NORWEGIAN CHURCH AID

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HEALTH, HIV AND AIDS PROGRAMME

END OF PROGRAMME EVALUATION REPORT

"DETERMINING SPACE BETWEEN PROJECT IMPLEMENTATION AND RESULTS"

Norwegian Church Aid

Box 30793 Lilongwe

Malawi

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Eric Phiri

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ii. Acronyms

AIDS	
ADC	Area Development Committee
ART	Anti Ritroviral Therapy
CBDA	Community Based Development Agents
CBCC	Community Based Child Care Centre
CBOs	Community Based Organisations
CC	Children Corner
CCC	Chisomo Children's Club
CHAM	Christian Health Association Malawi
CHC	Catholic Health Commission
DHO	District Health Officer
DREAM	Drug Resources Enhancement against AIDS and Malnutrition
EAM	Evangelical Association of Malawi
EBF	Exclusive breast Feeding
ECD	Early Childhood Development
FBO	Faith Based Organisations
FGD	Focus Group discussion
FP	Family Planning
HCW	Health Care Workers
HIS	Health Information System
HIV	
HR	Human Resources
HTC	HIV Testing and Counselling
HTC	HIV Testing and Counselling
ICT	
IGA	Income Generating Activity
IEC	Information, Education and Communication
ICDP	
MOH	Ministry of Health
MMR	Maternal Mortality Rate
MNCH	Maternal, Neonatal and Child Health
MIAA	Malawi Interfaith AIDS Association
MoU	Memorandum of Understanding

NMCM	Nurses Midwife Council of Malawi
NCM	Nurses Council of Malawi
NCA	Norwegian Church Aid
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PSS	Psychosocial Support
SLA	Service Level Agreements
STAR	Societies Tackling Aids through Rights
SLA	Service Level Agreement
SOPs	Standard Operating Procedures
SRH	Sexual reproductive Health
SPSS	Statistical Package for Social Sciences
SDA	Seventh Day Adventist
VDC	Village Development Committee
VHC	Village Health Committees
OPD	Out Patient Department
QMAM	Qadria Muslim Association of Malawi
TBA	Traditional Birth Attendants
VSL	Village Savings and Loans

iii. Executive Summary

Malawi has poor health indicators, especially on maternal, neonatal and child health; and also HIV. Major causes of maternal mortality include poor decision making at household level; teenage pregnancy and lack of knowledge on danger signs of pregnancy[1]. Shortage of health workers has also contributed to high mortality rates among these people groups, especially in rural areas. Furthermore, most health facilities have worn out and dilapidated infrastructure. All these have contributed to poor service delivery. Against this background, Norwegian Church Aid implemented a programme, to improve access to quality health care and well being for the mothers, children, including men in targeted communities in Malawi. The programme commenced in 2012 and phased out in December 2015.

The phasing out of the programme necessitated an evaluation, to assess the extent to which the programme has contributed towards achieving results in key health areas. As such, NCA hired the services of Watipatsa Consulting to facilitate the process. The evaluation design was informed by understanding of Terms of Reference. A mixed methodology approach was engaged, in which both qualitative and quantitative methods were employed to collect and triangulate data. Data collection processes included: literature review, development and review of data tools, data collection, data processing and report writing.

Respondents were purposively and randomly sampled to ensure representativeness and proportionality of people groups and thematic areas. Focus group discussions and key informant interviews were conducted to collect qualitative data. Quantitative data was obtained through individual interviews with mothers and their husband; children and parents or guardians of the HIV affected and infected children. Secondary data was obtained largely through review of relevant literature. Both quantitative and qualitative data gathered were analyzed accordingly. Data from key informant interviews and focus group discussions were developed into themes and analysed using thematic content analysis. The quantitative data were analyzed in the SPSS computer package.

Partners in this programme planned and implemented interventions in various thematic areas; with training; advocacy; infrastructure development and service delivery as major components. Implementing partners were faith based organisations, health training colleges, health facilities and their surrounding communities.

[1] Malawi Health Sector Strategic Plan 2011-2016

The programme invested a lot to build capacities of the partners, which was a right approach to development. Now, various community structures are well capacitated and articulate issues and do their duties well. Health facility staff; college tutors and administration staff have knowledge and experiences in project management administration. CHAM's capacity has also improved greatly; just like the faith based organisations which also were given opportunity to reach the hard to reach areas.

Training in and access to ICT has connected the facilities to the world. Now, processing of reports and information is done with the expected speed than was the case before. Health structures, equipment and books were provided to supplement the training and service delivery aspects of the programme. Such assistance enabled the colleges to balance theory and practice; while others met NCM requirement in registered nurse upgrading course. Conducive environment for teaching and learning was also enhanced; leading to the colleges increasing intake and attaining increased pass rate, compared to the past. In health facilities, the initiative has significantly supported promotion of safe motherhood agenda in that there is now adequate space for maternity and other services; among other gains.

Most of the baby deliveries are now happening at health facilities, because the people have appreciated the importance of doing so. The few deliver at home or TBA, and its because of bad staff attitude; religious and cultural beliefs and economic challenges. Slowly men are getting involved in MNCH issues. And various strategies are engaged to persuade more men.

The choice of interventions (projects) was found to be good. Their implementation really contributed towards improving access to health services - not only by mothers and children, but others also. Outcomes 1, 2, 3 and 5 were linked to compliment each other. Health structure development, equipment, ICT and material provision cut across these outcomes; also complimenting them. Thus, mothers were encouraged to deliver at facilities which were equipped to support them. Secondly, improvement of teaching and learning in a classroom was supported by availability of skills lab, books in library and good accommodation for both tutors and students.

In the same vein, outcomes 2 and 4 would have been cutting across, especially in outcome 1. This is because the study found that advocacy issues were embedded in this outcome. And the nature of the issues required the level of charisma that was exerted in outcome 2 and 4. Doing so could have empowered communities to hold accountable TBAs and gatekeepers for example. It was reported in this study that NCA decided to start small with outcomes 2 and 4

to give learning a chance. However, our view is that the learning would have been much if these were piloted together with some of the outcome 1 communities and partners. Similarly, a thin line exists between outcomes 2 and 4. Some of the interventions were either the same and similar. Integrating them in one outcome would have made the response more comprehensive.

The programme was robust and relevant. However, the concern lies in that fact that the implementation period was too short; especially considering the numerous delays that characterized it. Next time, there is need to thoroughly prepare the partners before taking off.

The evaluation process identified practices that were good in that they supported effective programme delivery. Partners are therefore encouraged to learn from, to inform future programming.

i. Some of the interventions were sourced from partners' strategic plans. The approach helped partners not to deviate completely from their core business. It therefore denotes that partners were relevant to the agenda under pursuit.
ii. Related to this, the degree of flexibility with which the programme was managed. Social development programmes are dynamic in that some of the framed assumptions may not hold true during implementation time. When such situations arose, partners were allowed to make changes after giving convincing explanation. This gave the programme chance to still be relevant amid changes that would otherwise negatively affect implementation.
iii. Periodic (quarterly) review meetings provided forums for partners to discuss important programme issues. As a result, sense of awareness and uniformity among the partners were reinforced. Some of them were motivated to work hard upon learning from how progress others were making.
iv. After noticing that low disposable incomes were constraining some mothers from accessing services, some facilities introduced relevant innovations like VSLs to economically enable the mothers pay for health services. This means that partners facilitated the programme while thinking outside the box.
v. Throughout the evaluation process, NCA was commended for facilitating the programme with a human face – treated partners with respect; being able to understand situation of partners – asking the people their views. Although partners were many, NCA paid attention to individual differences and needs; thereby assisting them accordingly.

A number of areas were noted to be areas that need improvement, which in our view, hindered progress to a certain degree. These include the following:

i. Food security and water availability negatively influenced access to improved health aspiration. In communities where food was in short supply, attainment of some programme components was compromised. For example, food and water shortages impinge upon operations of CBCC in most of sampled sites. Young children travel long distances to fetch water. On the other hand, communities' willingness to provide food to the CBCCs has waned due to critical food shortages at household level.

ii. Delayed funding was experienced during the programme period. Several factors were responsible for these delays which included funding arrangements; partners' lack of capacity to meet requirements.

Recommendations are that:

i. Several factors determined access to health services like place of delivery. These included bad treatment at facilities, religious and traditional beliefs and economic hardships. These need to be reviewed to inform next programming.

ii. Gatekeepers existed in this programme. Put a mechanism to encourage future partners to deliberately be conscious of such. Since some of the may be context specific, partners must be empowered to be able to identify them. NCA must make deliberate efforts to follow up, to ensure they do not skip through the implementation process unattended.

iii. Getting males involved is a big milestone for the programme. Work on the hindrances to ensure more are brought on board. Such decisions may call for innovativeness like was the case with bawo in Lumbira.

iv. Role of TBAs in maternal and child health will not be overemphasised here. By now, we have learnt how much women expect from them which is influenced by their beliefs and what the TBAs promise to offer. There is therefore need to critically reflect on this to find practical solutions. Turning a blind eye will negatively affect delivery of future programmes.

v. Most of the facilities in this programme were paying. Therefore work to improve economic status of the clients who are mostly the vulnerable groups in society to ensure that their economic status does not counteract efforts on improving access to health services. SLA arrangement could have been idea if government was capable of

accommodating all the facilities. In the absence of this, devise feasible means like the VSL initiative that was implemented in some of the facilities.

vi. Delayed funding existed at every level and caused by factors that were with the control of implementers, coordinating unit and donor. Future programming must serious find mechanisms to address these.

vii. There are instutions that exist forever such as the church. Find ways of bringing them on board as one way of reinforcing sustainability of the gains.

We conclude that the programme was the right delivery vehicle which enabled NCA to translate long term goals into action. It delivered on all outcomes; and was strategic - worked with partners who have strong legitimance and representation in their communities. Doing so enabled the programme to respond to the call by Malawi Government to improve quality and quantity of health workers. As a result; significant contributions were made towards improving access to health services by mothers and children; supporting HIV and AIDS infected and affected children; building capacities of partners and CHAM secretariat and strengthened relationships among them.

Various stakeholders are of the opinion that the programme was a success, and wished if it continued and extended into other areas. We also recommend implementation of a similar programme, in the same and/or other areas. Doing so will consolidate the gains, especially now that the partners are capacitated and have experience.

1. INTRODUCTION

Malawi has poor health indicators, especially on maternal, neonatal and child health; and also HIV. Major causes of maternal mortality include poor decision making at household level; teenage pregnancy and lack of knowledge on danger signs of pregnancy[2]. Shortage of health workers has also contributed to high mortality rates among these people groups, especially, in rural areas. And most health facilities have worn out and dilapidated infrastructure. All these have contributed to poor service delivery. HIV and AIDS has led to increase in number of orphans, who face a number of challenges, including traumatic experiences.

It is against this background that Norwegian Church Aid implemented a programme, to improve access to quality health care and well being for the mothers, children, including men in targeted communities in Malawi. The programme's overall goal was to improve health and environment of the mother and child through the provision of quality maternal, neonatal, child, health services, psychosocial support and quality health workers in Malawi by 2015.

The programme focused on four main areas: improved access to maternal, neonatal and child health; psychosocial support to affected and infected children; improved health training in Malawian health colleges; improving collaboration and advocacy for health stakeholders and capacity building of CHAM secretariat.

The different components of the programme were implemented by different partners: the maternal, neonatal and child health component was implemented by 23 CHAM and 2 government health facilities. The psychosocial support component was implemented by six faith based partners in six districts. The health training component was implemented in collaboration with CHAM secretariat as well as Norwegian university colleges, in 15 health training institutions. The faith based organizations were also implementing partners and included Malawi Interfaith Association (MIAA), DREAM, Evangelical Association of Malawi (EAM), Quadria Muslim Association of Malawi (QMAM), Chisomo Children's' Club and Chikhwawa Health Commission (CHC).

[2] Malawi Health Sector Strategic Plan 2011-2016

2. EVALUATION METHODOLOGY AND LIMITATIONS

The programme was phased out in December 2015, with a no cost extension into first three months of 2016. This then necessitated an evaluation to assess the extent to which the programme has addressed and contributed towards achieving results in key health areas. As such, NCA hired the services of Watipatsa Consulting to facilitate the process.

The evaluation design was informed by an understanding of the scope of work stipulated in the Terms of Reference. A mixed methodology approach was engaged in which both qualitative and quantitative methods were employed to collect and triangulate collected data. Data collection processes included: literature review, development and review of data tools, data collection, data processing and report writing.

The review of documents gave the consultants understanding of the task; thereby informing the sampling process, development of data collection tools and overall planning of the study. Once drafted, the data collection tools were subjected to a review exercise. Prior to data collection, the consultants held meetings with NCA management to review and clarify the ToR, to agree on the study's principal objectives, and select key stakeholders to participate.

Respondents were purposively and randomly sampled to ensure representativeness and proportionality of people groups. Sixteen focus group discussions and twenty key informant interviews were conducted to collect qualitative data. Secondary data was obtained largely through review of relevant literature. The study administered questionnaires to pregnant and lactating mothers and their husbands; children; children's parents and guardians.

Both quantitative and qualitative data gathered were analyzed accordingly. Data from key informant interviews and focus group discussions were developed into themes and analysed using thematic content analysis. The quantitative data were analyzed in the SPSS computer package to measure the proportion of health workers currently using the skills acquired, the degree of perceived training relevance and other variables.

Major limitation of the study was the inavailability of the relevant data. The purpose of this report therefore, is to document outcomes of the study process. Once finalised, the report will be shared with major programme stakeholders.

3. EVALUATION FINDINGS

Programme partners pursued several outcomes with the aim to improve access to health services in targeted communities of Malawi. Implementation of related interventions produced results, and these are documented in the proceeding sections.

3.1 Outcome 1: Increased availability and utilisation of maternal, neonatal and child health services in selected communities surrounding CHAM facilities.

To achieve this outcome, interventions were planned and implemented using various strategies and concepts; involving partners at community and facility levels; to save lives of mothers, neonates and children in the communities surrounding health facilities and beyond.

a. Planned and Implemented Interventions

The planned and implemented interventions included trainings, delivery of antenatal care, under 5 services, family planning, HTC, distribution of IEC materials. Equipment and structures were also provided to compliment the delivery of services. The IEC materials carried messages on importance of using under-five clinics, importance of good diet to pregnant women and male involvement.

Community Stakeholders

Community structures (VHC; maternal death audit; emergency transport; community based distribution agents) were established and trained, on commencement to implementation. The training empowered them to coordinate implementation at community level. They were responsible for: encouraging mothers to access antenatal and postnatal services early; exclusively breast feed their babies; know and prepare six food groups; family planning. Males were encouraged to be involved in maternal and child health issues. They follow up mothers who: died within 6 weeks after delivery and find reasons for the death; those who delivered at TBA, home or on the way to health facility. The committees meet regularly to review and follow up activities and share responsibilities.

Community leaders are also a force to reckon with in this work. Therefore, they were engaged, though not to the level of committees. They were supportive, as evidenced by owning the related by-laws. In places like Lunjika, elder female relatives determine when a woman who has just delivered should go for check up. As a result, some go for check up, 2 weeks after delivery instead of 1 week. The reason is that they are told to wait for navels to

fall off. This suggests that these clan leaders are gatekeepers to access to health services. Yet the programme (the partner responsible) did not identify and involve them.

1. Prenatal and Postnatal Services

Access to prenatal and postnatal services is important to delivery of quality health care to mothers and children. As such, the programme promoted these services among the target communities. The study followed up this issue and found that 79.27% of mothers take their children to under 5 clinic once in a month; once in 3 months (5.09%); once in 6 months (2.18%). And 6.18% of women never take their children to under 5 clinics, it was not applicable to 4.36% women who had this as their first pregnancy. On the other hand, 49.45% reported to have started attending prenatal clinics in 1st trimester; second trimester (47.64) and only 1.82% said in third trimester.

2. Outreach Clinic Sessions

Community outreach clinic sessions were conducted as one strategy used to reach pregnant women; lactating mothers and under 5 children with the right information and services. And indeed many people were reached in their communities, even the hard to reach areas.

3. Nutritional Status of Mothers and Children

A strong link exists between nutrition and health improvement. This is why nutrition was mainstreamed in outcome 1 to help mothers and children access right foods. Vegetable gardens were established both at health facility and community levels. Home craft workers from facilities visited the communities to facilitate menu sessions in which the people learnt how to prepare balanced and nutritious. And quantitative survey revealed that most women (84.36%) expressed knowledge of the food groups, only 15.27% were ignorant. A total 73.09% of them said that there are six food groups; 7.27% did not how many food groups are there. The rest mentioned different number of food groups.

Assessing children's nutritional status was done. Those found under nourished were referred to NRU or given supplementary foods. This exercise confirms that efforts to promote nutrition have resulted into reduced malnutrition among mothers and children. In 2015, only 9 children were malnourished in M'bwatalika and Thembe communities. Years before, 96 malnourished children were registered in Sukasanje in Phalombe, Madisi in Dowa, and Mbwatalika in Lilongwe rural. Mothers know the correct food groups and endeavour to

prepare them for their families. Taboos about foods have been reduced among the community members. All these have contributed towards reduced malnutrition among women and children.

4. Place of Baby Delivery

Awareness on the importance of delivering at health facilities and not at home or TBA, was created among the people. Former Traditional birth attendants (TBAs) are involved and their new roles are restricted to referring the pregnant mothers to health facilities; give health education and report the non complying women to authorities. Those the evaluation engaged complained that they were stopped from delivering women without being given alternatives to compensate for the loss of business. The study confirms that most of the formers TBAs stopped practicing. Those who do it are few, to get some income and do it secretively for fear of heavy penalties. Engaging them provided an opportunity to tap from their vast knowledge in maternal issues; but also reduced chances of continuing practicing.

The initiative has yielded positive results in that the majority of women now deliver at health facilities. There are very few deliveries at home or TBA or on the way to a health facility. "*Number of people going to TBAs has decreased;"* said Kaseghe - Lumbadzi health centre nurse. Outside facility deliveries are followed up to establish the causes and also encourage the mothers to go for check up at the facility. Those due to negligence and poor planning attract penalties (a goat to the chief and MK 2,000 extra fee at the facility). Because of such tough by-laws, most women do comply with the requirement.

To avoid delivering on the way, women are encouraged wait for delivery at the facility deliver. But some still delay for two reasons: to reduce costs and when they think their experience to help to detect exact day of delivery. And sometimes, labour starts earlier than their predicted day. The end result is either home or roadside delivery. A total of 37.45% women consulted expressed knowledge that some women deliver at home or TBA; while 59.27% said they did not any. It was further reported that others deliberately choose to deliver at TBA for the following reasons:

i. **When suspecting bewitchment** - a woman may suspect that her pregnancy is bewitched. On the other hand, TBAs claim to have charms that are able to reverse the fate. She therefore choose a TBA to ensure safe delivery. Similarly, some TBAs

claim to have concoctions that stop labour and delivery pains. Such claims motivate women to deliver at their place to bypass this painful phase of baby delivery.

ii. **Bad attitude of some staff** is another reason why women choose to deliver either at TBA or home. "*Amatishuta pakabwera odwalike"* Said one woman during a focus group discuss in Mpingu – M'bwatalika. This is translated as: they push as around when there is an emergency case.

iii. **Many deliveries & outside marriage pregnancies** - when a woman has delivered many children, she would not prefer delivering at a facility avoid being ridiculed by facility personnel. Similarly those without husbands, do everything to avoid being laughed at, for being pregnant without husbands. If during a previous pregnancy, a woman delivered through caesarian section, she gets referred to deliver at a district which she may not like idea due to bad experiences. She may therefore choose to deliver at home or TBA.

iv. **Previous bad experiences in waiting room** - waiting space at a facility may not be enough at time. Then women get bullied to give room to emergency cases. Next time, they will not be keen to go and wait.

v. **Lack of transport & cost of delivering at a facility** - lack of money for user fees forces some women to shun the paying facilities which may be the only one within their vicinity. On the other hand, TBAs accept to offer the service at lower price than facilities. If clients do not have money, the service is offered on credit or paid for in kind. Such flexibilities attract women to consider delivering at TBA. Lack of transportation is another setback and was highlighted by almost every community the evaluation team visited.

That is why Nthorowa, Matandani, Lulwe, Thomasi and Lumbira Health Centres introduced village and savings loans scheme for pregnant women and lactating mothers. This economically empowers them to afford paying for the services when need arises. It is a revolving fund managed by health committees. The women borrow money to do business, and repay without interest after six months. In 2015, loan portfolio per committee was MK250, 000 in Lumbira communities. Now, some families can afford to pay for medical expenses; improved food security in homes.

vi. **Unfavourable religious beliefs** - some religious beliefs (like the Zionists and the Apostolic Believers) deter their members from accessing health services or take any form of medication including antenatal and postnatal services.

5. Male Participation in MNCH Issues

Participation of men in maternal, neonatal and child health issues was promoted. Men were targeted because, apart from fending for the families, they are decision makers at household and community levels. As such, community mobilization; sensitization meetings and motivational talks, were made to solicit their involvement. Men are asked to go with their wives for antenatal sessions, especially during the first visit and delivery. Women whose husbands are not residing in the communities, get letters of confirmation from chiefs to present at facilities. Otherwise, they are either not assisted or penalized for going alone.

Those who support their wives extraordinarily are considered champions and are tasked to encourage fellow men to support their wives as well. Lumbira introduced bawo competition in order to target those who play the game at Sigerege market and other public places. Through this initiative, messages on importance of male participation are shared. Other facilities used mobilisation campaigns, radio programming and non-monetary incentives like dramas, football tournaments and competitions to achieve the same.

Most focus group discussions indicated that male participation is gradually picking up. Women participants said their husbands have been supportive in the following ways: encourage them to access antenatal and postnatal services in time (10.9%); accompany them for HIV testing (6.6%); accepting family planning method (4.5%). A significant proportion (65.1%) said the husbands never support them. *It was a taboo for a man to escort his wife to a facility. But now, message on their involvement is like meal time prayer. Nowadays, before any function is concluded, male involvement message is disseminated.* said Halmiton Mwandama of Sigere – BT. And Vinjeru (Lumbira Health Centre Administrator) said *'when I just came in 2013, one could rarely see men coming to the facility to access services'*.

Secondary data also supports this finding which reports that more men were registered in 2015 (4,192) as compared to 2014 which registered 739 men (2015 NCA Reports). In Chibembe - Mzimba, men indicated that 80% of men are supportive, while women said it is 50% of men who participate.

Some reasons caused some men not to participate. Some of them do not feel obliged, since they are not the ones carrying the pregnancies. Others feel provision of necessities is enough and all they can help with. Some do not get involved for fear of being tested for HIV.

6. Exclusive Breast Feeding , Vaccinations & Family Planning

To ensure that babies are growing health, parents were encouraged to breast feed their newly born babies, within the first hour after birth; then breast feed them exclusively, up to six months. Follow up on this practice revealed that between 60 and 80% of the women who attended FGDs indicated to be practicing it. A total of 69.45% who participated in the one to one interviews follow it; 16.36% don't. The issue was not applicable to 13.45% because they were pregnant the first time. Others fail to breast feed exclusively, due to the following reasons:

i. Children are given other foods in order for the mothers to have quality time to do chores and piece works.
ii. Poor mothers' nutrition due to food shortages leads to low milk production levels. Therefore, the children do not get enough milk, no matter how much and frequently they suck. Then other foods are introduced to avoid starving them.
iii. Drunkardness prevents some lactating mothers from breast feeding their children exclusively; while others feel ashamed to breast feed in public.
iv. Family disagreements result in some women moving out of their matrimonial homes; leaving their nursing babies behind. In such circumstances, other foods get introduced to save the babies.
v. Traditionally, some women do not believe that babies can survive just on breast feeding alone, for that long period of time. To such women, giving extra foods is normal and being wise.
vi. Lack of proper understanding of EBF also contributes to the non compliance. During FGD sessions, some women failed to define exclusive breast feeding. This means they would not practice something they do not fully know.

Efforts were also made to create awareness on the role of immunisation in children's health. The people are now knowledgeable; as reflected in their endeavour to have them vaccinated; a complete dose and in time. Some fail on the two aspects; of timeliness and completeness because they forget, especially the last vaccines (measles at 9months). Non availability of the vaccines on days of facility visitations affects completion and timeliness. The mothers are also knowledgeable of the vaccine types. And this is mostly expressed through the times and body part onto which they are administered. A total of 88.73% of the mothers interviewed indicated that their babies received vaccine; 5.45% of them said the babies did not receive;

the question was not applicable to 5.45% of the sampled women. A total of 68.73% had their babies receive complete vaccination; 24% said the vaccination was not complete.

Size of family is a determinant of mothers' and children's health. As such, the programme embarked on creating awareness on the same. CBDAs were also trained and deployed to provide family planning services right in the communities. Gradually, the people are appreciating the need to have manageable number of children. They realise how difficult it is to raise children in light of the economic hardships. In this regard, family planning is accepted by significant numbers, especially women since they are the ones who bear most of the burden of child bearing. Between 2 and 4 children per family is reasonable. "*Dziko silikufutuka ndiye iwe ungofutula ana?"* This was said by one of FGD participant at Kumayani outreach centre in Kanyama. The translation is that the land is not expanding, then why should one keep on increasing number of children?

Other husbands do not follow any family planning methods because of misconceptions and negative attitudes about it. As such, their wives follow planning methods secretly. The only problem with this approach to non cooperation of husbands is that, the husbands may react negatively. And 43.64% women reported that it is husbands who make decision on family planning; while 8.36% said it is wives; 43.27% said both are responsible; 3.27% said family planning just happens naturally to them.

Institutional policies prevented Catholic partners to implement the family planning component of the programme. However, community structures are allowed to promote it, and people to access the service from other players if available. In our view, those promoting it lack technical backstopping from the health professionals. Hence delivery could not have been as effective as it would be if the partners were involved.

b. Key Findings

This section documents results that have been registered as a result of implementing various interventions under outcome 1. These include:

i. Community's knowledge on MNCH and related issues has notably improved over the past 3 years. "*This is a big milestone to me"* said Vinjeru Mhango, of Lunjika Health Centre. For example, now, the people know that pregnant women must:

- Start antenatal clinics within 3 months of pregnancy with minimum of 3 to 4 antenatal visits.
- Decide way before delivery where their baby to be delivered.
- Go for antenatal and postnatal services; HIV test together with husband. If positive, they must deliver at the facility to prevent transmitting HIV to the baby.
- Breast feed the babies within one hour after delivery; and exclusively breast feed for six months.
- Ensure children attend postnatal services and have their growth monitored.

Acquisition of such vital knowledge has resulted among others, into:

- Increased number of women accessing antenatal and postnatal services, health facility deliveries; compared to the past. The 2015 CHAM annual report indicates that number of 1st trimester ANC visits increased from 338 for January to September 2013 period, to 716 the same period in 2015.
- Neonatal death rate has reduced from 31 (6.9 per 1000 live births) in January – September 2013 to 15 (5.5 per 1000 live births) in the same period in 2015.

Number per mother	Number of Still Births	Cases of Death Within:		
		28 Days	1 Year	5 Years
1	10	11	9	5
2	5	1		1
3	1			
Totals	**16**	**12**	**9**	**6**

Source: End of programme evaluation 2016 (n=275)

No significant change in maternal deaths observed, only 1 in January – September 2013 and 4 in the same period in 2015. These occurred at different facilities. The causes were due to hemorrhage and delayed referral from communities and primary health facilities (2015 CHAM Annual Report).

- Births before arrival at facilities (BBAs) have also reduced from 235 for January – September in 2013; to 113 in the same period in 2015.
- Improved health seeking behavior. Matandani had a monthly OPD average 230 visits in 2014. In 2015, the OPD attended to 400 patients per month.

- Male involvement in MNCH issues has increased from 1,091 (13.9% of total ANC visits) in January – September 2013 to 2,989 (40.4% of total ANC visits) in the same period in 2015.

ii. Capacity building; provision of equipment and other resources, have enabled service providers to master knowledge and skills which has resulted into improved quality care. Emphasis on reporting has improved report writing and dissemination skills.

c. Suggestions for Improvement

The study has identified some factors that may not sustain gains in access to health service. Below are some them:

i. **Unfriendly attitudes of facility personnel** - some health facility staff was mentioned as a major hindrance to the people's quest for improved health service access. At Kanyama Health Centre, management transferred one nurse because she was rude to clients.

ii. **Cost of accessing health services** - nine in ten participating partners are paying facilities; and are often the only providers in the rural areas. At the same time, the people's incomes are mostly too low to afford paying for the services; thereby impinging upon service utilisation.

Authorities know about this challenge, and SLAs are being signed with respective DHOs to address this problem. However, to date, very facilities are into such arrangement. In Dedza for example, only 3 Catholic facilities were on SLA with the DHO at the time of the evaluation. Some facilities have introduced village savings loans to economically empower their clients, especially women.

The SLA arrangement was the right way towards improving facility utilisation. Studies have shown that there is more utilization of health services where SLAs are in place than where they are absent. However, at the moment, the Government does not have adequate resources to enter into this kind of arrangement with all private facilities. CHAM is still working on this with government.

iii. **Long distances to facilities** - the facilities are far apart in most areas; causing people to travel very long distances to reach them. Those without bicycles or cannot pay for transport have to walk, which is difficult for children, the elderly and very sick.

iv. **Delayed or non implementation** - some planned interventions were not implemented, while others delayed. The following factors attributed to this development:

- Some respondents said that facility staff given the management responsibilities, were not trained in project management, prior to commencement of implementation. As such, their facilitation was a trial and error; leading to delayed implementation, reporting and subsequent funding disbursements. Others indicated that the implementers were oriented in project management, but later in course of implementation. Yet others were of the view that some had problems facilitating the programme because either they did not want to go out of their comfort zone, or desire to get extra remuneration for the perceived extra work was the issue. High staff turnover; poor communication and weak finance management systems; poor governance system were responsible for this under performance.
- Delays happened at various levels: from NCA to CHAM secretariat; from health proprietors' central office to facilities; from CHAM to facilities and from NCA to facilities. The delays by NCA came about partly because of its condition – to disburse funds only when CHAM capacity challenges were addressed. This took one year; causing the CHAM coordinated facilities (13) to implement only in two of the three years.
- Funding for SDA partners was effected through their central office in Blantyre. This arrangement delayed work because transfer of the funds from the central office to the facilities delayed often due other commitments. At one facility, it took 2 months before the facility knew of the funding transfer. CHAM only offers guidance but the decision is left to facility owners to decide basing on capacities and previous performances of the facilities.
- One of the causes of the delayed funding (from CHAM to facilities) was delay in finalising contracts between secretariat and facilities, which was a back and forth process; hence eating time for implementation.
- The last delayed funding from NCA to CHAM happened towards the end of the programme. The March 2015 funding ($107,000.00) was received towards end of December. And a no cost extension was given for a period of 3 months (January to March 2016). The period was too short to utilise the

remaining financial resources; considering the capacity of the facilities and the logistics of disbursing it to the facilities. And CHAM had no power to negotiate for the second no cost extension. As a result, MK 30,000,000 was returned to NCA. NCA said the delay had to do with failure to meet requirements like audit and progress reports. NCA Malawi made request for funding (when all requirements are met by partners) to head office in Norway who will make transfers only on Tuesdays and Thursdays.

Other factors included the following: head office was strict with contents of addenda which justified how the remaining money will be utilised – and guidelines on this have also been dynamic. Meeting this requirement also caused some delays. There were protracted wars on budget in that NCA and partners would not easily agree on reasonable proportions of overhead costs against the budget. Misunderstandings also arose when overheads were applicable to some outcomes but not others. Request for typed reports was another problem as most of the focal persons did not have typing skills let alone computers. Instead, they used bureaus and internet cafes. And this delayed submission of reports.

v. These days, few people get committed to voluntary work. Partly this is because communities are socially more dynamic than in the past. As such, those willing are few and end up working with many organizations. The development reduces time to fend for the families. In the end, programme delivery gets compromised. There have been cases elsewhere, where volunteers complained that voluntary work has made them economically worse than before.

On another note, volunteers accepted conditions of voluntary work at the time the work was commencing. As time went by, they began to demand some form of compensation. Failure to get it, negatively affected their involvement; and later on, programme delivery. Because of the same issue, some staff did not get committed to this work since it did not provide allowances. Now that the programme phased out, committees in Kanyama do not go out in villages due to absence of allowance. Instead, they meet clients at the outreach center.

d. Recommendations

i. The programme partners must reflect on the various factors that contributed to delayed funding and find mechanisms of addressing them. This will be good for a short lived programme like this one where time is critical. Before a programme commences, NCA must assess partners' capacities in critical areas like project and financial management and capacitate them if need be.

ii. In view of the role traditional leaders and gatekeepers have on MNCH issues, future programme must involve them more. This will make them appreciate the programme which may lead to their commitment to provide the needed support.

iii. Former TBAs must be engaged more than currently done. Empowering them economically will give them alternatives to their risky trade. Otherwise reliance on the by-laws may not effectively discourage them from practicing.

iv. VSL initiative is a good model that can provide a feasible alternative to health funding option. There is therefore need to strengthen the link between VSL, user fees and health service access. Replicate the initiative in the other facilities to promote health service utilisation.

3.2 Outcome 2: improved care, protection and support systems for HIV-affected children

a. Planned and Implemented Interventions

Under this outcome, interventions were planned and implemented with the aim to provide and improve care, protection and psychosocial support for HIV affected and infected children. This project was implemented in partnership with Community of St Egidio (DREAM), EAM, Chisomo Children's Club, Chikwawa Catholic Health Commission and QMAM. Nkhata Bay, Lilongwe, Ntchisi, Blantyre and Nsanje districts were the project sites.

Communities were mobilised and capacitated to provide the support through concepts and approaches such as: CBCCs; children corner and journey of life and STAR circle. The training sessions were facilitated by Government (social welfare office). The rest of the work was also done jointly with staff from district council.

The CBCCs gave the young children an opportunity to have their childhood develop through interaction and playing. And the rest of the concepts provided an environment and promoted youth participation. As such, they freely discuss issues that affect them, like education, employment and sexual and reproductive health. The adults were also challenged to reflect on issues affecting their day to day living and how they treat and care for the children. Apart

from CBCC structures, some communities also built youth centre/hall for both income generation and venue for their meetings and events.

1. Early Childhood Development

CBCC operations started in 2013 with the purpose to provide reception to children aged between 2 and 5 yrs. The sessions include playing, singing and learning basic mathematics and English. This prepared the children for primary school education. Structures were constructed and the caregivers were trained to enable them provide quality ECD. Parent care committees were also established and trained to give support to the ECD initiative.

2. Children Corner (CC)

Older children (6 to 17 years) were targeted through CCs concept. Committees and volunteers were trained to run the sessions after grouping and allocating activities according to their ages. These created opportunities for the children and youth to: get psycho-social support; gain skills in establishing own gardens, art and craft (weaving mats, making hoes). They also learned about their rights and responsibilities. Now the children work hard in school; and are aware of health related issues that concern them and make informed decisions. The art and craft compliments their expressive art subject in school.

3. STAR Circle

The concept focused on the adult population where they met to reflect on their problems with the aim of finding solution. A stakeholder analysis is done, to help them identify duty bearer they can hold accountable for their problem. STAR circle committees were trained in advocacy skills, to be able to advocate for education and access to health services. Some of the issues discussed were around early marriages. By-laws were put in place to prevent children from getting into early marriages. Any chief who approves a forced early marriage, is fined K10, 000 in addition to losing his chieftainship.

The communities then started demanding services from government. Communities around Chingulube health centre picked up the issue of understaffing at the facility with DHO. This is because, for many years, the facility had one staff only. After the advocacy work, two nurses were deployed; bringing the number of personnel to 3. In Kachenga – Balaka, 3 children were withdrawn from early marriages. Oliver Nkhoma of Malengamzoma in Nkhata Bay, was rescued from arranged marriage.

4. Journey of Life (JoL)

Journey of life sessions were conducted in which the youth met and were encouraged to reflect on their journeys of life with the aim of learning from them. The participants also learnt about human development - including life's challenges. Then identification of their own challenges and finding solutions was the next step. Now, young people realise their potentials; make correct decisions regarding their lives; develop coping strategies and are protected from contracting HIV.

5. HTC Services

HTC services are provided at the CBCC structures; thereby bringing the service closer to the people, especially the youth. In the past, people used to travel long distances to access these services. And due to education on HIV and AIDS issues, those who reveal their HIV positive status get help from support groups. As such, the people are encouraged to declare their status, when found HIV positive, for them to access right services.

6. PMTCT

DREAM worked with its partners to increase drug adherence and minimize the risk of developing resistance to antiretroviral drugs among HIV+ Pregnant women**.** As such, PMTCT outreach clinics were conducted with pregnant women at ANC sessions. During these sessions, HIV testing was promoted. If positive, the women were enrolled, followed up from pregnancy until when a child is 2 years. Blood samples were collected to determine viral load, CD4 count. Expert clients were actively involved and they assisted to promoting access to health services. As a result, default rate among women and children was reduced compared to the national figures. The project results attracted demand that could not be met. Using existing staff crippled partner's other operations and this one as well.

7. ICDP

The approach focused on children with disability (mental or physical challenges) and the neglected; fostering relationship between them and parents. It helps children and adults to open up to meaningful dialogue.

b. Key Findings

i. PMTCT in Balaka was able to reach hard to reach areas. People were able to access viral load early. As such 98% of children were being born HIV negative; unlike in ordinary facilities which is at 85%.

ii. Children are able to know more about life. Those living with HIV accept their status and get the right medication. This is partly because stigma has reduced, even among orphans, HIV positive children and other children. Now, the PLHIV are not isolated, but socially interact with others.

iii. JoL has encouraged parents to no longer treat their children as objects, but as human beings. Now, children are sent to CBCCs and later on, to primary school. A trained volunteer of Chitala CBCC – TA Kalomo in Ntchisi taught Alinafe Paulos' mother how to care for her daughter who is suffering from epilepsy. Parents or guardians of children living with HIV or disabled, raise them as the other children.

Children do well in school, says Catherine Chimphoyo of TA Mwazama in Nkhotakota (stories from Malawi). Today Florence Mankhwazi knows that being harsh to kids can negatively affect their minds. An ICDP trained volunteer of Tiyanjane CC saved a teen age girl (Elicy Ngwira of sub TA Fukamalaza in NB) from working in Tanzania. *"After embracing ICDP concept, the approach to raising kids is changing. Initially the best food was reserved for adults and children ate left overs. Now the people know the need to give best foods to kids for their growth and development."* said village headman Galeta (ICDP – Stories from Malawi).

iv. CBCC structures provided uninterrupted learning – children are protected from wind, rains and intense heat. Provision of porridge and play materials is an attraction for the children to remain in CBCC. Building blocks help children to develop their thinking capacities. The CCBCs have provided opportunity for children to meet, play, interact and learn at early age. Diana Munthali is a headmistress in M'bwatalika community who said that the CBCC children do better in primary school, than to those who bypass it. They are able to read just after 4 weeks in primary school. "*This is very encouraging especially to us caregivers who work on voluntary basis."* Said Lazaro of Kaphwiti CBCCs. CBCC operations have created time for parents to do other productive activities.

v. Using the CBCC structures for other activities like under 5 clinic is like killing many birds with one stone. This has brought the needed services closer. Hence the programme helped the partners reach communities they otherwise not reach.

vi. The processes were empowering in that the people now demand services from duty bearers. The Chingulube health centre story is one good example. Chimwemwe is a 14 years old boy from Nchikunda village – M'bwatalika community. He had 3 girls he was having sexual relations with, but stopped and went back to school. STAR circle members went to frighten a woman in M'bwatalika who was assisting girls to abort to stop and she stopped. Yet the chiefs failed to stop her.

c. Suggestions for Improvement

i. Provision of psycho-social support in this programme, has been done without proper guidance; materials and tools. There is also lack of creativity in the way the sessions are run, making children get bored doing the same stuff all the time; thereby affecting attendance.

ii. Squabbles derailed implementation in some community like Nkhata Bay. The people took time to agree on where to construct a youth hall; thereby delaying the construction work. It was still in progress at the time of the evaluation – months after programme phase out.

iii. Government officials have been promised ECD volunteers honorarium, which had not been fulfilled by the time of the evaluation. This unfulfilled promise has resulted in volunteer dropout rate. The study also revealed that most of the Caregivers are fatigued. The concept recommends 10 Caregivers per CBCC for them to alternate. But few are available and work throughout. In TA Kachenga – Balaka alone, 22 of 90 trained Caregivers have since left for South Africa. Nkhata Bay has a similar case. And also the volunteers are discouraged by some people's perception that they get involved in CBCC work because they have nothing productive to do.

iv. In previous growing season, food production for the CBCCs has been hampered by unfavourable weather conditions; unlike in the past 3 years. And yet, without porridge, it is difficult to keep the child up to 11 o'clock.

v. CBCC establishment overlooked provision of toilets and boreholes. In Kachenga, only 7/31 CBCCs have water close by. Although water baskets were supplied as an alternative, the provision of clean water was still not regular because of long distances to water points.

vi. NCA did not closely monitor construction of center in Nkhatabay. A total of MK 11 million out of the MK 10 million budgeted, has been spent, yet it is at foundation level.

d. Recommendations

i. By nature, religious institutions are found in every corner of society, and are there to stay. Involving them would therefore be strategic for sustainability.

ii. There is need for a sustainable solution to getting food for the CBCCs.

iii. Consider integrating PSS in all healthy centers target communities to bring holistic health services to the areas. WHO says that being healthy implies that a person has access to physical, spiritual, emotional and psychological healthy services.

3.3 Outcome 3: improved capacity of tutors and college management teams to deliver and manage health care training

The programme equally focused on efforts to improve capacities of tutors and college managements so that effectively deliver the needed services.

a. Planned and Implemented Interventions

Capacity building; provision of equipment, books and other resources were the interventions implemented under this outcome. Choice of these interventions was informed by the perceived potential contributions their achievement would make towards improvement of capacities of tutors and college management to deliver services.

1. Capacity Building

Capacity building was facilitated in 15 healthy training colleges; targeting tutors, finance managers and administration staff. Areas covered included financial management for non financial managers; procurement and fraud detection; auditing processes; performance appraisals; teaching methodologies; health related research; curriculum benchmarking; corporate governance; SPSS, report writing resource mobilization. The tutors were also oriented on the utilisation of the skills laboratory; while clinical mentors were trained on how to guide the students in the clinical area. Audit exercise was also supported, and an accounting package were also provided to improve the financial resource management and reporting in 4 colleges.

2. Development of Strategic Plans and Other Documents

Development and review of key college documents was also facilitated as follows:

- **Strategic plans** were developed and reviewed in 7 colleges. Since then, the documents have guided college operations.
- **Clinical assessment tools** listed in nursing and midwifery guides were developed for Mzuzu University, St John's and Trinity colleges. Availability of these tools enables the institutions to adherence to quality standards. The process also equipped the academic staff with skills to develop more learning guides.
- **Policy documents** – four policy documents were developed to guide management's decision making in the concerned colleges. The students' policy; the students' HIV and AIDS policy; housing policy and procurement policy, were some of these policy documents. After dissemination, students now comply with what is stipulated in those relating to them. On the other hand, colleges do everything to avoid legal conflicts when executing their operations.
- **Curriculum development** exercise was another strategic process for the colleges because these are documents that guide delivery of quality training. In total, 3 curricula were updated; while others were reviewed and standardized. They have standard guidelines for teaching procedures which ensures quality nursing education and makes teaching and learning easy. Then the documents were reviewed and approved by Nurses and Midwives Council of Malawi (NMCM). Availability of the document facilitated introduction of nursing and midwifery degree programme at Malamulo College.
- **Standard operating procedures** (SOPs) – for MCHS Lilongwe and other colleges, were developed and aligned to the strategic plan and public sector reform concept. The document includes training policy; guidelines for recruitment and admissions, procurement and finance management. SOPs give colleges guidance on how to manage students, examinations, student nutrition aspects, among other issues.
- **Document on conditions of service** is also another strategic paper for effective administration of the colleges. Its proper utilization can have a positive influence on staff retention, among other aspects. Therefore, having them reviewed and updated was needful for Ekwendeni College.

- Finance management coaching and internal audit was conducted for CHAM facilities implementing the MNCH project. The audit involved checking internal controls, capacity building and contracts checking.
- The procurement capacities of the 10 colleges were strengthened in that, all colleges have operational internal procurement committees, 5 of the 10 colleges have developed IPC policies and 3 colleges managed to detect and correct fraudulent practices in their procurement procedures.
- Memoranda of understanding (MoU) were developed and signed between 85% of the colleges and their host hospitals. The document clearly stipulates duties and responsibilities for staff members in clinical areas and the colleges. Since then, management of clinical practice has improved.

3. Enhancing Communication and ICT Capacity of Facilities and Colleges

Sets of IT equipment were procured and installed at some colleges to improve internet connectivity for enhanced communication. These included 3 servers and local area network equipment for Trinity, Mulanje Mission and Holy Family. The installation enhanced access to vital and up-to-date professional information and improved record keeping in these colleges.

Under integrated capacity building programme (ICBP), Luke International was a partner that built capacities (on health information system) of rural CHAM facilities in the northern. These were Saint Annies hospital and Kaseye, Lunjika, Tchalo and Chambo health centres. Through it, health workers and students were trained (short and semester long courses) in computer use, data entry and analysis, and generation of reports. The facilities were also assisted with IT hardware, network installation. HIS computer laboratory was established at Mzuni; equipment was purchased for St John's and ECHS.

The initiative has helped the partners with basic data management skills; patient registration and management; improved patients' record keeping; monitoring of patients and quality of reports. Now, the facilities are able to run national electronic medical records system for outpatient department, antenatal care and HIV clinic, consultation room, ART and OPD. However, utilization of the knowledge gained is hampered by the fact that the learners did not

have computers to help keep the skills. Another challenge was movement of the trained staff away from the intended institutions.

Materials and equipment were also purchased and distributed to colleges to improve the quality of teaching and learning. These included: LCDs, laptops, voice recorders, video camera, still camera, TV Screen, home theatre, desktop computer, classroom chairs. Various books, on various topics were procured for the college libraries. Most of the books were put on reference shelf – signifying their value and importance.

4. Strengthening Research Capacities

In 2015, 28 tutors were trained and later participated in the research process. Topics covered were: how to develop a research question; write research proposal; conduct data collection and processing and write a good report. Then each college wrote a research proposal which underwent selection process. The successful proposals were adopted by the cluster colleges onto which research processes were conducted. The findings were then disseminated during a national research dissemination workshop. And some research abstracts were presented at an international conference in South Africa. And one of the research findings has already been implemented; thereby helping the colleges to plan clinical placements better. The research topic was; factors leading to poor performance of students in practice compared to classroom work. Students said clinical areas are not supplied with the resources needed; and that there is minimal supervision and inadequate support from facility staff.

Sustainability of the research agenda is questionable because after dissemination, much progress has not been made towards publishing the research papers in journals. The Northern cluster is failing to conclude the quantitative component of another research. This is because partners have problems to meet, due to resources and busy individual schedules.

b. Key Findings

i. **Increased student intake and graduation; improved pass rate** – number of those enrolling and later on graduation haves increased exponentially. At Nkhoma College for instance, enrolment increased from 50 students in the year 2000, to 250 in 2015.

- Ultimately this has led to increased number of graduating nurses in CHAM colleges. Only 385 nurses graduated in 2013, compared to 542 and 584 in 2014 and 2015 respectively.

- Passing rates also improved during the period under review. In 2013, only one college attained a 100% pass rate; while in 2014, four colleges registered pass rates of 95% and above. And in 2015, more than five colleges attained 100% pass rates. At MCHS Zomba, pass rate has improved recently; ranging between 90 and 100%. In the past, the rate was between 50 and 60%.

Gradually, this performance is contributing towards number and quality of nurses serving the Malawi population. And in 2015, 584 of the 981 national total, graduated from the participating training colleges; representing 60% contribution.

ii. **Key documents developed and reviewed** - before this programme, colleges like MCHS Lilongwe campus had loose procedures that were located in different documents. But the new SOP document pulled all of them into one document and also filled existing gaps.

iii. **Skills laboratories -** have been lacking in most medical training institutions in Malawi. It thus has been tough for the students to do the basics. Instead they had been trying directly on people without prior practice which is unethical in medical profession. Therefore, provision of skills laboratory and training has enabled colleges to ably train students on skills; thereby giving them confidence as they prepare for real life situations. The initiative has brought good balance between theory and practice; in addition to simplifying teaching. Now the students are passing the practical part of their examinations, unlike in the past.

At MCHS Lilongwe campus, orientation on skills laboratory opened the facility up to other users (expanded the scope). The assistance therefore went beyond the intended nursing course.

iv. **Enhanced tutor capacities** - now tutors know how to formulate objective questions, and not essay type only. In the past tutors would not differentiate between recall and analysis questions. Comments from external examiners indicate that there is improvement in this area. "*Ana ndimawanamiza!"* This was a comment from one of the Nkhoma college tutors who underwent training in teaching methodologies. The translation is: I was not teaching the students in the right way.

The tutors gained knowledge and skills in research which help them supervise students in similar exercises. And working in groups helped the tutors to learn from

others. *"Unlike when I single handedly carried a research for my Masters Degree; this group work brought much learning in me."* - Grace Massah; Deputy Principal at Nkhoma College. Clustering of partners with different calibers to work together helped partners to share knowledge and appreciated one another's role. "*Sometimes when you work at a university, you think you are better than others; not knowing others are also talented in certain areas."* said a Nursing Lecturer at Mzuzu University. Colleges have been affiliated with public universities which has strengthens the profile of CHAM colleges.

v. **Reduced computer to student and student to book ratios** - the supply of books helped MCHS Lilongwe to comply with NCM requirement attached to upgrading of RN course and speeded up the process. Before the books were supplied, MCHS Lilongwe students (most of whom are females) were going to KCN library at night (which is a kilometer away).

c. Areas Needing Improvement

i. **Research initiative experienced some challenges like**:

- Coordination among research cluster members was a bit of a problem since each of them moved at own pace, as dictated by schedules at respective workplaces. And some members chose not to do what was agreed; thereby delaying in submitting research paper for example. Partners also embraced different approaches to community development which brought antagonisms into the cluster work. For instance, some partners give allowances to employees attending cluster meetings, while others implement full board arrangement. This development brought some tensions among them.
- Research processes were owned by the partners who originated the proposals. They became too protective to allow any necessary alterations. To some extent, this frustrated the rest of cluster members.
- Inconsistency in research standard used – some used National Research Council while others used College of medicine standards. because there are no guidelines. As such this has been put in the current strategic plan.

ii. **High staff turnover** - negatively affected implementation of interventions. For example, MCHS Lilongwe has had 3 programme coordinators in 3 years. Management of Utale health facility could not participate in the evaluation because they were new.

d. Recommendations

1. Training colleges must budget for maintenance of the skills laboratories, structures and other equipment to ensure their sustainability.
2. In future, NCA must consult partners more in order to jointly address any logistical issues; and also for a common understanding of modus operandi – knowing that these partners also have and are working with other donors who may have different approaches.

3.4 Outcome 4: improved collaboration and advocacy for all stakeholders in health issues.

Lack of transparency in the operations of health services provision continues to be the major set-back to efforts trying to improve access to health care in Malawi. Most of the duty bearers in the health sector continue to treat community members as mere recipients and not as participants in the health service delivery.

a. Planned and Implemented Interventions

In view of this shortfall, the programme engaged some partners to plan and implement interventions to lobby and advocate for change. This is a change that will lead to the people (the youth inclusive) attaining equitable and improved access to health services. To amplify voices of rights holders to ensure their active participation in decisions that affect them.

At national level, CHAM partnered with other players to advocate for improved access to health services by the people, especially the vulnerable groups like women and children. CHAM sits on different national level advocacy committees. As such, the institution has managed to make contribution towards influencing policy change or implementation. The grouping also lobbied with parliamentary committee on health on related issues. there are regular meetings on reproductive health and HIV and AIDS. CHAM is in partnership with White Ribbon Alliance; MEHN. They made it clear to Government that abortions need properly qualified personnel, considering that once passed the abortion will be done even at health centre level. The group continues to lobby for free health care in all health facilities including CHAM facilities.

To date, people in Ntcheu, Salima, Mwanza and Neno districts have been mobilised; using peer education model; gender and human rights approaches; and producing the following outcomes.

i. Communities were empowered to demand their rights on access to drugs and medicines. Advocacy meetings were initiated to address health related issues such as ART and drug shortages.

   Drug related issues have so far been discussed during District Executive Committee meetings in Salima and Ntcheu. This was the time when local leaders presented to DEC, issues such as shortage of drugs and personnel in most public facilities.

ii. Religious institutions were empowered to make politicians accountable to Malawians on access to drugs. These institutions held sessions on the need for congregations to hold politicians accountable on drugs. Furthermore, the country's 6 largest religious institutions developed a communiqué; expressing opinions on the current challenges being faced in accessing drugs and medication and budget allocation on health. And a position paper on the drugs situation in the country was presented to the President through the Presidential Advisor on Religious Affairs in 2014.

   And also some members of parliament were engaged to be accountable to Malawians on access to drugs. The process started with engaging rights holders at community levels in areas like Ntcheu and Salima. The communities were mobilised to summon Members of Parliament on challenges being faced in accessing drugs and medication.

iii. The youth were mobilised to demand youth friendly health services in their local health centers. Youth representatives were oriented in SRH and are able to identify gaps in YFHS provision within their localities. Later, youth representatives in Salima and Ntcheu petitioned the District Youth Friendly Health Services Coordinators and DHOs on why it was important for the young people to access these services.

   Young people (14 to 25 years) were given chance to discuss sexual reproductive health (SRH) related issues. By the time of the evaluation, the programme had empowered young people living with HIV with adequate information as well as forming support groups. Ensuring young people has access to SRS services within their communities. Some of the myths and misconceptions young people have and were discussed for example, there is a myth that one cannot contract HIV if has sex while standing.

iv. Mobilize PLHIV to petition the Speaker on access to drugs challenges. A series of mobilization initiatives engaged PLHIV who organised meetings with the DHOs on various issues concerning ART, shortage of Drugs and food in hospital especially for those PLHIVs in hospitals. The organization has built strong capacity for people

living with AIDS to advocate (they were given a voice) on drug availability and access.

Interface meetings were facilitated between female PLHIV support groups, chiefs, religious leaders and health service providers on patients' rights and the increasing instances of stigma and discrimination within the communities. Chiefs and religious leaders formed committees to facilitate sensitization of communities.

b. Key Findings

i. Community groups have continued to put pressure on the duty bearers as they push for transparency in the delivery of health care. Community groups have in turn drawn simple commitment plans outlining roles of different concerned groups.

ii. There is good integration of advocacy at all levels national, district and community. Partners were enabled to have active participation at district and national levels. This has created general awareness of advocacy issues such as early marriages, school dropouts and HIV and AIDS services.

iii. Young people have been mobilised around SRH and HIV and AIDS issues. Many youth have known a link between HIV and SRH. The programme has mobilized wives of chiefs and religious leaders and trained them on HIV and AIDS modules so they can advocate effectively, especially among girls and young women.

iv. Pre marriage HIV couple testing is now being practiced both among Christians and Muslims more than before.

c. Suggestions for Improvement

i. When the young people were mobilized, health facilities were unable to cope with demand for HIV services.

ii. Some religious beliefs prevent access to SRH services. There are also practices that promote HIV infection e.g. choirs, night of prayers.

iii. Most politicians continue to be uncomfortable with community empowerment initiatives. There is a general misconception among most politicians that an empowered community is difficult to govern. As a result of this, booking them to have an audience with community groups continued to be a challenge.

e. Recommendations

i. Community advocacy initiatives need to involve political leaders throughout the process in order to allow them appreciate the need to have a well-informed community that is willing to engage them in improving things.

ii. There is need for clear monitoring standard in tracking contributions made by efforts on advocacy and also to track government policies that have put in place or revised because of contributions of the programme.

3.5 Outcome 5: enhanced capacity of CHAM Secretariat to effectively coordinate and manage health service delivery in its health facilities

Prior to commencement of the programme, CHAM was tasked to conduct a situation analysis for the institution to identify gaps in HR, finance and ICT. In response to the findings, NCA played an important role to stabilize CHAM at a time of high staff turn-over and donor pullout. Specifically, the programme supported CHAM in the following areas:

- Capacity building in HR, IT network, finance management and audit coaching and support, on standard procedures for the training colleges and health facilities.
- Purchased IT equipment and accessories like server, hard drives for storing documents and communications from partners.
- Funding of some core salaries for the core staff some at 100% (Technical Manager) others at 50% training manager 25% finance and 10% ED respectively. Also paying for utilities (water and electricity bills).
- Overhauled and upgraded MIS –CHAM to improve connectivity. This is a monitoring system which keeps contacts and contracts with various stakeholders, it is also procurement system and it's hosted by the server. IT manager has been trained and still working with the consultant. The IT consultant is also working closely with M and E department. The system is efficient, however, there are sensitive data that one may not want to upload on the data base. The system is user friendly as it used android application. Therefore, the facilities should be able to use the system once decentralized. With this system, CHAM will be able to monitor various different diseases as per the input and can be sent from any facility to the server. Any indicator that is needed by M & E can be monitored. Once info is inputted straight way it can be accessed from the server.

- The local network was restricted and created an email account for each facility has an email address and it's all hosted by CHAM—it's not personalized for sustainability sake. This has increased communication.

In turn, CHAM played various roles is this programme the overall was coordination of programme activities at CHAM facilities and colleges. Specific ones were:

i. Managing programme funds for both the secretariat and some of the facilities. The partners were oriented on how to manage the programme and specifically how to track use of funds through finance management coaching and internal auditing processes which were periodically done.

ii. Helped partners in planning and budgeting – ensuring donor requirements were met i.e. budget according to agreed terms.

iii. Executing M&E function that included: quarterly site visits; regular reporting. The finance team also visited the facilities for monitoring purposes. NCA and CHAM had to agree on indicators to be monitored because baseline report was not shared. First quarter figures acted as baseline data. Monitoring of training colleges through use of train-smart software; while health facility are monitored using the Government health management system the software is called (DHIS).

Key Findings

i. The procurement of office IT equipment and services was successfully conducted. This has enabled CHAM to restructure its local area network and hence improving the internet connectivity at CHAM secretariat by reducing the down time from an average of about 8 hours/week to about 1 hour/week.

Through the same activity CHAM also managed to upgrade and support the payroll system and Accpac finance systems. This has further reduced the payroll errors reported by the health facilities

ii. Increased communication between secretariat and its facilities. The email account has reduced paper trail. In the past, there were some delays and errors in information transmission because it would take months for partners to submit reports to CHAM. Due to lack of stationary, the hard copies of the reports were submitted to government without retaining copies. This is through increased number of facilities having institutional emails from about 45% to 100% and increased number of facilities

accessing emails from about 40% to 70%. Some of the HR functions are done through the system.

Suggestions for Improvement

i. Delayed funding as funding was based on clean annual audit report which took time to come by, from the auditors and also because the auditors were not engaged in good time.

- It took one year to resolve capacity issues in CHAM. It was a period when CHAM was going through transition because the ED and head of programmes were relatively new; while the coordinator had just resigned, leaving no one to write proposal. Because of such delays, NCA decided to coordinate the first 25 facilities; while CHAM started coordinating 13 of the 25 facilities in second year. This means that the CHAM coordinated facilities only implemented in two years.

ii. It was learnt that the programme baseline report was never shared with CHAM, unlike the proposal. In the absence of the baseline, CHAM agreed with NCA on indicators to be tracked. So the first quarter indicator data were shared and became baseline data.

iii. Although staff turnover has recently improved, but it was partly blamed on the gap that exists between one project cycle to the other which left the institution with no source of paying the staff so people go once the project phases out.

3.6 Crosscutting Issues

1. Health Infrastructure Development and Others

Construction and renovation of health structures were done to complement training and service delivery across the outcomes. The work was done in 9 health centers and these included: maternity wards; guardian shelters; elevated water tanks; staff houses; sinking of bore holes; refurbishment of out-patient departments; sanitary facilities. Solar panels and geysers were also installed in some of the non electrified health facilities like Chambo, Tchalo, Thomasi and Masenjere.

Through this effort, beautiful maternity wings were provided – having beds, equipment, enough rooms. For example, Lumbadzi maternity wing comprises of examination rooms, delivery room, antenatal and postnatal room, kangaroo and nursery rooms.

Most health facilities are located in hard to reach areas; making transportation critical to programme delivery. As such, motorcycles; bicycle; bicycle and boat ambulance were procured and 3 vehicle ambulances were repaired and distributed to health outreach teams. This contributed towards increasing the number of outreach sites and sessions.

At times, there is need to refer patients to next tier in the health system. However, the challenge has been lack of communication (on the same) between the facility and referral hospital. The programme provided support to enhance the communication.

Networking and Collaboration

Networking and collaboration was embraced in this programme at community, district, national and international levels. And partners were challenged to learn from one another; and also share resources – including human. As such, the practice significantly influenced realisation of results, despite challenges of working in groups.

Among partners, the colleges networked with partners to plan students' allocation to placement areas and this minimized congestion. Health facilities networked with colleagues and organized exchange visits to enhance learning. At community level, different committees worked together. For example, in Ntchisi, EAM worked with World Vision to construct CBCC structures; while World Relief Malawi provided vitamins for the CBCC children. Collaboration and networking was also enhanced with government like social welfare department. Partners also worked with religious and traditional leaders. All this brought synergy and shared resources.

At national level, NCA was organized regular planning and review meetings which helped partners to learn from one another and also share resources. CHAM was also having stakeholders meetings where consultations were made with the colleges and health facilities, on what should be included or considered in next programming. At international level, Norway students were coming quarterly to teach in colleges, work in facilities and supervised research work by the colleges. Some of the tutors were going to Norway to learn.

Such arrangements have strengthened relationship between the facilities and DHOs. "*NCA encouraged us to work with government experts. Since then, my negative attitude about the DHO office has now changed*", said Madise – Dedza Catholic Health Commission Coordinator. On the other hand, colleges were encouraged to sign MoUs with student

placement hosting facilities. This worked well in that each one of them knew their responsibilities. SLA was another area of collaboration and at the time of the evaluation, some strides were made towards this. Collaboration between NCA and Luke International improved capacities of the latter; to manage their work. For example, accountability and management capacity of Luke International improved in the course of meeting some requirements before partnering. Need for auditing of the organization and other preparations was reported to have improved management of the organization.

a. Key Findings

Provision of structures positively impacted on the health facilities and colleges' operations. Examples include:

i. **Improving the facilities' standards of care** - in terms of beds and space for provision of services to the surrounding communities. Therefore, the facilities have been enabled to meet national health services delivery standards.
   - Pregnant women have waiting shelters; hence they have no excuses for delaying to go to the facilities to wait for time of delivery. After delivery, women and their babies are discharged on time and not prematurely because of wanting to create space for new arrivals. *We have been discharging women soon after giving birth in order to create space.* Says Kalonga - health worker at Masenjere health centre. *We used to sleep on the floor and chairs when we came to deliver; and cooked our meals on the ground which felt unsafe*, recalls Thandi Biliati a mother of 3 children (NCA Malawi Newsletter – june December 2015).
   - Increased number of houses – helping on staff retention.
   - Electricity has come to Kanyama because of the health structure provided.

ii. **Deliveries at night are possible** – with solar and electricity backup system. The only problem is replacing of the 16 batteries after 4 or 5 years, which each cost MK 495,000. Training was conducted on utilization and maintenance of the system in an effort to elongate lifespan.

iii. **Adequate space for office & service delivery -** most of the facilities had office space shortages but now have enough. They also had services that did not have own office space. But now there are rooms for family planning; HTC; hence increasing access. Partitioning work helped Lumbadzi to have a pharmacy; hence helped in management

of drugs. Now Lumbadzi has a staff room for meetings. *At first they were meeting in the corridors where patients would interrupt any time and there was no privacy the discussions*; said Lumbadzi staff.

iv. ICT training through Luke International has helped antenatal and clinics work. Able to know number of women given appointments for consultations and when, rescheduling is easily done and helps quality of care. In the past, since scheduling was done manually, women used to wait for long hours or sent back because they were too many in one day. Helps in safe keeping of records and easy access to information. Training in computer use – registration, prescription, diagnosis, follow up, how to make connections (computer with printer etc), how to replace cartilage and how to produce reports.

v. For the colleges, the teaching and learning environment. Now the colleges have doubled students' intakes. For example, at Ekwendeni College, enrolment for nurses and midwifes increased from 40 to 80 in 2015.

b. Suggestions for Improvement

i. Windows at Lumbadzi maternity wing do not provide privacy at night. They need replacing or curtains. This was reported but nothing has been done, and NCA was not aware of this. Instead the facility has improvised curtains which do not match with beauty of the structure.

ii. In some instances, there were issues with contractors doing sub standard work. As a result, some works were suspended; obtaining court injunctions; which delayed completion of work

iii. Timing was not realistic as it did not consider that the sites are live. Budgets were also not realistic – resulting in 9 construction works instead of 13 that were planned.

c. Recommendations

i. NCA must assist CHAM to align its M&E system to the ICT system that is being developed.

i. NCA must develop M&E framework which partners should align to. Also work with partners to develop simple tools to capture and document indicators in a more systematic way.

3.7 Assessment on Key Evaluation Pillars

Programme relevance; efficiency of planning management; programme effectiveness; programme impact and sustainability of the gains were tracked in this study and results are detailed below:

a. Programme Relevance

Both the design and implementation of the programme were found relevant and appropriate to the targeted population in many aspects:

i. The programme balanced between implementing the obvious interventions that are directly related to service delivery, with provision of support towards development and review of partners' strategic plans and key documents; health structures, equipment and materials; transport provision; capacity building. Under outcome 1 for example, the programme looked at a number of aspects like place of delivery, male involvement, role of TBA and local leaders, family planning, issues of breast feeding and nutrition**.** All these made the programme appropriate and relevant to the needs of the communities; partners and government. The psychosocial support system was a key element in primary health services delivery and HIV impact mitigation. All these made the programme holistic and responsive to issues on the ground; thereby aligning itself *policies and strategic thinking of government.*

ii. The choice of programme population was appropriate since mostly, mothers and children are among the vulnerable groups in every society. Hence making the programme relevant to priorities of these vulnerable groups and the communities.

iii. Training was considered highly at every level of implementation, which strengthened capacities of target communities and partner organisations. In so doing, the programme empowered the people to be active participants in their own development and also organise themselves to claim their rights.

iv. Although the programme engaged multiple partners. Similar partners were allowed to implement the programme with some degree of variation in terms of interventions. This helped partners to address context specific needs. As such, the outcomes were not only key to the achievement of the Health, HIV and AIDS programme strategy, but also the Malawi National HIV and AIDS Strategic Plan (July 2011- June 2016).

b. Effectiveness – the study assessed major achievements of the programme to date, in relation to its stated goal and objectives. And found that, the programme achieved most of the intended outputs; leading to realisation of outcomes. What partly

contributed towards the programme becoming effective was the flexibility to make the necessary changes. This helped to respond to issues as they happen on the ground. Involvement of key stakeholders such as Ministry of Health, CHAM also contributed. The consultation meetings with these stakeholders ensured that relevant areas were incorporated and tackled. There was also great emphasis on working with others especially government.

Negative effects came from delayed funding; failure to incorporate important elements in a particular intervention like water and food in CBCCs. The projects were scattered, geographically and in terms of thematic areas; making provision of technical backstopping a bit of a challenge.

There was a direct link between programme achievements and strategies and interventions that were designed and implemented. For example, efforts on male involvement resulted into males getting involved and supporting their wives and children, unlike in the past. There are now fewer home and TBA deliveries because the programme embarked on efforts to promoted facility deliveries and also involved the TBAs.

c. **Impacts -** the study managed to identify impact the programme outcomes have already started having on both direct and indirect beneficiaries. These have been highlighted under respective outcomes.

Unlike other development work which focus on soft spots, this programme was unique in that it assisted on as need basis. That is why partners implementing the same outcome were different in certain aspects. Freedom given to partners to implement unique but yet doable initiatives like Bawo and VSL contributed to realisation of these impacts.

d. **Sustainability** - of gains in development processes is what every stakeholder desires. This evaluation process was therefore interested to assess if the programme outcomes will be sustainable or not. The study found that partners are at different levels of capacity and readiness to sustain the programme gains. Some have budget line for this; while others indicated that their resources too limited to achieve this. NCA had

closures in contracts and key documents, encouraging institution to be financing laboratory repairs and other maintenance works. Our view is that the gains can be sustained if proper mechanisms are put in place.

Major factors that are influencing sustainability of the programme interventions are:

i. The programme fed into the national plans and also integrated partners' priorities. These players will therefore endeavour to sustain the gains.
ii. The partners were encouraged to network and collaborate, through which linkages and relationships were created and strengthened at all levels.
iii. Programme used already existing structures like local leaders and community structures. In the course of implementation, passion was created and behavioural change realized which will be sustainable. Once the people are empowered this cannot be reversed.

The study further noted that there was no sustainability strategy in place. Partly, that is why the evaluation picked some signs indicating that some interventions may not be sustainable. Aspects that need money to facilitate like community outreaches, consumables; be problematic to sustain. For example:

1. Facilities like Lunjika indicated that it will not take over responsibility of following up, due to lack of resources. Mbofwa community received a bicycle ambulance in 2008 which broke down in November 2015. Since then, it has never been repaired because the people did not have money. And no contributions were made towards bicycle maintenance. In Kajolwe, construction of an under 5 clinic started in November 2015, with all materials supplied. It was at roofing phase during the evaluation team visit on 21st September 2016. And our view was that roofing commenced upon hearing of the team's visit.
2. Outreach clinics, ADC meetings stopped immediately when the programme phased out. The reason was that nobody was able to pay allowances at the meetings, as was the case during programme implementaiton. In Kanyama, the antenatal outreach clinics and HTC services stopped after phase out. And the mothers come to Kanyama facility to access the services.
3. The computers and other gadgets provided will definitely need maintenance and purchase of consumables. Currently Luke International is responsible for those it

supported. However, no mechanism has been put in place to ensure continuity when the responsibility is withdrawn.

4. Most of the HTC services that were provided within the community were closed soon after programme phase out.

5. At Lumbadzi, a water tank was constructed in 2014 and got broken down in February 2016. The authorities consulted the contractor who was reported to be out of the country at the time of the evaluation. They said if nothing materializes with the contractor, the authorities will consult DHO. NCA said that a 1 year detect period expired before this was reported, hence the contractor was given his defect liability money.

4. KEY FINDINGS, RECOMMENDATIONS AND CONCLUSION

4.1 Key Evaluation Findings

a. General Findings

1. Investing in capacity building was a right approach to development. As a result, various community structures are well capacitated and articulate issues and their duties well. This has motivated them to ensure that mothers and children access good health services. Health facility staff are not where they were before the programme was implemented. Now they have knowledge and experiences in project management for example. Capacities of college tutors and administration staff are enhanced in many ways. For instance, training in teaching methodologies equipped tutor/ colleges to deliver courses effectively. Now tutors know how to formulate objective questions, unlike in the past when they mastered essays questions only. The research training has upgraded the colleges' status and enabled them to competently supervise students' research work. CHAM's capacity has also improved greatly in many areas; just like the faith based organisations which were given opportunity to reach the hard to reach areas.

2. Training in and access to ICT is another milestone which has connected the facilities to the world. Now processing reports and information is done with the expected speed than was the case before. Health structures, equipment and books were provided to supplement the training and service delivery aspects of the programme. Such assistance enabled the colleges to balance theory and practice; while others met NCM requirement in registered nurse upgrading course. Conducive environment for teaching and learning was also enhanced; leading to the colleges increasing intake and attaining increased pass rate, compared to the past. In health facilities, the initiative has significantly supported promotion of safe motherhood agenda in that there is now adequate space for maternity and other services. Colleges and health facilities are able to retain staff because of improved housing.

3. For years, a lot of sensitisation has been done to discourage TBAs from practicing. Instead, they were given new roles which are in tandem with promotion of safe motherhood. And it was good that this programme involved them. Doing so reduces chances for them to go back to their old trade. However,

the few TBAs the evaluation engaged complained that they lack alternative economic activities after denouncing their former trade. Helping them with IGAs would even be better.

4. The study found that most of the baby deliveries are now happening at health facilities, because the people have appreciated the importance of doing so. The few who deliver at home or TBA, it is because of bad staff attitude; religious and cultural beliefs and economic challenges. And slowly men are getting involved in MNCH issues. In an effort to cast the net wider, Lumbira health centre used of Bawo to coax men who play the game at Sigerege market and other public places.
5. The people, especially mothers, have understood the need to exclusively breast feed babies. A good number of them adhere to the practice. Others fail when the babies cry uncontrollably due to low milk consumption. The low milk production is mostly as a result of mothers not eating enough due to food shortages. Another reason is when the mothers get involved in demanding household chores and piece works.
6. Gradually the people are appreciating the need to have manageable number of children. They do appreciate the fact that it is their obligation to bring up the children; which is not easy, in light the prevailing hard economic times. Hence family planning is accepted by the people, especially women who bear most of the burden of child bearing. Misconceptions hinder some husbands from following any family planning methods. And due to institutional policies, Catholic facilities did not implement family planning component of the programme. Instead, the facilities just allowed communities to promote it. This means that the communities did not have technical backstopping from the health professionals; which may have affected programme delivery.
7. PSS delivery comprehensively engaged several concepts like children corners, star circles; journey of life and CBCC. Results from these processes are phenomenal. To date, stigma has reduced; parents treat their children well; some children have been rescued from early marriages.
8. The choice of interventions (projects) was found to be good. Their implementation really contributed towards improving access to health services - not only by mothers and children, but everyone. Outcomes 1, 2, 3 and 5 were well

connected; they complimented each other. Health structure development, equipment, ICT and material provision cut across these outcomes; thereby also complimenting them. For example, after convincing mothers to deliver at a facility, the facilities were equipped to support their new decisions. Secondly, improvement of teaching and learning in a classroom was supported by availability of skills lab, books in library and good accommodation for both tutors and students.

In the same vein, we expected outcomes 2 and 4 to be cross cutting as well, especially to outcome 1. This proposal is informed by what the study found – that a lot of advocacy issues were embedded in outcome 1. And this required the level of charisma exerted in outcome 2 and 4. If this was done, communities could have been empowered to hold TBAs and gatekeepers accountable, for example. We appreciate there was need to start small with outcomes 2 and 4 to give learning a chance. However, the learning would have been much if these were piloted together with some of the outcome 1 communities and partners. Similarly, a thin line exists between outcomes 2 and 4. Some of the interventions were either the same and similar. Integrating them in one outcome would have made the project more comprehensive.

9. Another area of concern was that the programme very robust and relevant. However, implementation period was too short in our view; especially considering the delays that characterized it. Next time, there is need to thoroughly prepare the partners before taking off.

b. Best Practices

Practices that were good and therefore supported programme delivery were identified; and are highlighted in this report for partners to learn from, to inform future programming.

1. Some of the interventions were picked from partners' individual strategic plans. This implied that the partners did not deviate completely from their core business. It therefore denotes that partners were relevant to the agenda under pursuit.
2. Similarly, the programme was managed with some degree of flexibility on both budgets and plans. Social development programmes are dynamic in that some of the assumptions framed at design stage, may not hold true. In such situations, the partners were allowed to make changes after giving convincing explanations. This

approach gave the programme chance to still be relevant amid changes that would otherwise negatively affect implementation.

3. Periodic (quarterly) review meetings provided forums for partners to discuss important programme issues. This was good because it brought a sense of awareness, uniformity among the partners. Some of them were motivated to work hard upon learning from others.
4. After noticing that low disposable incomes were constraining some mothers from accessing services, the progranne allowed some facilities to introduce relevant innovations like VSLs to economically enable the mothers pay for health services when need arises. The partners encouraged to facilitate the programme while thinking outside the box.
5. Throughout the evaluation process, NCA was commended for facilitating the programme with a human face; treating partners with respect; being able to understand situation of partners – asking the people their view. And although partners were many, NCA paid attention to individual differences and needs; and assisted them accordingly.

c. Suggestions for Improvement

A number of areas were noted to be areas that need improvement, which in our view, hindered progress to a certain degree. These include the following:

1. Food security and water availability influenced access to improved health aspiration. In communities where food was in short supply, attainment of some programme components was compromised. For example, food and water shortages impinge upon operations of CBCC in most of sampled sites. Young children travel long distances to fetch water. On the other hand, communities' willingness to provide food to the CBCCs has waned due to critical food shortages at household level.
2. Over the years, different innovations have been introduced in the communities, which is a way makes them get used. Such development is negatively affecting any call to action. There is therefore need for creativity to effectively mobilise them.
3. Delayed funding was experienced during the programme period; especially among the SDA partners. SDA internal policy requires that funding to facilities be channelled through the SDA central office. And central office often delayed to remit the funds

because of other assignments. Other factors had to do with partners' lack of capacity to meet requirements such as progress and audit reports.

4. Equipment given to communities like bicycles may not be sustained. The people are failing to repair them when broken down. Most of the partners did not put mechanisms in place to sustain the outcomes of the programme.

5. The programme communities also host other development players who used different approaches. Some of these approached were counterproductive to sustainability consideration. For instance, demand for allowances has marred continuation of interventions after phase out of the programme. Both staff and community volunteers expressed desire to be remunerated for their involvement. The desire was exacerbated by the fact that other organisations were paying their volunteers.

4.2 Recommendations

1. Several factors determined access to health services like place of delivery. These included bad treatment at facilities, religious and traditional beliefs and economic hardships. These need to be reviewed to inform next programming.
2. Gatekeepers existed in this programme. Put a mechanism to encourage future partners to deliberately be conscious of such. Since some of the may be context specific, partners must be empowered to be able to identify them. NCA must make deliberate efforts to follow up, to ensure they do not skip through the implementation process unattended.
3. Getting males involved is a big milestone for the programme. Work on the hindrances to ensure more are brought on board. Such decisions may call for innovativeness like was the case with bawo in Lumbira.
4. Links existed between food security and some of the aspects of the programme like nutrition, breast feeding and CBBC operations. Mainstreaming food security is a health programme like this one, will be strategic
5. Role of TBAs in maternal and child health will not be overemphasised here. By now, we have learnt how much women expect from them which is influenced by their beliefs and what the TBAs promise to offer. There is therefore need to critically reflect on this to find practical solutions. Turning a blind eye will negatively affect delivery of future programmes.

6. Most of the facilities in this programme were paying. Therefore work to improve economic status of the clients who are mostly the vulnerable groups in society to ensure that their economic status does not counteract efforts on improving access to health services. SLA arrangement could have been idea if government was capable of accommodating all the facilities. In the absence of this, devise feasible means like the VSL initiative that was implemented in some of the facilities.
7. Delayed funding existed at every level and caused by factors that were with the control of implementers, coordinating unit and donor. Future programming must serious find mechanisms to address these.
8. There are instutions that exist forever such as the church. Find ways of bringing them on board as one way of reinforcing sustainability of the gains.
9. Some outcomes that were supposed to be implemented together were separated. Mainstreaming them will achieve more. There is need to consider integrating PSS in all healthy centers target communities to bring holistic health services to the areas. WHO definition of healthy implies that every person should have access to physical, spiritual, emotional and psychological healthy services as well.

4.3 Conclusion

We conclude that the programme was the right delivery vehicle which enabled NCA to translate long term goals into action. It delivered on all outcomes; and was strategic - worked with partners who have strong legitimance and representation in their communities. Doing so enabled the programme to respond to the call by Malawi Government to improve quality and quantity of health workers. As a result; significant contributions were made towards improving access to health services by mothers and children; supporting HIV and AIDS infected and affected children; building capacities of partners and CHAM secretariat and strengthened relationships among them.

Various stakeholders are of the opinion that the programme was a success, and wished if it continued and extended into other areas. We also recommend implementation of a similar programme, in the same and/or other areas. Doing so will consolidate the gains, especially now that the partners are capacitated and have experience.

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6. APPENDICES

6.1 Appendix X: Data Tools

6.2 Appendix XXXX: Evaluation Programme

6.3 Appendix XXX: List of Research Participants

1.	Isaac Khonje	Tutor/Research Coordin.	Ekwendeni College
2.	Mrs. Mwagomba	Deputy Principal	Ekwendeni College
3.	Jessie Kaunda	Dean of Facaulty	Ekwendeni College
4.	Alice Konyani	Lecturer	Mzuzu University
5.	Florence Lungu	Lecturer	Mzuzu University
6.	Masambuko Baluwa	Head of Department	Mzuzu University
7.	A		Luke International
8.	Vinjeru Mhango		Lunjika HF
9.	Chibembe Community		Lunjika
10.	Mphofwa Community		Lunjika
11.	Kajolwe Community		Lunjika
12.	GVH Mchepa		Lumbadzi
13.	Madalitso Nkhata	Assistant EHO	Lumbadzi
14.	Dorothy Chide	HA	
15.	Frackson Banda	HAS	
16.	Josophat Saka	HAS	
17.	Mtambo	Cty Health Nurse	Lumbadzi
18.	Dr Magai	College Principal	Nkhoma
19.	Grace Massah	Deputy Principal	Nkhoma
20.	Denis Simango	College Principal	MCHS – LL
21.	Madise	Project Coordinator	Dz Cath Health Com.
22.	Mbozi Community		
23.	XXX Community		Kanyama
24.	XXXX		Kanyama HF
25.	Charles Gomiwa	HF Admin	Lumbira
26.	Andrew Leo	PA	Lumbira
27.	Eluby Khalani	HCW	Lumbira
28.	Daniel Bandawe	Nurse	Lumbira

29.	Mariya Community		Lumbira
30.	Anderson Community		Lumbira
31.	GVH Zinganguwo Safe Motherhood Committees		Lumbira
32.	GVH Nsigala Safe Motherhood Committee		Lumbira
33.	Chiringa Community		Chiringa
34.	Rose Pangani	PA	Chiringa HF
35.	Chrisie Tabuleti	HCW	
36.	Grace Matchona	PA	
37.	Grace Matsimbe	PA	
38.	Charles Nupera	HSA	
39.	Eliza Kachala	NMT	
40.	Isaac Banda	CO	
41.	Kambale Village HAC		Holy Family
42.	Nyambalo Safe Motherhood Committee		Holy Family
43.	Phipter Gangu	CO	Holy Family
44.	Agnes Phiri	Nurse	
45.	Victor Namalawa	Acc Assistant	
46.	Mrs Mzunga	Deputy Principal	St Lukes
47.	Mvula	Lecturer	
48.	Magaret Nkangala	Principal	MCHS – ZA
49.	STA Kachenga Committees (JoL, CC, Star, CBCC)		Balaka
50.	Tifelakaso CBCC in Nyanyala CBO		Balaka
51.	A		Chiringa
52.	A		M’bwatalika
53.	HAC		Utale
54.	Grace Namponya	Cty Nurse	
55.	Annie Thawani	HCW	
56.	Shupikai Piason	NMW	
57.	Abdul Kamwendo	HSA	
58.	Nixon Chawinga	DSWO	Balaka Assembly
59.	Darlington Thole		Dream Balaka
60.	DNO		Balaka Hospital
61.	XXX		Balaka Hospital
62.	Ellen Msuka	Nurse	
63.	Ivy Kapatuka	HTC Counsellor	

64.	Mbingu Ngoma Community		M’bwatalika
65.	GVH Mbingu		M’bwatalika
66.	Emerson Lungu	Nurse	M’bwatalika
67.	Kombe Community		M’bwatalika
68.	Robert Ngaiyaye	ED	MIAA
69.	Mr. Saiti Jambo	Executive Director	QMAM
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72.	Alphias Banda	Program Officer	EAM
73.	Dr Dzowera	Head of Health Prog	CHAM
74.	Adrian Kalua	Finance Manager	CHAM
75.	Mafasy	Programme Officer	CHAM
76.	Rodney Maganga	ICT Manager	CHAM
77.	Taonga Mwenifumbo		NCA
78.	Wellington Kafakalawa		NCA
79.	Paul Manjamwada		NCA
80.	Kondwani		NCA