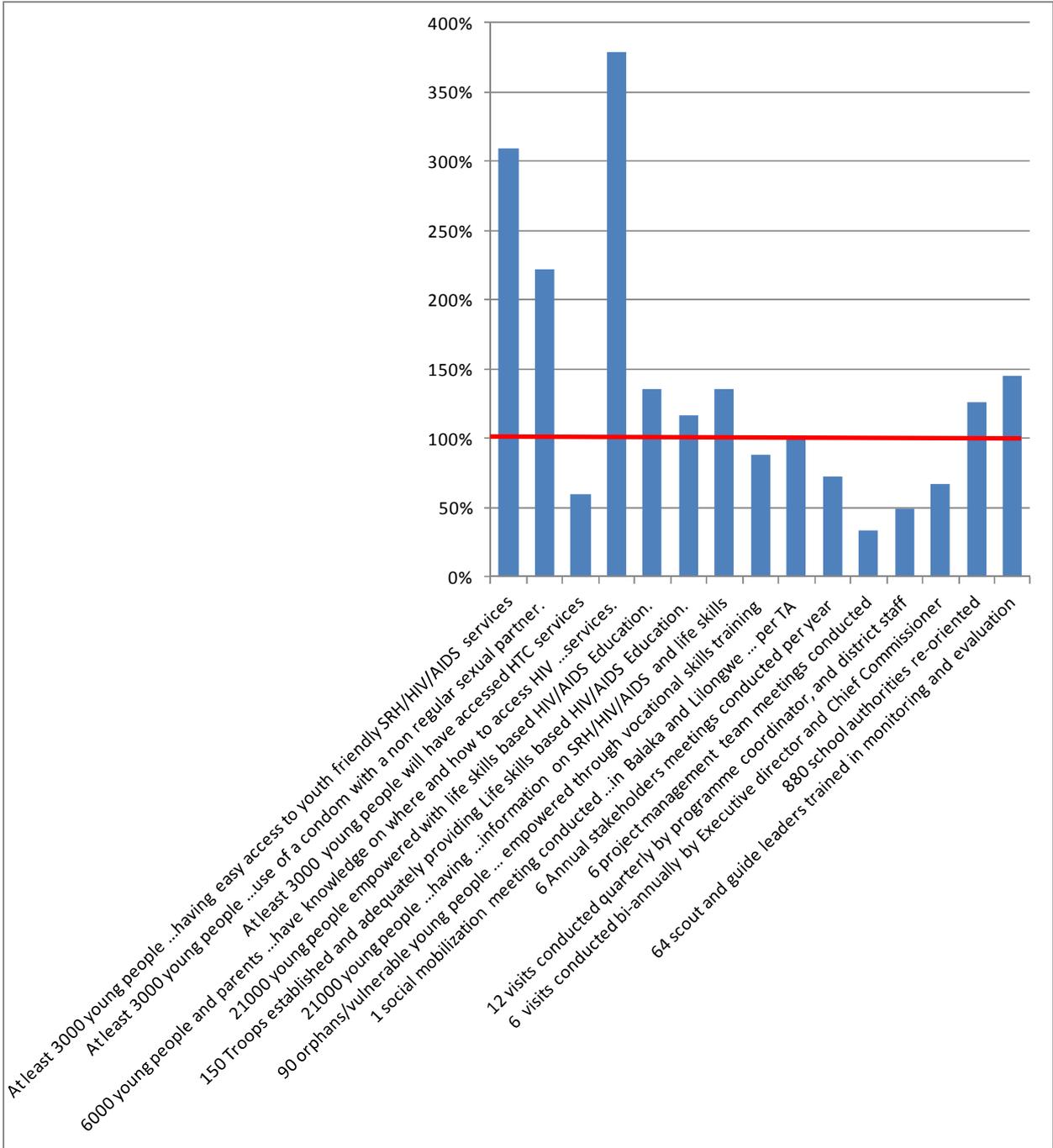


Fig. 4.3.1. Percentage of obtained vs expected results MAGGA

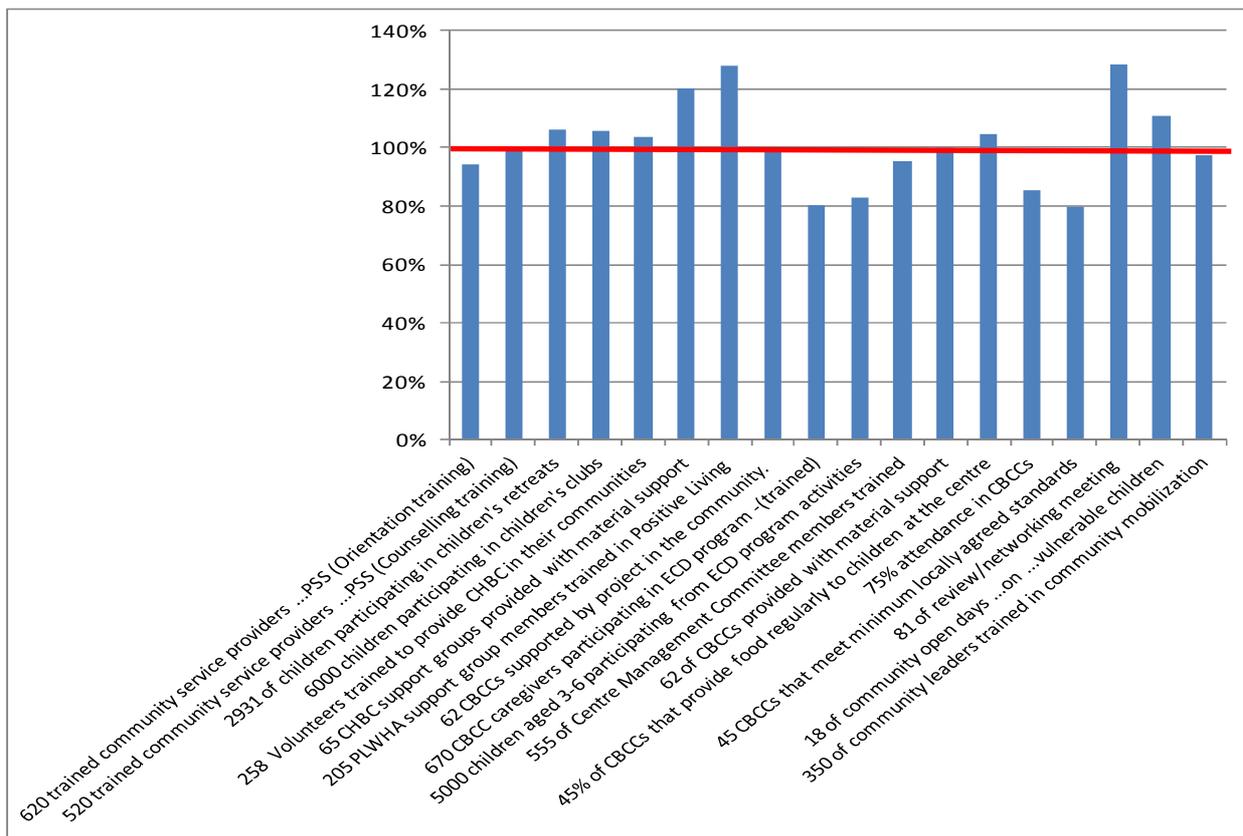


Fig. 4.3.2. Percentage of obtained vs expected results STC

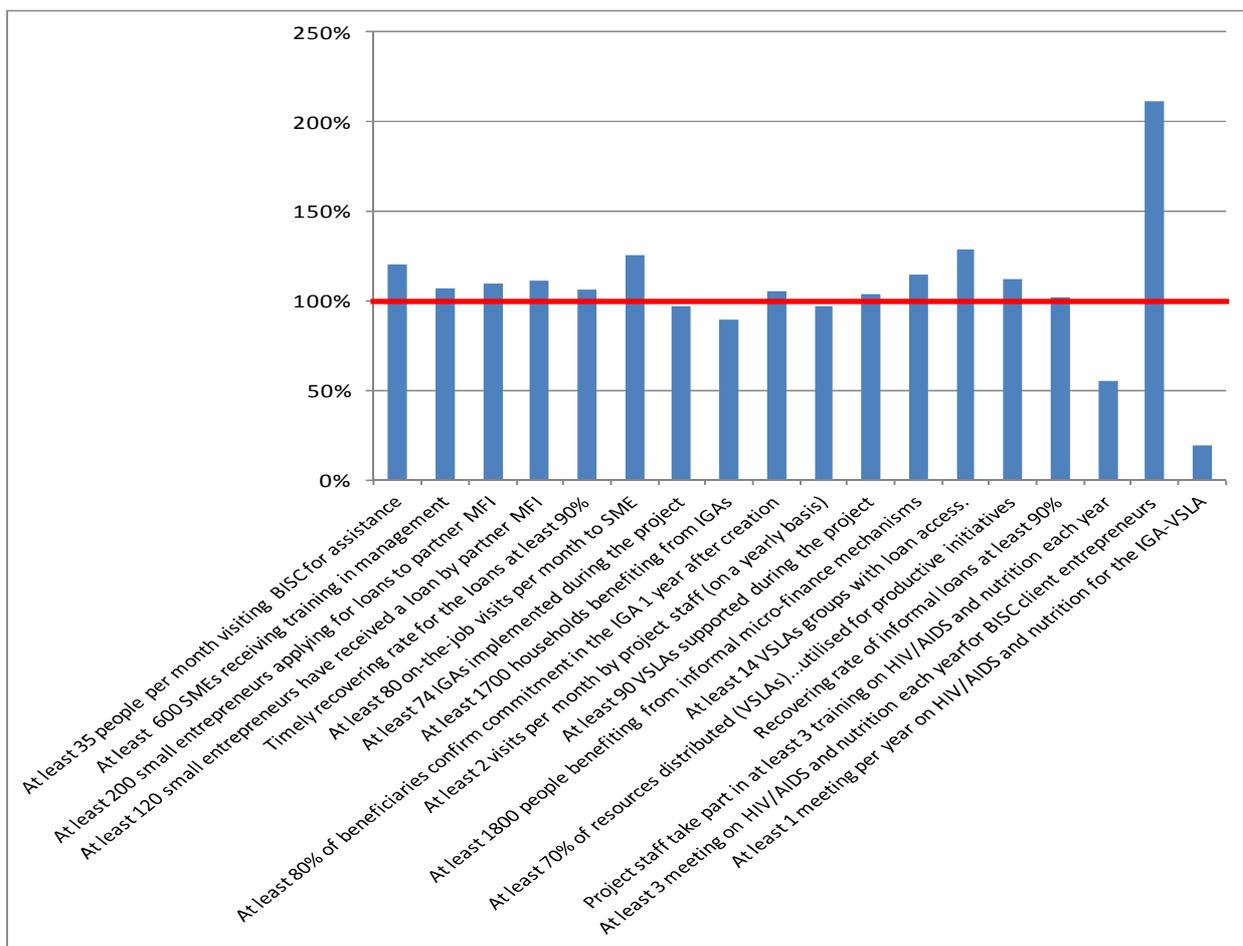


Fig. 4.3.3. Percentage of obtained vs expected results CISP

4.4 - Synergies within PM2 partners

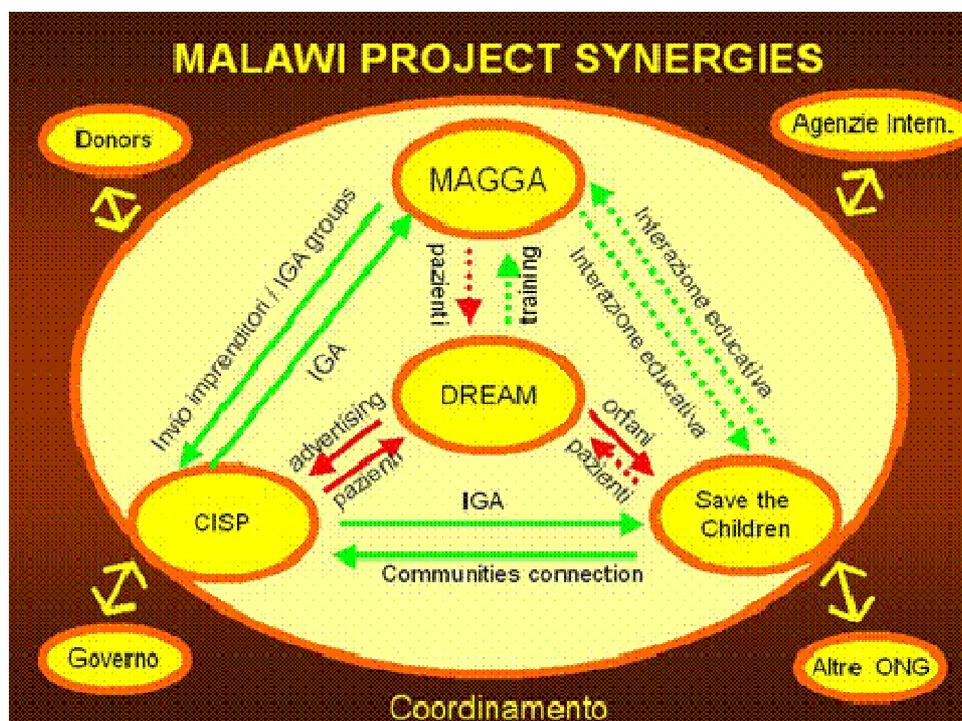
We have seen major improvements in the way in which the four partners interact and try to cooperate. Of course things could be improved even more, but since our first visit and report the attitude and the ability to work together has made very significant improvements. PM was a very ambitious and complicated project from the very beginning, which implies that with respect to a standard development project of an NGO there were many more difficulties.

However it is our impression that as far as coordination activities are concerned the past six years of PM are marked definitely more by successes than by failures, notwithstanding the changes which over the years have taken place in some organisations in the people involved in the management of the project.

Many of the flaws that we had seen in the beginning have been removed, as witnessed also by Mary Shawa at the very beginning of her interview: *“I’ve seen the project changing from being individualistic to be a group... in Lilongwe they have been able to act as a team ... and also other projects rush to see what PM does just to learn from them”*.

Yet more important, partners themselves learnt to appreciate the meaning of a teamwork: *“Synergy with CISP, DREAM and MAGGA complimented to each other very well which led to overall project objectives and ultimate goal”* (STC annex 4).

Just to give a pictorial illustration of the changes in the synergies in the history of Project Malawi, we duplicate here the picture describing synergies in the first report of PM1, June 2007, and the table included in the last report, August 2011. It’s striking how the picture has changed.



	CSE	CISP	STC	MAGGA
CSE-DREAM		<ul style="list-style-type: none"> - HIV/AIDS awareness sessions - DREAM facilitated the sharing of Piglets - Participation in the HIV awareness organised by CISP at Mabala 	<ul style="list-style-type: none"> - HIV/AIDS awareness sessions - Joint Participation in ADC meetings - Joint Participation in Support Group meetings - active joint mobilisation at TA Chitukula (CBCC open days and ADC meetings) 	<ul style="list-style-type: none"> - HIV/AIDS awareness sessions - MAGGA participated in the HIV Testing and Counselling session organised by DREAM in TA Kapeni and TA Chitukula - DREAM provided some testing reagents to MAGGA - Joint Participation in ADC meetings
CISP	<ul style="list-style-type: none"> - CSE facilitated HIV/AIDS awareness sessions for CISP IGAs/VSLAs - IGA and VSLA mobilisation (Identification of vulnerable households) - Referral of clients to DREAM centres 		<ul style="list-style-type: none"> - STC facilitated HIV/AIDS awareness sessions for CISP IGAs/VSLAs - IGA and VSLA mobilisation (identification of vulnerable households) 	<ul style="list-style-type: none"> - MAGGA facilitated HIV/AIDS awareness sessions for CISP IGAs/VSLAs - MAGGA provided female condoms to CISP beneficiaries
STC	<ul style="list-style-type: none"> HTC activities at the World AIDS Day commemoration - Joint supervision of the activities in the districts 	<ul style="list-style-type: none"> - CISP trained support groups members in VSL - ADC monitoring visits - Joint supervision of the activities in the districts 		<ul style="list-style-type: none"> - Youth behaviour change sessions at the World AIDS Day commemoration - Training of Centre management committees' chairpersons and CBCC mentors caregivers in girl-guide manual - Joint supervision of the activities in the districts
MAGGA	<ul style="list-style-type: none"> - Joint participation at ADC meetings - agreement for the supply of testing kits when out of stock at DHO 	<ul style="list-style-type: none"> - Monitoring visits - MAGGA/SAM and CISP conducted an HIV and AIDS awareness meeting with VSLA 	<ul style="list-style-type: none"> - Participation in STC "World AIDS Day Commemoration" - Joint participation at ADC meetings 	

4.5- Comprehensive evaluation of PM2

The table below considers activities and results one by one; associate to each are the observations which can be drawn from the three sources of information presented in this final report, namely:

- Partners' reports
- TA level meetings
- Partners' meetings

For the sake of simplicity the evaluation scale adopted is:

- *** very good, result fully attained
 ** good, result satisfactorily attained
 * result attained below the expectations

			REPORTS	TA MEETINGS	PARTNERS MEETINGS
CSE	R1	Health Centres Strengthening	***	** DREAM activities were not known in Somba, Chitukula and Chiumutu TAs where centres are not available	** Lack of a centre in Somba and Chitukula pointed out as regrets
	R2	HAART	***		** Stopping in enrolling new clients pointed out as a regret
	R3	PMTCT	***		NA
CISP	R1	Training	***	NA	NA
		Loans	***	NA	NA
		BISC Sustainability	* Sustainability plan not implemented	NA	** BISC sustainability concerns, also due to not enough networking with governmental Institutions
	R2	VSLA	***	***	***
		IGA	** Few IGA in Balaka	** Few IGA in Balaka (not even mentioned) IGA sustainability concerns	** But there are concerns for IGA sustainability
		VSLA and IGA monitoring	* Few visits	NA	NA
R3	HIV awareness	*	NA	NA	

			Few sessions		
STC	R1	PSS Trainings	** Few in Balaka and Blantyre	NA	NA
		Children Retreats/Corners	** But few children in Blantyre	** Seldom mentioned	NA
		HBC	** But few volunteers trained and few group supported in Blantyre.	*** But not as good as elsewhere in Kapeni TA (Blantyre)	NA
		SG	** But almost nothing done in the third year	** Sometimes not mentioned	NA
	R2	CBCCs	** Most indicators below targets	***	*** But drop out of volunteers as a challenge
	R3	Community Capacity	** But very low number of community leaders trained in Blantyre	NA	*** in Balaka and Lilongwe (not mentioned in Blantyre)
MAGGA	R1	Limbe activities and awareness	* Few tests	NA	NA
	R2	Peer education	*	** But not good or not mentioned in Chimutu, Somba and Kapeni TAs	** The PE methodology was considered a failure
	R3	Livelihood skills training kapeni	**	* only one person knows the initiative	**
	R4	Monitoring and management	* Few monitoring visits	NA	NA

4.6- Conclusions and recommendations

PM is well known all around the country and in general the judgement is a positive one, given the initial ambition of the project and its size this has to be considered a

success. In the final report of PM1 we stated that this project was in need to evolve and to improve in its second three-years term, namely PM2. In particular, we detailed three main conditions for the realization of these ambitions, here reminded:

- 1) the need of deepening the knowledge of the possibilities offered by Project Malawi, working together in a real synergy and not merely as a nice wish;
- 2) the need of sharing the locations of intervention, following the successful experience of Kapeni. Being at that time CSE-DREAM active in the district of Blantyre, Balaka and Dowa, we were suggesting that all partners would work together in all these districts;
- 3) the need of reconsidering the chain of command and the modalities of management of Project Malawi, clearly defining “who” should decide to do “what”.

At the end of PM2 it is worth of interest to consider if and how these conditions have been fulfilled.

About synergies, what has been described in par. 4.3. well demonstrates that the goal has been reached: the partners are no more introducing themselves as a single organization, but as a member of a wider project, naming themselves as “Project Malawi”.

About locations, this very report emphasizes that now all four partners are present in all the 6 TAs where PM2 is operative, even if not always in the very same villages; also this condition has been therefore satisfactorily accomplished, even if some further improvements could be recommended for the future. This refers to CSE, whose activities naturally tend to be more centralized for a number of reasons, but also to MAGGA, apparently due to the shape of Educational Zones. During PM2 MAGGA opened up and worked in a number of villages where none of the other partners was present, while there are some villages covered by both CISP and STC where MAGGA is not present.

About the project management, we must sadly observe that the situation is more or less the same recorded at the end of PM1. In saying that we feel that after six years of collaboration we can be quite frank, as we have always been, on providing our comments on aspects which do not strictly belong to our commitment to Monitoring and Evaluation of PM2 in the strict sense of the terms. We have been informed that for the coming there years there will be some changes in the relationship between the donors and the four partners (yearly contracts to be renovated?), and also in the logistic of the relationship between the donors and the partners: there will not be in Malawi a person formally representing PM3 as it has been the case for PM1 and PM2. We feel that two comments on that might be useful.

- First, probably the absence of a national coordinator who is an expatriate can be sustained because of the increased synergies among the partners and in the light of future sustainability of the project based only on nationals, but it is absolutely essential that there should be a precise indication of:
 - how do the partners relate among themselves locally ? Is anyone in charge of coordination? Which are his duties, powers and responsibilities ?
 - how do the partners relate to the donors for reports and for receiving the financial instalments ? Through the general coordinator in Italy ?

- Second, PM is a very relevant project in financial terms for Malawi, and also already a relatively long lasting one. It would be extremely useful - not to say absolutely essential - that the donors should define in precise terms whether or not this is the final phase of the project.

Actually, if we want to offer some recommendations for the successful development of PM3 – as much if not more brilliant than PM1 and PM2 -, they can be summarized in three tasks: to strengthen what existing, to involve local communities, to struggle for sustainability.

To strengthen what existing can be further detailed as tightening synergies among partners, and to root the project more deeply into the six TAs already involved, with no further spreading in other TAs until this stable rooting has been achieved. This work together should be conceived in PM3 not just as a mere conservation of what has already been done (this could be exactly the risk we reported in our previous field visit, *“...that in the partners is insinuating the feeling that a “plateau” in activities has been reached, that these activities must be carried on in a mood such as ‘business as usual’, with no further boost for changes and improvements”*), but rather as a training for the future, aiming to a Project Malawi able to go ahead with no further external support.

This achievement could be extremely important not only for the partners themselves, but also for all the other organizations working in the Country in these fields, spurred to emulate a similar experience. It is for this very purpose that the Secretary of the OPC herself, Mary Shawa, is constantly urging to publish the *“training manual”* to serve as an example for other organizations wishing to work together as PM2 has done.

It is encouraging from that point of view to read in the partners’ reports that *“...extra meetings were attended to design the synergies for the third phase of Project Malawi...”*; *“...having learnt from the challenges faced in the second phase they are ready to embark on the new targets and to work in new ways with their partners ... in this phase CISP continued to work alongside its Project Malawi partners with a focus on looking forward to Project Malawi 3 and introducing new methods of working together”*.

To involve local communities is the key issue for guaranteeing survival of many of the initiatives realized in PM2. A good example of that is the so called *“Chitukula initiative”* widely described in this and in previous reports. If other communities could verify what has been done in Chitukula an emulation mechanism could be triggered, and it would be fully “Malawian”.

This concept is what expressed in STC report: *“Save the Children contributed a lot to the Project Malawi partnership through its robust community mobilisation action cycle management”*.

Also the involvement of Govt. officials and within governmental bodies such as the District Executive committees is to be sought for: as properly emphasized in CISP report, *“...as part of the third phase of Project Malawi CISP will be partnering with local government officials and community members to ensure that the VSLA and IGA model is sustainable so that these individuals be able to monitor and set up groups after the exit of PM”*.

The struggle for sustainability should be “the” main task of PM3. Paradoxically, the moment in which Project Malawi should learn how to walk alone is one of the worse the Country has ever faced, as discussed at the par. 1.2. A common complaint of all reports deals with *“lack of..”*: forex, fuel, more sophisticated commodities such as

condoms, chicken feed, food for children – not necessarily in this order –; the Kwacha has been devalued once and is expected to devalue again shortly; and so on.

It is exactly in this situation that PM3 partners will be called to an extraordinary effort to find out all the possible ways to endure the crisis and to sustain the project in the long run. The edition of the training manual could be one way; broadly speaking, educational activities could be another one, as suggested also by Dr. Mwenda in his interview about laboratory activities: “...*just long term capacity building has not yet been seen and sustainability on the long run has yet to be improved. A possible suggestion could be to implement Masters PhD’s courses within the institution, to breed some high level laboratory experts*”.

In this very direction goes the observation in CSE-DREAM document ⁽³⁾ where it emphasizes “...*the ever more active role played on the field by the local staff... it’s a fundamental activity also from the ‘political’ point of view to foster program acceptance by the Malawian health staff*“. To be sustainable in the long run a program has to be felt as “own” by the Malawians, and no more conceived as somewhat “alien” to them.

As we said few lines above, what PM3 management will be called at in the next project is to help the partners to design and to realise this strategy. First of all, they’ll need to have a clear picture of what is expected from them and of what they can expect from the donors: how much money, over which period and under which conditions.

Actually, the perception in the partners is that the next will be the last run of PM: “*Lessons learnt from phase 1 and 2 of Project Malawi provided strategies for next phase ... At the end of the second phase of Project Malawi we have reached many of our targets and are looking forward to the third and final phase*”. It would be highly advisable to clarify this point from now, to design together (management and partners together, not only among themselves they must have synergies !) what could be defined a “*continuation strategy*” - including the possibility of finding alternative sources of funding, and even if on a remarkably reduced scale - better than “*exit strategy*”.

The need to continue in the work undertaken since six years is badly hoped for by the Malawians: as Dr. Chimbandwira put plainly and clearly in his interview, “...*the extension of the program to PM3 is a good news because HIV will not stop for ages to come, and partners supporting the fight will be always welcome*”.

PM1 saw the partners just working side to side, and just occasionally working together; in PM2 they learned to consider themselves not only as separate organizations, but as a single entity, working together and in the same places; once this acquired, PM3 should see the partners working together in order to learn how to go on in the very long run with the capacities built on them and with them.

Annexes

Annex 1: details about people to be invited at TA level meetings

Annex 2: pictures

Annex 3: indicators from partners' reports (annexes 6)

References

- 1) Government of Malawi, Ministry of Health: Quarterly HIV Programme Report (*HIV Testing and Counseling, Prevention of Mother to Child Transmission, Antiretroviral Therapy*), April - June 2011
- 2) Republic of Malawi, National Statistical Office, 2008 Population And Housing Census, Preliminary Report
- 3) Project Malawi - Secondo triennio - 2008-2011 - Impatto del programma DREAM sulla salute delle persone sieropositive in Malawi - Gennaio 2011
- 4) Pujades-Rodríguez M, O'Brien D, Humblet P, Calmy A. Second-line antiretroviral therapy in resource-limited settings: the experience of Médecins Sans Frontières. *AIDS*. 2008 Jul 11;22(11):1305-12
- 5) Laurent Ferradini, Vara Ouk, Olivier Segéral, et al. High efficacy of lopinavir/r-based second-line antiretroviral treatment after 24 months of follow up at ESTHER/Calmette Hospital in Phnom Penh, Cambodia *J Int AIDS Soc*. 2011; 14: 14.