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MALAWI BASICS PROJECT MID-TERM EVALUATION

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The Global Health Technical Assistance Project
1250 Eye St., NW, Suite 1100
Washington, DC 20005
Tel: (202) 521-1900
Fax: (202) 521-1901
info@ghtechproject.com

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Despite the best efforts of the BASICS project and USAID/Malawi, factual errors may persist in the report. These must be considered the responsibility of the principal authors, who tried to grasp the complexity of the environment in a short period of time.

ACRONYMS

ACCESS	Access to Clinical and Community Maternal, Neonatal, and Women's Health Services
ACSD	accelerated child survival and development
ANC	antenatal care
ARI	acute respiratory infection
ART	antiretroviral therapy
ARV	antiretroviral drugs
AZT	azidothymidine
BASICS	Basic Support for Institutionalizing Child Survival
BCC	behavior change communication
CA	cooperating agency
CAS	CTC Advisory Services
CBDA	Community Based Distribution Agent
CCM	community case management (community IMCI)
CHAM	Christian Hospitals Association of Malawi
CIDA	Canadian International Development Agency
CMAM	community management of acute malnutrition
COOPI	Cooperazione Internazionale
CPT	cotrimoxazole preventive therapy
CTC	community-based therapeutic care
DA	District Assembly
DAPP	Development Aid from People to People
DC	District Coordinator
DEC	District Executive Committee
DHMIS	District Health Information System
DHMT	District Health Management Team
DHO	District Health Office
DHS	demographic and health survey
DPPR	district program performance review
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EID	emerging infectious disease
ENA	essential nutrition actions
ETAT	Emergency Triage Assessment and Treatment
FP	family planning

GH Tech	Global Health Technical Assistance Project
GOM	Government of Malawi
GMP	Growth Monitoring and Promotion
H/A	HIV/AIDS
HBC	home-based care
HC	health center
HCT	HIV counseling and testing
HEU	Health Education Unit
HF	health facility
HII	high-impact intervention
HIV	human immunodeficiency virus
HMIS	Health Management Information Systems
HSA	health surveillance assistant
HTC	HIV testing and counseling
HW	health worker
IEC	information education and communication
IMCI	Integrated Management of Childhood Illness
IPC	interpersonal communication
IPTp	intermittent preventive treatment in pregnancy
ITN/LLIN	insecticide-treated nets/long-lasting insecticide-treated nets
IYCF	infant and young child- feeding
L&D	Labor and Delivery
LA	Artemether-lumefantrine
LMIS	Logistics Management Information System
M&E	monitoring and evaluation
MCH	maternal and child health
MFSG	mother-father support group
MICS	Multiple Indicator Cluster Survey
MIP	mother-infant pair
MOH	Ministry of Health
MOU	memorandum of understanding
MSH	Management Sciences for Health
MTCT	mother-to-child transmission
MTE	mid-term evaluation
MUAC	mid-upper-arm circumference
NGO	non-governmental organization

NMCP	National Malaria Control Program
NRU	Nutrition Rehabilitation Unit
ORS	oral rehydration solution
ORT	oral rehydration therapy
OTP	Outpatient Therapeutic Program
PCR	polymerase chain reaction
PedART	Pediatric Anti-Retroviral Treatment
PEPFAR	U.S. President's Emergency Fund for AIDS Relief
PHI	Pediatric Hospital Initiative
PITC	Provider Initiated Testing and Couseling
PLWHA	people living with HIV/AIDS
PMI	U.S. President's Malaria Initiative
PMTCT	prevention of mother-to-child transmission (HIV)
PSI	Population Services International
PVO	private voluntary organization
RH	reproductive health
SFP	Supplementary Feeding Programme
SOW	scope of work
SP	Sulfadoxine-pyrimethamine
SWAP	sector-wide action plan
TA	Traditional Authority
TB	tuberculosis
TBA	traditional birth attendant
TH	traditional healer
TNP	Targeted Nutrition Program
TWG	Technical Working Group
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
VCT	voluntary HIV counseling and testing
VHC	village health clinic
WFP	World Food Programme
WHO	World Health Organization

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EXECUTIVE SUMMARY

A mid-term evaluation (MTE) of the BASICS Strengthening Child Health Care Malawi Task Order (2007–20011) Project led by Management Sciences for Health was conducted in Malawi from February 17 through March 23. The objectives of the evaluation were to determine the project's progress in achieving the results outlined in its workplans and then formulate recommendations for use in the project's future programming.

The evaluation team consisted of four consultants hired by the Global Health Technical Assistance Project (GH Tech) as part of their contract with USAID to manage the MTE process. In addition, the team was joined by a Malawian logistics person in-country. The team spent the first week in Malawi receiving documents and briefings from USAID/Malawi and the BASICS project staff, as well as conducting selected interviews. During the next 10 days the team traveled to five of the eight BASICS districts for site visits and interviews. Upon return to Lilongwe the team spent the remaining time conducting interviews, making additional site visits, and preparing reports and debriefings. The team debriefed USAID on March 18 and had another debriefing with the project staff on March 19.

In general the team found the BASICS project to be making significant progress in its support of Ministry of Health (MOH), district-level, and community-level services. The project's alignment with national MOH structures, excellent working partnerships with DHMTs, and flexibility in adapting approaches at district levels have all contributed to the project's success. The team recognizes that project support is hampered by government logistics, drug supply issues, staffing, and lack of emergency transportation. Despite these and other difficulties described in the report, however, the team found that the project is making solid progress toward its objectives, and also discovered additional strengths not reported in its documents.

In the area of child health, BASICS has made considerable progress in providing community case management (CCM) training, equipment, and reporting materials to 400 health surveillance assistants (HSAs) so that they can run village health clinics in remote areas. Additionally, BASICS is initiating a mentoring program that will train health facility in-charges to support the HSA/village health clinic (VHC) work. BASICS has also supported training of facilities in the Integrated Management Of Childhood Illness (IMCI) Strategy, as well as providing materials and semi-annual supervision to facilities by the District Health Management Teams (DHMTs). With the emphasis on CCM, there has been less focus on facility IMCI, and a recent survey by the IMCI program found challenges with referrals, inadequate supervision, and reduced health worker performance. The BASICS staff are working with the IMCI Unit to develop strategies for this. One suggestion is to combine aspects of the Emergency Triage Assessment and Treatment (ETAT) training with the IMCI training, thus bringing hospital ETAT down to the health facility (HF) level and strengthening the referral and supervision aspects of IMCI. The hospital ETAT program was adopted by the MOH in 2009, and so far 800 health workers (HWs) and 1,000 support staff have been trained (half of this was supported by BASICS). Since the program was introduced, all hospitals have reported (and are encouraged by the fact) that they are triaging patients and seeing fewer child deaths. BASICS has also introduced a monthly report system for ETAT, a peer review tool, and a death audit tool—all of which are assisting district hospital staff to track emergencies and gain satisfaction in reducing child deaths. Quarterly review meetings of ETAT staff and IMCI staff, both of which are supported by BASICS, serve as reinforcement for training as well as opportunities to update staff and resolve problems. Two issues beyond BASICS's scope that affect service delivery are inadequate staffing (particularly at health facilities) and the lack of emergency transportation at all levels.

BASICS's HIV-related activities are aligned with national strategies, plans, and guidelines. BASICS works closely and well with government and other implementing partners to integrate and scale up HIV testing and counseling (HTC) for adults, infants, and children; implement combination therapy for the prevention of mother-to-child transmission (PMTCT); and scale up HIV-related pediatric

services, including emerging infectious diseases (EIDs), cotrimoxazole preventive therapy (CPT), and antiretroviral therapy (ART) to facilities in the eight target districts. The project has helped strengthen district-level monitoring and evaluation (M&E) systems by supporting collection of PMTCT data generated by the U.S. President's Emergency Fund for AIDS Relief (), which is then reported to the MOH and at monthly and quarterly review meetings. At the zonal level the project has strengthened monitoring of District PMTCT Coordinator activities.

BASICS is one of the few HIV projects in Malawi to strengthen and implement services on a national scale, spanning eight districts and serving national-level facilities as well as village clinics and community-based programs. In the project's first two years, all HIV services targets were exceeded. The project has proved highly flexible in finding innovative strategies to address barriers and challenges, and in adapting strategies based on newly identified needs or circumstances. Particularly notable achievements include technical assistance at the national level for the development of a PEPFAR PMTCT database; ART guidelines and drug procurement; mentoring at the zonal level for supervisors of District PMTCT Coordinators; development and introduction of a new set of pediatric guidelines for a non-prescriber's training module; expanded CPT services for HIV-infected mothers and HIV-exposed/HIV-infected infants and children; expansion of PMTCT services to new sites; piloting of a mother-infant pair (MIP) follow-up model that links a facility-based mothers' support group model with community-based nutrition counseling and growth monitoring; piloting of a successful village-to-village testing model that emphasizes family testing; increased testing of children through placement of a third HTC counselor at eight district hospitals or major health centers to focus on "Under 5" clinics and pediatric wards; and increased cross-referrals between PMTCT, Under 5, follow-up of exposed infants, and pediatric ART clinics.

The BASICS grants program that supports malaria communication appears to be both well-administered and implemented. BASICS has established a sound grants-making methodology, a credible process results reporting system, and strong levels of supervision. In April 2010 the program will administer grants to 12 NGOs operating in a total of 20 districts. In its first cycle, grantees exceeded their goals for reaching target groups with core malaria messages. The consensus view from a range of informants is that the grants program is producing the desired behavior change outcomes, but the lack of baseline and follow-up behavior change research makes it difficult to evaluate behavior change impact conclusively. Interpersonal communication methodologies appear to be reliable, and the radio broadcast component of one grantee has attained a nationwide reach. Grantees are becoming experienced in behavior change communication (BCC), and the best practices they have learned may serve as a reservoir of knowledge on malaria BCC for Malawi and other countries. Some stakeholders believe that the grants program is underfunded for the tasks at hand. Since the program is rapidly expanding to cover 20 districts, it may be advisable to increase the size of the staff managing the program.

Because nearly half of Malawian children under five are malnourished, BASICS has established community-based therapeutic care (CTC) and community management of acute malnutrition (CMAM). BASICS has also reinforced the health system, particularly the nutrition rehabilitation units (NRUs), through building the capacity of clinicians and health surveillance assistants (HSAs) to detect malnourished children, as well as referral and management in six districts (namely Balaka, Chikwawa, Kasungu, Mangochi, Phalombe, and Zomba). In addition, BASICS participated in the Supplementary Feeding Programme (SFP), which focuses on management of the mildly and moderately malnourished. In conjunction with improved curative services, BASICS also launched a pilot program in the districts of Phalombe and Zomba with a prevention approach to malnutrition. This consists of an essential health package that includes the essential nutrition actions, high-impact interventions, accelerated child survival development strategies, and PMTCT, with a continuum of care from pregnancy to two years through mother-infant pair follow-up of all mothers. BASICS promotes this health package through mother-father support groups (MFSGs), which has led to greater male involvement, a reduction in maternal and child mortality, and improved nutrition.

I. INTRODUCTION

The main purpose of this mid-term evaluation is to provide a basis for USAID/Malawi and the Ministry of Health (MOH) to assess progress made by the Basic Support to Institutionalizing Child Survival (BASICS) Task Order, which is being administered by Management Sciences for Health (MSH). The Task Order supports child health and health care system strengthening activities and extends from September 2007 to September 2011.

This report addresses a series of questions about the strengths and weaknesses of the BASICS project both in strengthening health systems in child health and nutrition, and in supporting infectious disease priorities in HIV/AIDS and malaria. The report also examines potential future directions and activities during the two remaining years of the project, and provides an opportunity to make recommendations that will enhance results before the project ends.

II. BACKGROUND

CHILD HEALTH IN MALAWI

Malawi has made notable progress in reducing childhood deaths, with under-five mortality dropping by 30% between 1990 and 2004—from 190 deaths per 1,000 children to 133 deaths per 1,000 children. During the same period infant mortality declined 27%—from 104 deaths per 1,000 infants to 76 deaths per 1,000 infants (MDHS, 2004). Malawi is thus one of the few African countries on track to reach the reduction in the under-five mortality rate set by Millennium Development Goal Number 4.[1] However, mortality rates remain high. The 2006 Malawi Multiple Indicator Cluster Survey (MICS) found infant and child mortality rates of 69 per 1,000 and 118 per 1,000 respectively. Seven in ten child deaths are due to neonatal causes, malaria, diarrhea, pneumonia, anemia, and malnutrition, acting in concert or independently. Malaria alone continues to cause about 30% of under-five deaths, pneumonia still accounts for 18% of deaths among hospitalized children, 45% of children are stunted, and the high prevalence of HIV/AIDS has affected both life expectancy (43 years) and child mortality (National Plan for ACSD 2006).

In response to this situation the MOH, together with donors, have developed a Sector-Wide Action Plan (SWAP) Program of Work for 2004–2010 to align donor inputs with MOH activities. The BASICS project was designed to support MOH programming, particularly in the area of child health. A major outcome of this alignment has been the increased flow of funding to the districts allowing strengthened provision of services. The MOH's acceptance of the Integrated Management of Childhood Illness (IMCI) and the Accelerated Child Survival and Development (ACSD) Strategy along with community case management (CCM) have guided this service provision. This policy has involved several ministries in Malawi, including Health, Agriculture, Gender, and Youth Development. The United Nations Children's Fund (UNICEF) has played an important role in facilitating the process of donor inputs, including those from the U.S. Government like the BASICS project. Recently the MOH has begun to hire more health surveillance assistants (HSAs) to help implement the ACSD/CCM approach, thus expanding child health services to rural villages. Salaries are being supported by the Global Fund, which is ending this year. Increased numbers of health workers have also been trained; however, now that the 2004–2010 SWAP period is ending, funding for this training has stopped.

The BASICS Project Response

The IMCI policy and the ACSD strategy, as well as the new Emergency Triage Assessment and Treatment (ETAT) program adopted by the MOH in 2009, have provided the main focus for BASICS support in child health and nutrition. As the project has evolved, the U.S. President's Emergency Fund for AIDS Relief (PEPFAR) has provided additional financing for HIV/AIDS support in the areas of PMTCT and HIV testing and counseling (HTC). Also, the U.S. President's Malaria Initiative (PMI) supports a small grants program for communication activities administered by BASICS. While the HIV/AIDS support is aligned with the MOH HIV/AIDSprogram nationally and in the district facilities, the malaria support relies on NGOs to conduct BCC activities in rural areas. BASICS has supported scale-up of services firstly by training a variety of players (health worker trainers, HSAs, district-level technical working groups, and District Assemblies), and secondly by providing technical assistance at several levels of the health system. Such assistance includes direct support of advisory positions within the MOH, development of training and reporting materials, job aids, and equipment, and helping District Health Management Teams (DHMTs) in the implementation of ACSD/CCM/ETAT/PMTCT/HTC/CTC. Fortunately, BASICS was designed with the flexibility to support onsite technical assistance and materials, supplies, and equipment needs when other donors are able to provide funding for training.

[1] Millennium Development Goal Number 4: "Reduce by two thirds the mortality rate of children under five." United Nations Millennium Campaign, at http://www.un.org/millenium goals.

BASICS uses a three-step strategy to implement its activities. These steps center around the MOH's Essential Health Package of evidence-based interventions delivered in the eight target districts of Balaka, Chikwawa, Kasunga, Mangochi, Nsanje, Phalombe, Salima, and Zomba. The first area of focus has been on facility-based treatment (IMCI, Pediatric Hospital Initiative (PHI)-ETAT), serious infections, severe malnutrition, and Pediatric Anti-Retroviral Treatment (PedART) (including increased HIV testing in children), as well as facility-based preventive care (PMTCT, immunizations, essential nutrition activities). A second area aims to expand community-based delivery of services through CCM and village health clinics (VHCs) in hard-to-reach underserved areas. A third area lays a foundation for sustainability by establishing links between communities and community-based care, and between community-based care and facility-based care.

All of these strategies aim to help the MOH meet its objectives of improving the effectiveness, quality, and accessibility of child health services through development of interventions that prevent and reduce illness, mortality, and malnutrition among children under five. This activity contributes to the USAID/Malawi goal of supporting the Malawi Growth and Development Strategy.

III. FINDINGS AND CONCLUSIONS BY TECHNICAL AREA

CHILD HEALTH FINDINGS AND CONCLUSIONS

a) Progress made to improve access to and quality of CH services at district-level facilities

b) Progress made through BASICS to improve health systems and services management at district level

In general, significant progress has been made in most child health results indicators addressed by the BASICS project. Many of the indicators have already been met, or are close to being met. Those indicators that have not been met are planned to be met during the coming period.

Accelerated Child Survival and Development (ACSD) and Community Case Management (CCM)

Through ACSD and CCM, BASICS has expanded access to and use of key child health interventions that primarily focus on the prevention and treatment of key childhood illnesses. The project has provided extensive technical support, training, and assistance in its eight districts for both ACSD/high-impact intervention (HII) and, more recently, the CCM activity focusing on the primary causes of child deaths. During the first year, BASICS provided training to 144 HSAs and 36 health worker trainers on the 12 high-impact interventions for ACSD. The project also produced and distributed copies of the ACSD strategy document in all 28 districts. However, since the primary focus in the last year and a half has been on the CCM activity, the project has trained approximately 400 health surveillance assistants (HSAs) in hard-to-reach areas to manage village health clinics (VHCs). These individuals received CCM training to diagnose, treat, or refer children under five for malaria, diarrhea, acute respiratory infections (ARIs), and eye infections; the HSAs were also given drug boxes with essential drugs for treatment. BASICS will shortly be providing them with 200 more drug boxes, equipment such as ORS (oral rehydration solution) kits (500), bicycles (500), and register books (1,500) for documenting diagnosis and treatment in the VHCs. In a recent assessment by the IMCI unit, preliminary results indicated that 70% of clinics visited showed that children were appropriately referred and 80% of those needing antibiotics were correctly treated.

From observations and interviews the evaluation team concluded that HSAs who live in villages see large numbers of patients (many see between 100–200 patients per month). HSAs not living in villages tend to see far fewer patients (an average of 20 per month) and are not available every day or at night. The MOH now requires new HSAs to live in villages, although the current HSAs continue to run VHCs. However, housing can be an issue, as most HSAs do not want to live in villages without housing. Some forward-thinking villages in Kasungu have accessed funds from the District Assembly and have built housing for HSAs. The District Coordinator sees this as a model/best practice and is taking other village committees to see such housing developments and learn about them. Another issue with the village clinics has been the unavailability of Artemether-Lumefantrine (LA) for malaria—only two districts visited had a supply at the HSA level. Because 50% of cases are malarial fever, many patients must be referred to already overloaded health centers, even though such patients could have been treated in the villages. According to BASICS, the supplies of LA from the Global Fund and PMI are in-country and will be distributed once the systems are organized.

There are documentation/reporting concerns in getting information from the village clinics to the health centers, and from there to the districts. HSAs are slow to report how many patients they see, and only the health centers, not the HSAs, keep records of drugs dispersed. HSAs have forms for patient visits and referrals, but these tend to run out. The new register books created by BASICS should help with documentation, as these are large and should last a year. The new Frontline Short Message Service (SMS) reporting system being developed by Management Sciences for Health (MSH) should help with reporting from VHCs once the technology is understood. Another issue raised by the health centers is that the HSAs do not document diagnosis and treatment in the

patient's passports (they have been told not to do this). Because patients typically lack referral forms, when they arrive at the health centers the staff tend to be unaware of the patients' history and unsure how to treat them. The Phalombe District Health Officer has adopted a best practice in that he has developed his own forms, and the HSAs do dispense LA. The officer then calculates health center needs based on documentation of fever cases from these reports. He seems to have a sufficient supply of LA and can redistribute surpluses from one health center to another.

In trying to maintain transparency of the drug boxes, the Ministry of Health has recommended that keys to the boxes be kept by both the HSAs and the village drug committee. When the evaluators visited the VHCs, they were shown boxes with two locks—before an HSA can dispense drugs, he/she must ask a village elder to open one of the locks, and return later to lock it again. The DHMT in Phalombe decided this was too confusing and does not require the two keys. Instead they rely on their own drug reporting forms that are reviewed by the village committee and the health center.

Another best practice is the mentoring program that BASICS has encouraged, which has involved organizing the training of health center in-charge mentors in all eight districts (four per district). Phalombe in particular has promoted this activity, which started three months ago. Each HSA is supposed to spend five days at the health center being mentored by the in-charge. Although in most facilities observed the HC in-charge cannot spend more than an hour a day on mentoring due to a heavy workload, this experience is at least strengthening relationships between HSAs and HC in-charges, and this relationship-building may help resolve some of the VHC drug disbursement and reporting issues. Supervision of the HSAs has become an issue. Presently they are supervised by the HSA-in-charge, but these have not been trained in CCM. Instead of training the remaining 80 HSAs planned for the current year, BASICS is considering focusing on training the HSA supervisors. This would not only strengthen supervision but would also relieve the VHCs' drug supply pressures.

Facility IMCI

BASICS is supporting the MOH and DHMTs conduct follow-up and supervision of staff trained in IMCI. The project supported two IMCI training courses in 2008, as well as the printing and distribution of 1,000 IMCI chart booklets in eight districts. To date BASICS has supported two rounds of IMCI supervision per year in each district. Supervision was intended to be quarterly with IMCI Trainers and IMCI District Coordinators, but in the districts visited it has been difficult to maintain this schedule. In most facilities visited, a major proportion of staff have been trained. However with staff turnover, updates and training are always needed. The training course is six days, which some interviewees feel is insufficient. Some also feel that the course needs more practical training and that the IMCI department should consider an eight-day course. A study conducted in 2009 to examine quality of care found that sick children were not being appropriately referred, supervision was insufficient, and health worker IMCI performance was reduced. When asked about this, IMCI coordinators stated that while the charts that were distributed are useful, many HWs lack time to use them because of their huge patient loads. HW interviewees concurred, stating that they only have enough time to concentrate on a child's immediate medical problem, although some said they would do the full IMCI review on selected patients when time permitted.

BASICS is currently working with the IMCI department to address some of these issues. The districts have asked BASICS to help the DHMTs develop a system for cross-supervision whereby with appropriate checklists and tools, different DHMT members could review each other's areas when one or two members visits a health facility. Since it is almost impossible to schedule the whole DHMT team of 10 members for one visit (which would overwhelm the facility for that day), this seems a better option. Apparently, this was something that MSH had supported under its bilateral project, and some felt it might be helpful again. While this may indeed be helpful, there is a larger issue of trying to consolidate a team function at the district level when personnel are rotating so often. However, everyone recognizes that the IMCI supervision issue needs attention. One solution that BASICS is exploring with the IMCI and ETAT programs would be to combine ETAT training with the IMCI training for health facilities. Generally ETAT is for hospital emergency care, but

BASICS thinks the principles could be applied at lower levels. When IMCI is done correctly, 20% of patients are referred, so the first chapter of the IMCI guidelines would be for emergency management of the sick child. It is felt that ETAT guidance would strengthen the referral system, as well as the guidelines, by incorporating emergency care principles. The thinking is that once they have the ETAT training schedule, districts could use opportunities during training to provide IMCI refresher sessions. Connecting emergency care with IMCI case management principles would also increase understanding of the care continuum. However, because ETAT and IMCI depend on task sharing and teamwork, it will be challenging to make this work at an HC with one nurse and one medical assistant.

Transportation is an issue at all levels. All the health centers visited have operational radios to call for ambulances, but staff say the transport does not arrive in a timely fashion. Again, if IMCI is done correctly, 20% of patients will need to be referred. According to interviews with district and project staff, this is a management more than a resource issue. For example, evaluators viewed several motorcycle ambulances parked at district hospitals. There was confusion about which patients the ambulances were to be used for—some say they are only for pregnant mothers since they were probably bought by the safe motherhood programs. Evaluators also heard that transportation for sick children must be prioritized, and that ambulance use must be prioritized. For instance, the ambulances are used to transport various district health staff to meetings or to fetch supplies from Blantyre or Lilongwe. Another issue is the amount of transport time and resources spent delivering dead bodies back to their to communities, which districts are required to do. Another problem is that ambulances are not made available to the HSAs and village clinics, so the villages must use their own resources to get to a health center where they then wait for an ambulance. This village transportation issue is bound to grow given the anticipated growth of VHCs and referrals.

Pediatric Hospital Initiative (PHI)/Emergency Triage Assessment and Treatment (ETAT)

The Pediatric Hospital Initiative dealing with in-hospital case management of childhood illness is new and has not yet been implemented in Malawi. Professor Molyneux (Queen Elizabeth Hospital in Blantyre) who has been working in this area with WHO since 1990 has been contracted by BASICS to adapt the WHO *Handbook* into a series of modules for in-service training. Once the materials have been completed, BASICS will support the training of hospital staff in the eight districts. This is anticipated for the second half of 2010.

Although ETAT was earlier introduced in Malawi as part of a quality-of-care initiative through the College of Medicine, it was officially adopted as a Ministry of Health program in 2009. To date the program has trained 800 health workers and 1,000 support staff in 48 hospitals and four health centers. BASICS has supported training in 23 facilities. Previously, only some staff were trained in each facility; upon supervision and assessment it has been decided to train all facility staff. The course is four and a half days with a mix of theoretical, clinical, and group skills-building. Participants are trained by district rather than by facility. The ETAT coordinator works with BASICS and WHO to determine which organization will support training in which districts. Since an organization can be in overlapping districts, this often needs to be sorted out. At this point, BASICS is interested in working with the MOH to develop a broader ETAT strategy that includes linkages with IMCI and PHI (evaluators heard that training is not enough to establish a program).

BASICS staff have observed that once training is completed, there is no follow-up reporting guidance. In January BASICS held a training session to introduce three tools: (1) a monthly report form on ETAT activity; (2) a peer review tool wherein ETAT staff are asked monthly to note staff levels, locations where patients were seen, common causes of death, availability of essential drugs, appropriate supplies and equipment in the pediatric ward, lab supplies, etc.; and (3) a death audit tool to review the cause of a patient's death and determine if death could have been prevented. BASICS is working with the districts to establish a supervision system to have death audits and peer review audits done quarterly. Once the PHI modules are completed, these meetings could be used as a forum for in-service training. BASICS has had 200 copies made of ETAT wall charts/job aids for the

eight districts, and evaluators saw the wall charts being used in the intake areas of the pediatric wards. BASICS is also procuring essential emergency equipment, such as oxygen concentrators, glucometers, and baumonometers, for 18 hospitals.

In general, evaluators found that hospital staff trained in ETAT were pleased with the program, finding the training to be useful and motivating. All the hospitals visited were triaging patients whether staff had been trained or not. Each child under five was assessed by support staff and assigned a status of "emergency," "serious," or "non-emergency"—those with emergency status were seen first. The ETAT team has been keeping a monthly record of under-five deaths and were motivated by the declining death rate. They are pleased with the quarterly review meetings and the availability of some emergency equipment. In general, staff feel that since all staff deal with children, all staff need ETAT training, and that those who lack it can miss serious cases. Staff also believe that the ETAT coordinator should be based in the pediatric ward.

c) Progress in child-health-related health promotion and BCC at the community level

To date BASICS has not put much emphasis on BCC in the child health area. Evaluators viewed a flip chart produced by UNICEF addressing the 12 ACSD program areas, which may be a little complex if intended for use by the VHCs. The MOH is currently reviewing the chart for message content before deciding whether to release it for the VHCs; if approved, BASICS will print these charts for distribution to VHCs. During field visits it was found that the HSAs do not have any BCC materials to use when explaining care instructions to mothers. The HSAs commented that they would like materials for this purpose, such as a flip charts and pamphlets when talking to parents.

BASICS is planning a BCC campaign for zinc once the new oral rehydration solution (ORS) with zinc currently being packaged by UNICEF become available for distribution at the health centers. BASICS has developed an information education and communication (IEC) strategy for this with help from the MOH/Health Education Unit (HEU). They have developed 3,000 posters to distribute to communities and health centers about zinc, and they have produced radio spots to run on the national radios of MBC (government) and Zodiac (private) for three months (although there will be only five spots per week). There will also be community campaigns that include "open days" and meetings with chiefs. Theatre artists, village groups, headmen, and chiefs will be trained to disseminate zinc messages. In addition, messages and features will be published in national newspapers and a press release will be sent out at the time of the launch. Due to limited funding for the campaign, messages will not be disseminated as frequently as BASICS would like. However, the project may be able to work with one of its malaria grantees, Development Communication Trust, which has regular programming on Zodiac (see Malaria section of this report), to gain further exposure of this issue.

d) Effectiveness of child health service-delivery packages and capacity-building (technical training, administration, management) interventions used by BASICS

BASICS has focused much of its activity on capacity-building and support at all levels of the district health system, and some at the national level. (See Annex D for information detailing the training conducted by BASICS.) In addition to the extensive training provided to HSAs and HSA supervisors in CCM, to health workers in ACSD, ETAT/PHI, and IMCI (see Annex), BASICS has also provided systems support to facilitate reporting such as development and training for reporting forms, including VHC registers, LMIS (Logistics Management Information System), SMS training and equipment for HSA reporting, ETAT monthly report forms, peer review and death audit tools, and chart booklets for facility IMCI. Other technical, administrative, and financial support at the national and district levels includes support for ACSD Technical Working Group meetings; annual meetings with district executive committees (DECs); annual CCM review meetings implemented by the IMCI Unit; ETAT district-level quarterly review meetings; district-level ETAT quarterly peer review audits; and national-level meetings for dissemination of ETAT baseline assessment results. These meetings are key to keeping the programs on track to reach desired objectives. However, despite these meetings which include donor partners, confusion remains over what support and roles the varying

donors are to provide. This situation has not been improved by the recent appearance of new players in the same areas where BASICS operates, such as the Catalytic Initiative, Gates, and CIDA.

Other administrative and financial support provided by BASICS includes the procurement of items for child health programs—200 drug boxes, 500 ORT kits, and 500 bicycles for HSAs running VHCs. The project is also procuring telephones, software, and other equipment for the SMS reporting system that is being set up to facilitate monthly reporting from the VHCs and district facilities. Additionally, BASICS is procuring emergency child health equipment for district hospitals and health centers.

Because the evaluation for child health services included no budget review, no assessment can be made of financial systems. However, as district and MOH officials have reported, all of the administrative, financial, and technical support provided to them has been critical to the success of their programming. BASICS's flexibility to fill gaps not covered by other donors has proved invaluable—the project has been able to procure equipment; provide transportation for supervision; develop, print, and organize reporting systems; and provide support for additional training or meetings when needed. For this reason, district and MOH officials have expressed concern over the end of the project in 2011. BASICS has also expressed its appreciation for USAID's flexibility and support for its innovative approaches.

e) Effectiveness of BASICS's organizational structure in achieving child health program objectives

In general the central project staff work well and have good relationships with district project staff and MOH counterparts. For the evaluation visits, the District Coordinators organized meetings with counterpart district health staff, prepared briefing documents with information on district activities, organized village and health center visits, and briefed the evaluation team on the district health activities they support. When asked about having to manage two MSH project activities, the DCs admitted that this was initially difficult because, in addition to the BASICS project activities, they must keep track of 150 community-based distributor agents per district, and meet quarterly. However, the DCs said that they developed a strategy of relying on district staff to help keep track of activities, thus forming strong teams of BASICS and MOH coordinators. In addition, BASICS has hired community liaison officers in order that some of the districts might share the workload. Staff turnover among District Coordinators has been high, mainly related to salary, and MSH is addressing this issue and will be able to meet salary requirements better. The DCs indicated that having to fill out separate reports for the two areas is time-consuming and they would prefer a consolidated report format.

Similarly at the national level, BASICS has developed good relationships with counterparts such as the IMCI coordinator, who spoke specifically about the technical and administrative support he has received from BASICS, including the furnishing of his office. Likewise, the ETAT coordinator was very positive about his relationship with BASICS staff and the support that he has received. One issue for donors rests on the fact that because both these programs are supported by several donors, their coordination role is crucial. The districts have learned that they can apply to multiple donors, and if one will not support what they want, they can go to another, which is making it difficult for the donors to plan.

BASICS is addressing the issue of understaffed facilities, which typically occurs when many staff are transferred and/or other staff are often out at frequent trainings offered by the numerous NGOs in the districts. While this issue is beyond BASICS's scope, it needs attention. An underlying factor in the understaffing issue, particularly in the nursing shortage, is that the government no longer provides support (SWAP) for training health workers, so each worker must fund his/her own education. Students who can afford to come will most likely be from the city. Without government bonds, rural students are unlikely to come, which affects health center staffing.

f) Progress toward achieving child-health-related monitoring and evaluation goals and targets

In general BASICS is on track to meet, or may have already met, its contractual targets in terms of HSAs and health workers trained (CCM, ACSD, IMCI), VHCs established, and ETAT/PHI implemented at hospitals. The treatment targets are a little harder to determine depending on the data sources used. The initial targets may have been set too high given population size and data problems. However, after inclusion of hospital data, the numbers have increased. The project may need to revise targets for treatment.

Keeping the district reporting information on track has been difficult due to the absence of an M&E Officer, but now the new officer is revising the data collection systems and correcting errors. He has been trying to reconcile monthly narrative reports from the districts with quarterly indicator data; unfortunately, the quarterly data are often late and compiled under pressure, and are thus inaccurate. To address this, the new officer is putting in place a system to collect indicator data monthly. Although BASICS provides funds for the district assistant statisticians to follow up on data from the HCs, not all of them go to the HCs. However, the system is much improved, and the District Coordinators are making sure that the data are turned in by the 5th and 15th of each month. Further to improve this system, the M&E Officer will begin making visits to the 3–4 district health centers that are having problems retrieving data on time in order to try to improve monthly outcomes (Kasungu, Mangochi, Salima, and Zomba). The officer is also organizing training courses with the MOH HMIS office for different cadres of district staff (nutrition, IMCI, PMTCT) to improve data reporting skills, particularly at the health center level, using the new registers as tools (VHC, ANC, LMIS registers).

Evaluators observed use of new ANC registers at hospitals and piloted VHC registers in the VHCs. The BASICS staff noticed some errors in the pediatric reporting on the ANC register and used it as a training opportunity. The HSA who piloted the VHC register provided useful feedback for organizing summary data on the registers.

Once the new system is in place and the HSAs are using the registers, it will be important to measure how much the load on the HCs has been reduced by the village clinics. At present, it is difficult to measure this, given the large numbers of referrals for LA and other out-of-stock drugs.

Conclusions

In sum, the BASICS project is making good progress toward its objectives. It is close to meeting its training objectives in ACSD, CCM, and ETAT/PHI. The project is also close to achieving its objectives regarding numbers of village clinics set up and hospitals where ETAT is implemented. BASICS support for IMCI and ETAT quarterly meetings has also strengthened the district programs. In addition, the extra support for supplies and equipment, as well as IMCI supervision support, has greatly helped the programs advance at the district, health center, and community levels.

HIV FINDINGS AND CONCLUSIONS

Overview

The BASICS project supports strengthening of HIV-related services at national, zonal, district, and community levels. Stakeholders interviewed for this evaluation confirmed that BASICS has been an excellent partner for MOH and other implementing partners (such as UNICEF, the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), Dignitas, and JPHIEGO) who strengthen or provide HIV services. BASICS HIV-related activities are designed to align with national strategies, plans, and guidelines. BASICS works closely and well with government and other implementing partners to integrate and scale up HIV testing and counseling (HTC) for adults, infants, and children; implement combination therapy for PMTCT; and scale up HIV-related pediatric services including emerging infectious diseases (EID), cotrimoxizole preventive therapy (CPT), and antiretroviral therapy (ART)

to facilities in the eight target districts. The project has also helped strengthen district-level M&E systems by supporting collection of PEPFAR PMTCT data and reporting of this data to the MOH, while at the zonal level the project has strengthened monitoring of District PMTCT Coordinator activities.

BASICS is one of the few HIV projects in Malawi to strengthen and implement services on a national scale, spanning eight districts and serving national-level facilities as well as village clinics and community-based programs. In the project's first two years, all HIV services targets were exceeded.

a) Progress toward improving PMTCT and pediatric HIV/AIDS services at the national, zonal, and district levels

At the national level, BASICS has funded two technical assistants to support scale-up of PMTCT and pediatric HIV/AIDS services at the MOH. The PMTCT technical assistance contract has ended, and the HIV/AIDS technical assistance contract will end September 2010. (Main accomplishments of both technical assistance contractors are included in Annex F.) The PMTCT technical assistant was particularly helpful in developing a database to help the eight target districts collect PEPFAR PMTCT indicators and report them to the MOH. The HIV/AIDS technical assistant has been highly engaged in developing national ART guidelines and protocols, and procurement of ARVs. The emphasis for both technical assistance positions has been on collaboration and a gradual handover of responsibilities to appropriate Ministry colleagues. At the zonal level, BASICS has successfully provided funding and technical support for the national PMTCT Unit to conduct quarterly zonal mentorship meetings for District PMTCT Coordinators. These zonal meetings are intended to improve the capacity of District PMTCT Coordinators to plan, implement, monitor, and evaluate PMTCT services in their respective districts. Meetings are well attended and highly valued. Activities linked with zonal mentoring also include roll-out of the newly designed antenatal care (ANC) register and meetings to train district-level staff about quantification of PMTCT supplies (test kits, drugs). At the district level, BASICS has supported the National Five-Year PMTCT Expansion Plan's emphasis on strengthening linkages between PMTCT, reproductive health/maternal and child health, and primary care services, and increasing the number of HIV-positive pregnant women receiving a complete course of ART from 19% in 2007 to 70% by 2012. In 2009 BASICS collaborated with Access to Clinical and Community Maternal, Neonatal, and Women's Health Services (ACCESS)and Population Services International (PSI) to set up an integrated maternal health/neonatal health/child health program in order to strengthen the overall continuum of care, and in particular to strengthen PMTCT and pediatric HIV services. Partners worked together to conceptualize an integrated services model and operation framework to link all MOH-approved maternal and child health service packages. BASICS also collaborated with ACCESS, Baylor, and the Clinton Foundation to develop a mother-infant pair follow-up register, which has not yet been field-tested. Results of this collaboration include integrated maternity/ANC registers, a mother-infant pair follow-up process, use of hygiene kits, and expanded introduction of CPT for infected mothers and exposed/infected babies.

Additional Project Accomplishments for PMTCT and Pediatric HIV/AIDS Services: PMTCT

Twenty-four trainers were trained for this module (three per district), with the goal of training a total of 240 health workers, 30 per district. A training module for orientation on PMTCT and pediatric HIV for non-prescribers was developed, at the request of the MOH.

Mother-Infant Pair (MIP) Follow-Up

BASICS is piloting an MIP follow-up approach in Phalombe District that includes intensive screening of exposed children, creating facility-based support groups, and monitoring community-based nutrition education and child growth (see Section 1.2).

Pediatric Testing/ART/CPT

One of the BASICS project's goals is to test as many children as possible for HIV. The project has supported increases in functional referrals between PMTCT, Under 5, follow-up of exposed infants,

and pediatric ART clinics. All district hospitals visited had implemented clinics for follow-up and testing of exposed infants. At one hospital the follow-up clinic was combined with the Nutrition Rehabilitation Unit (NRU) clinic. At several hospitals ANC, PMTCT, Under 5 clinics, and HTC rooms are located in close proximity for easy cross-referrals. Growth monitoring is also being used as an entry point for HIV testing and treatment.

The number of infants identified through EID continues to rise despite problems with lab specimens and lost test results. Building laboratory capacity to meet increased testing demand is beyond the scope of the BASICS project. However, the project has developed and pilot-tested an EID module for clinicians, and is waiting for TWG approval to schedule additional trainings.

Another notable accomplishment is the strong uptake in CPT by HIV-positive mothers and exposed/infected infants in 199 facilities. Additional accomplishments include:

- a pediatric HIV orientation module for health workers has been developed and is awaiting MOH approval.
- 464 health workers from 112 health facilities have been oriented in CPT guidelines.
- CPT cards and registers have been printed and distributed in 112 health facilities.
- 428 HTC counselors, 299 clinicians, and nurses from 78 health facilities have been oriented in pediatric HIV test and counseling guidelines.
- refresher trainings on new ART guidelines have been conducted for 291 service providers.
- 8,464 children from pediatric wards, NRU, Under 5, and CTC were tested for HIV from October 2007 through December 2009. Of this number, 1,696 children from 18 months to 14 years were HIV-positive (20%).
- 45,839 pregnant women attending ANC in eight districts were tested for HIV by BASICS counselors from October 2007 through December 2009. Of this number, 3,877 were HIV-positive (8%).
- 392 health workers from six districts attended refresher ART trainings (not in the original work plan; this was done at the request of the MOH).
- 20 health workers attended practical ART training in two districts at the request of the MOH.
- 100 HCT counselors (12 per district) received refresher trainings.
- health workers in pediatric wards were oriented to pediatric HTC. (This is an ongoing task: the goal is three district hospitals and seven CHAM (Christian Hospitals Association of Malawi) facilities.)

Year 3 plans include refresher trainings on prophylactic ART combination therapy, EID training, and trainings on new ANC/maternity registers; increasing the number of eligible women enrolled on ART; strengthening MIP follow-up strategies; exploration of routine testing at Under 5 clinics; continued provision of HTC for pregnant women, infants, and children; ongoing trainings to support quality HTC, including orientation to pediatric HTC guidelines; refresher trainings for providers on new ART guidelines, including presumptive therapy for HIV-affected children; orientation of HSAs on feeding for HIV-infected/exposed infants (the aim is 320 HSAs, 40 per district); and ongoing orientations for pediatric HTC and use of CPT in pediatric HIV.

Challenges for PMTCT and Pediatric HIV/AIDS Services

Mother-infant pair (MIP) follow-up: The MIP follow-up model introduced by BASICS in Phalombe District is conceptually strong and includes early infant diagnosis, care and treatment of HIV-infected

children, inclusion of a support family member through the MIP cycle, regular nutritional counseling, linkages for TB screening and clinical or laboratory assessment, and CPT and ART where needed. Mother-infant pair linkage with health facility appears to be strong through the first post-natal visit, often remaining so through the six-weeks' immunization visit. After this point, however, the number of MI pairs lost to follow-up is high. Improvement in follow-up visits generally occurs where support groups or nutritional supplements are provided, or where the community has a mother-father support group. Transportation is often identified as a challenge for mothers, who may make monthly ART visits for themselves as well as monthly visits for their children.

Mother-to-child transmission risk for infants during the breastfeeding period: In Malawi most babies are reportedly infected during the breastfeeding period. A national conversation is ongoing to consider the option of extended ART prophylaxis for HIV-positive mothers through the traditional breastfeeding period (reportedly 21 months average in Malawi), and perhaps beyond. While this approach has significant implications for national ARV procurement costs, given the testing and follow-up challenges in the country this may be the safest strategy to reduce MTCT.

Low numbers of eligible mothers, infants, and children on pediatric ART: The table below, taken from 2008 National PEPFAR PMTCT data, reflects striking differences between the numbers of mothers and infants on CPT and ART. (The number of children on ART is not disaggregated by age and includes teens.)

TABLE 1: THE NUMBER OF MOTHERS AND INFANTS ON CPT AND ART

Mothers tested for HIV (at 499 PMTCT sites)	HIV + mothers	Mothers on CPT	Mothers on ART	Infants on CPT	Children on ART
405,694	36,197	30,545	4,100	21,841	9,214

A review at representative sites to determine linkages between CPT initiation, ART eligibility testing, and ART initiation, as well as to assess how many mothers and infants started on CPT continue, would be helpful. If mothers are bringing their infants back for monthly CPT, then linking CPT and pediatric ART prescription at the same clinic may increase ART continuation and adherence.

Other challenges beyond the scope of the BASICS project to address include:

- transportation difficulties for mothers to return to clinics.
- maternal and child malnutrition—many HIV-infected mothers and children need nutritional support beyond counseling.
- less than 20% of ANC sites nationwide are implementing the new PMTCT combination regimen, while antenatal AZT and hemoglobin testing are available in most ANC/PMTCT settings
- the limited capacity of outlying health facilities directly to provide rapid testing or polymerase chain reaction (PCR) for infants and children (only 41 of the 544 national PMTCT sites provide PCR testing).

Plans to Address Challenges in Year 3

The project is scaling up pediatric testing through placement of HTC counselors in pediatric wards and Under 5 clinics. It supports CD4 testing of pregnant women through transportation of some blood samples to district hospital lab facilities. Borrowing from a Baylor best practice, BASICS is contracting with Baylor to train HIV-positive mothers as patient escorts for at-risk children in Under 5 clinics, to accompany mother and child pairs to the HTC room and support the mother to return for test results.

BASICS is also looking at the Baylor Tingathe program, which engages community health workers to meet PMTCT patients at the clinic, form supportive relationships with them, and conduct post-natal home visits for ongoing support for HIV-positive mothers and HIV-exposed infants. (The model may prove easier to implement in urban areas because of the shorter distances between clinic and home. Given the multiple tasks already assigned to HSAs, and HIV-related confidentiality concerns at the community level, it seems improbable that the HSAs can take on this role as well.)

BASICS will begin to explore use of routine testing of children at Under 5 clinics, linking testing with early immunization visits. This seems an efficient and feasible strategy to integrate routine pediatric testing with well-utilized child health services.

b) Progress toward improving access to and quality of HIV/AIDS services at the district level

c) HIV/AIDS health promotion at the community level

The BASICS project's main HIV-related goal is to expand the reach of HIV/AIDS service delivery, emphasizing bi-directional referral systems that link communities and families, particularly mother-infant pairs, to PMTCT, HTC, adult and pediatric ART, and CPT services.

Facility-Based HTC

BASICS has strengthened facility-based HIV testing and counseling through:

- training and placement of 16 (two per district) HTC counselors in target district hospitals.
- placement of eight (one per district) additional HTC counselors to focus on testing in pediatric wards, Under 5 clinics, and NRUs as a strategy to strengthen PITC (Provider Initiated Testing and Counseling) identify more infected children, and link them sooner with CPT/ART.
- orientation for 727 health workers in pediatric HTC guidelines.
- technical and financial support for 2007 and 2008 national HTC testing weeks at both the national and district levels.
- quarterly meetings with HTC counselors and supervisors.
- promotion of couples testing.

In Year 3, BASICS will finish piloting a contractual arrangement with one NGO each in Phalombe and Nsange Districts to hire and supervise additional HTC counselors at health facilities in order to fill coverage gaps, since HSAs employed by MOH cannot sustain HTC services five days a week.

Community-Based HTC

BASICS has implemented an innovative village-to-village testing campaign in Salima District, based on a model first implemented by SASO, Salima AIDS Support Organization, to bring HTC services closer to people where they live. This successful pilot included gaining endorsement of village leaders and community sensitization through existing communication channels, followed by one to two days of voluntary testing in 40 villages in Traditional Authority Msosa. Group pre-test education was provided, and families were encouraged to test together. People testing positive were clinically staged right away and referred to Khombedza Health Center for CPT, and ART where indicated. Other neighboring villages are now asking to have this testing service brought to them. Many village leaders had themselves tested to serve as role models for their communities. Advantages of village-to-village testing include alignment with family-centered care model, immediate linkage with clinical staging, and potential for psychosocial support from leaders.

BASICS also supported the target districts in two national HIV Test Week campaigns. These combined HTC efforts have resulted in a total of 143,620 people tested through project activities from September 2007 through December 2009.

Training to Support Increased Provider Skills

The following HIV-related trainings have been directly provided or facilitated by the BASICS project:

1. an HIV officer designed and delivered orientations on pediatric ART for non-prescribers that addressed PMTCT, ART, and EID.
2. the project funded a CPT orientation training package for health workers (MOH curriculum).
3. the project arranged an HTC training for all HTC counselors in facilities, not just those hired by BASICS, using national training curriculum and national trainers.
4. a BASICS nutritionist designed and delivered Mother-Infant Pair Follow-Up Training Module 1, focusing on nutrition and growth monitoring for HSAs, nurses, and clinicians.
5. a nutritionist provided training for mother-father support group volunteers.
6. a project officer and national trainers co-facilitated provider orientation in pediatric HIV guidelines, using MOH curriculum.

The project also:

1. designed data collection tools for HTC and CPT.
2. provided CPT registers and cards to 116 facilities.
3. at the TWG level, provided input into maternal/ANC registry design.
4. recommended one register for mother-infant pairs.
5. provided supervisory checklists to facilities.

Focus on Increased Male Involvement

Efforts to increase male involvement in family health and PMTCT have included promoting priority services at ANC clinics for couples who attend together, a focus on whole-family testing and counseling during village-to-village testing, and a focus on both mother and father involvement in the mother-father support group (MFSG) pilot project. The MFSG being piloted in Phalombe District aims to strengthen nutritional counseling and growth monitoring support at the community level and to prompt referrals to health facilities for infants and children with problems identified by volunteers. Where MFSG groups are set up, village heads encourage couples to attend ANC clinics early in pregnancy. Men support their pregnant and breastfeeding wives with manual labor, cooking, and taking their children to the clinic. This model appears to be working extremely well in terms of supportive counseling—and also to be changing gender norms in profound ways. Before BASICS ends, it would be useful to conduct a feasibility assessment of resources that would be required to expand this model to more communities, and potential training or mentoring roles for current volunteers. (See the nutrition section for further discussion.) BASICS has employed practical strategies in its forays into community-level activities, by first gaining the endorsement of village chiefs and headmen, and then conducting community sensitization through pre-existing channels.

Main Challenges

Transportation: Health workers and community members cite transportation challenges as a primary barrier to accessing HIV services. Giving HSAs the authority to request ambulance support would help in emergency situations.

Training coverage: While BASICS has conducted several different provider trainings, not all providers in the eight target districts have been included in these trainings, and other skills-based trainings are also needed.

Shortage of HIV test kits: This is a chronic problem that must be solved at the national level.

Inadequate capacity to test for CD4 counts: Testing limitations result in delays for HIV-positive pregnant women to access ART. BASICS's support for samples transport seems the most feasible strategy within the project's capacity.

Progress Made through Subpartners

BASICS works closely with District Health Management Teams (DHMTs) and other stakeholders to strengthen service provision through collaborative planning for district implementation plans and service-strengthening strategies; support district program performance review (DPPR) meetings; fund, organize, and, in some cases, deliver trainings and orientations for health workers directly; provide technical assistance for supportive supervision, including supervision checklists; assist with the design, printing, and roll-out of registries, patient cards, and job aids; support regular review meetings for HTC District Coordinators and PMTCT Coordinators; and place HTC staff in districts to fill counseling staff gaps. All district officers visited during this evaluation emphasized the excellent working relationship they enjoy with MSH and the BASICS project.

d) Effectiveness of service delivery packages in HIV/AIDS and capacity-building (technical, training, administration, management, financial)

MSH operates district offices that provide oversight for both the BASICS and the FP/CBDA (Family Planning/Community Based Distribution Agents) projects. This ensures integrated record-keeping and reporting systems within MSH, but sometimes creates challenges for District Coordinators whose time and responsibilities are spread across two large projects. The monthly project activity reports BASICS provides to DHMTs serve to model transparent, organized, and thorough reporting. As the evaluation for HIV services included no budget review, no assessment can be made of financial systems.

BASICS has collaborated in district implementation planning and other DHMT planning. The project has also strengthened capacity for the districts' PMTCT PEPFAR indicator reporting to the MOH. The documents, strategies, and activities reviewed during this evaluation are of high quality. All quarterly and monthly review meetings supported/facilitated by BASICS have included thorough documentation and mentoring support for presentations by district staff. BASICS uses MOH-approved HIV-related training packages and national trainers. New trainings developed at the MOH's request reflect national guidelines, and curricula, along with training reports, reflect high standards. BASICS has worked closely with the MOH and other implementing partners to design, integrate, and roll out MOH-approved HIV-related health services packages.

e) Effectiveness of BASICS's organizational structure in achieving program objectives (relationship of Lilongwe central team and District Coordinators, and links with district and national MOH staff and other stakeholders)

Although only the two technical assistant positions funded by BASICS have direct responsibilities at the Ministry level, HIV project officers regularly participate in three national technical working groups (PMTCT, HTC, and ART). District Coordinators hired by BASICS are supported through site visits and emails. The project may want to conduct a time management check at some point to ensure that staff attention is proportionately divided between national, zonal, and district tasks.

f) Progress toward achieving HIV/AIDS-related monitoring and evaluation goals and targets

Despite a lengthy M&E Officer vacancy, the project's HIV-related training/trip/meeting reports and monthly activities by district are all well-documented, as is progress toward a results framework.

PMTCT data are collected in the districts and reported to the MOH in a timely fashion. The project supports service delivery monitoring through strengthening supportive supervision at district facilities and strengthening of PMTCT coordinator mentoring at the zonal level.

Overall Project Strengths/Best Practices (see Annex F for details by district)

The project is framing its work within national structures for HIV/PMTCT/pediatric HIV services.
The project has developed close working partnerships with DHMTs in target districts and has helped to fill many gaps toward systems strengthening and operational capacity.
The project has balanced consistent overall strategies with the flexibility and ability to adapt approaches and activities to changing needs in each district (e.g., provision of refresher trainings on new pediatric ART guidelines was not in the original work plan, but was added based on request).
The HTC model emphasizes family HTC and testing of infants and children of all ages.
Village-to-village testing helps communities address HIV together and probably reduces the risk of stigma, particularly when village headmen participate in testing. Village testing supported by an HTC counselor and clinician allows for immediate clinical staging and referral of eligible individuals to ART as well as CPT.
The project has had outstanding success in strengthening CPT services in all eight target districts.
PMTCT services are consistent from the ANC visit and HTC to post-delivery counseling and referrals for follow-up visits, except for breastfeeding counseling, which in places is problematic.
Under 5 mobile clinics are incorporating HTC for children.
Some outreach ART services are underway and seem to be working well, although more resources are needed for expansion.
Monthly and quarterly review meetings are greatly appreciated and seen as strongly facilitating collaborative planning.

Overall Project Challenges (see Annex F for challenges by district)

PMTCT nurses understand program components and follow-up instructions, but there is great confusion over breastfeeding messages.
Inconsistent PMTCT drug regimens are used based on the availability of CD4 test equipment, or hemoglobin testing for AZT provision. Efforts to bring all facilities up to a uniform level would require more test equipment and training.
There is limited and inconsistent pediatric testing, based on the availability of/access to CD4 tests, PCR tests, and courier services for samples.
There are widespread shortages of rapid test kits.
Pediatric ART return rates are low.

Positive mother/exposed baby follow-up has been challenging, although onsite support groups are clearly improving return rates in some districts.
Psychosocial and nutritional support is not consistently available for patients who test positive. INGOs and NGOs providing psychosocial, nutritional, or income-generation support typically focus on only part of a district, so many patients cannot benefit from these services.
Phalombe District uses a different mother-infant pair follow-up form, which is easy to lose. Data collected by this form need to be integrated into existing registers.
Breastfeeding counseling is inconsistent, and in some cases dangerous (e.g., an HIV-positive mother was advised not to breastfeed an infant younger than six months, in absence of any other available food). EGPAF confirms similar findings.
Most babies become infected during the breastfeeding period—ART protection is needed during this time.
Transportation is a challenge for patients who need to make monthly clinic visits for ART or pediatric ART.
There is a continuing need for all facility-based health workers, including HTC counselors, to receive HIV-related trainings.

NUTRITION FINDINGS AND CONCLUSIONS

a) Progress made to improve access to and quality of child nutrition services at district-level facilities

Prior to the project launch, there existed in 2005 only 15 Nutrition Rehabilitation Units (NRUs) in six of the eight districts later supported by BASICS, namely Balaka, Chikwawa, Kasungu, Mangochi, Phalombe, and Zomba. These NRUs had frequent staff shortages, and staff had limited skills in nutrition rehabilitation. Patients were numerous in the wards (there were sometimes more than 30 patients, with and without complications), and sometimes had to stay for several months as inpatients. This destabilized households, compromising household chores and care of other children.

In an effort to decentralize and increase access to nutrition-related curative services in remote areas, BASICS has established 98 functional CTCs at health centers for community-based management of acute malnutrition (CMAM) in six of the eight targeted districts (except for Salima and Nsanje, which receive similar nutrition services from Cooperazione Internazionale (COOPI) and Concern Worldwide respectively). The most recent data indicate that CTC services reached a total of 8,779 severely malnourished children from October 2007 to December 2009. In collaboration with its partners, BASICS built capacity to 636 nurses, HSAs, and other clinicians, as well as 566 volunteers, in order to improve the quality of care for the malnourished. Quality of care has improved, as evidenced by decreases in mortality rates, improved levels of cure rates, default, and non-response rates measured within the sphere standards.[2] (See Annex F.)

> Once a child has attained his target weight or been discharged from CTC services, he graduates to the Supplemental Feeding Program (SFP) where he obtains a two-week ration (5 kg) of maize flour, soya, pulses, and oil for continued weight gain. Every two weeks he is assessed prior to receiving his ration. Performance indicators for the SFP are also within sphere standards, with a few exceptions. (See Annex F-4.)

[2] Sphere standards: Cure rate: >75%; death rate: < 10%; default rate: < 15%; non-response rate:

Overall, it seems that access to and quality of care has improved with BASICS. Clinicians and HSAs appear well-trained and knowledgeable as they follow the same protocols across the districts. Challenges for the CTC, CMAM, and SFP include defaulters, referral compliance problems, and an inability to follow up with defaulters because of problems with transportation, distance, and cost; minimal supervision for timely medical referrals; late care-seeking practices; and the belief among some individuals that malnutrition (sempho) is caused by male infidelity and must be countered first with a traditional healer, which delays treatment.

Recent problems affecting the SFP program include stock-outs since December 2009 of maize meal, corn soy blend, and cooking oil. It is important to point out that these stock-outs have not been the norm. The United Nations World Food Programme (WFP), which is responsible for providing these foodstuffs, explained that there was a breakdown in communication within their organization—it was believed that a particular order had been placed, but in fact it had not. WFP has since resolved the issue and made deliveries to health centers in February 2010. WFP also mentioned that food outputs need regular, timely-updated quantification to minimize food stock-outs. Additionally, WFP has stated that distributors are not keen on delivering such small tonnages to hard-to-reach areas such as health centers, since this is not a cost-effective approach. WFP will be unable to continue distributing to health centers at this rate, and is currently exploring delivery options with the MOH to more central locations such as district hospitals, which will then be responsible for ensuring delivery to its health centers. In contrast, community mothers have asked that supplemental feeding programs deliver food closer to the village clinics or outreach sites on program days, which would reduce the need for storage and increase access to the food. Currently, mothers find the distances long, as they typically make the journey on foot while carrying children.

b) Progress made through BASICS and subpartners to improve nutrition-related health systems and services management at the district level

To date BASICS and subpartners have strengthened nutrition-related systems both at the facility and community levels. BASICS has improved and adapted several nutrition-related training modules. The nutrition preventive trainings cover the seven Essential Nutrition Actions (ENA) and High-Impact Interventions (HII) in Accelerated Child Survival Development Strategies (ACSDS) in the context of maternal and newborn care, post-natal care, family planning, Under 5 clinics, IMCI, and malaria control, as well as PMTCT, mother-infant pair follow-up to two years, Growth Monitoring and Promotion (GMP)nutrition management of the sick child, male involvement in maternal and child health/family planning, and nutrition behavior change activities at the household level. CMAM trainings have focused on identification of malnourished children, children with complications, and provision of care. Below is a summary of the trainings.

TABLE 2: SUMMARY OF TRAINING

Type of Training	Audience	Total Trained
ENA	Master trainers	3
ENA	Health professionals (clinicians and nurses)	13
ENA	Environmental Health Officers (aka HSA Supervisors)	5
ENA	HSAs	53
ENA	Community facilitators	396
PMTCT MIP follow-up	Professionals (25) HSA (6)	31

TABLE 2: SUMMARY OF TRAINING		
Type of Training	Audience	Total Trained
CTC/CMAM	Nurses and clinicians	182
CTC/CMAM	Health workers and program coordinators	170
CTC/CMAM	HSAs and extension workers	284
CTC/CMAM	Volunteers	566
GRAND TOTAL		1,703

Overall, training materials have been technically sound and comprehensive. Most of the health professionals, HSAs, and volunteers encountered during the evaluation were very knowledgeable about the topics on which they had trained and seemed to practice accordingly. All were very dedicated to their work.

c) Progress in nutrition-related health promotion and BCC at the community level

The community nutrition promotion focuses on the Essential Nutrition Actions (ENA) package with an emphasis on four actions, namely (1) optimal breastfeeding, (2) complementary feeding, (3) feeding the sick child, and (4) maternal health (nutrition during pregnancy, early and regular antenatal care (ANC), birth preparedness, and health facility deliveries). BASICS launched the ENA package in Phalombe and Zomba Districts as a pilot through a holistic intervention mix composed of ENA, capacity building, and the mother-father support group (MFSG). To date all HSAs in Phalombe have been trained in the Essential Nutrition Actions Package with High-Impact Interventions. Facilitators conduct the MFSG twice a week and find that schedule to be satisfactory.

Focus group results indicate that the MFSG strategy is having a positive impact on healthful behavior change. Male involvement, support, and behavior change remains impressive. Both men and women alike were quite proud of their newfound relationships and teamwork as couples. Men report (and women confirm) that their husbands participate willingly in non-traditional male household chores such as cooking, laundry, washing dishes, and fetching firewood and water. They also participate in child care—bathing, preparing and feeding nutritious foods, and bringing children to medical and Under 5 clinics. Men also support maternal and child health by reminding, encouraging, and accompanying their wives to antenatal clinics beginning in the first trimester of pregnancy; ensuring that their wives get a varied diet from the six food groups; and participating in birth preparedness. Men also mentioned that gender-based violence has significantly decreased with their participation in MFSG. Prior to BASICS, men reported that domestic violence toward women was rampant. Men admitted that they beat their wives because meals were late. But now men cook and do not have to expect or rely on their wives for meal preparation because they share cooking responsibilities. The men now understand that teamwork and support of one another benefit the entire family. When asked if it was difficult to change their behaviors, men have answered affirmatively, stating that others might think they were bewitched with love potions. However, this no longer seems to be a major issue, as men report not knowing anyone who does not help or support his wife in the villages. Such behavior has become the norm.

In addition to the above, focus group participants have admitted to engaging in harmful cultural practices, such as discarding colostrum and forbidding women to eat protein sources such as eggs. Participants acknowledged using traditional healers, only seeking medical assistance when their children had become very ill. Because traditional birth attendants promote unhealthy concoctions for newborns and infants and forbid protein sources such as chicken, many children became severely malnourished and edematous, which was attributed to maledictions because the parents had failed to meet cultural expectations.

Men and women alike are now engaging in more healthful nutrition-related behaviors. The group village headman of Nyambaro (who heads 15 villages) has confirmed these findings. He stated that he was extremely satisfied with BASICS activities and had noticed a significant impact on the maternal death rate. According to his estimate, there were previously 300 maternal deaths per month from all his villages combined. BASICS has reduced maternal deaths to eight monthly, at most. He reported a similar trend for children—previously hundreds of children would die each month, whereas now fewer than ten do so. According to the HSAs, these positive results can be attributed to growth monitoring at the village level; earlier care-seeking practices for sick children and pregnant women; improved feeding of the sick child (continued breastfeeding, coaching the child to eat small, frequent meals, giving liquid food); early ANC attendance; and facility-based rather than home deliveries. Current program challenges include insufficient volunteer supervision for proper health passport and growth monitoring analysis, in conjunction with preventive nutrition messages and continued adequate nutrition and feeding practices for the well-nourished (normal) child. Other problems include late referrals and the loss of trained facilitators to marriage and relocation. The focus for Year 3 includes technical assistance and detailed capacity-building in growth monitoring and promotion, as well as referral-strengthening, followed by scale-up in the entire district of Phalombe and 52 villages in the Bimbi catchment area of Zomba. The MOH has requested that NGOs cease developing separate manuals and unite to provide technical assistance in completing a unique, standardized growth monitoring and promotion manual for Malawi. With the MOH's consent, BASICS will continue mentoring HSAs and volunteers, using selected materials developed for that purpose.

d) Effectiveness of service delivery packages in nutrition and capacity-building (technical, training, administration, management, and financial)

Overall, the quality of nutrition capacity-building has been adequate for the NRU, CTC, CMAM, SFP, and ENA programs. From a technical standpoint, the content of training materials follows the MOH's standards for treatment of severe acute malnutrition and the ENA. HSA and volunteer performances alike have been for the most part exemplary. In the field, it seems that the protocols are being followed. Measurements for weight, height, and assessment of edema, reporting and analysis of data and information, as well as referrals, seem satisfactory. Management of the program seems meticulous and well-thought-out. In sum, the program is well-managed. However, listed below are areas in which the service delivery package could be further strengthened.

Breastfeeding messages vary among districts and health service providers in PMTCT, ANC, pediatric wards, and Under 5 clinics at both district hospitals and health centers, as well as among nurses, medical assistants, counselors, lab technicians, and HSAs. Messages range from no breastfeeding at all, to exclusive breastfeeding and cessation at six months with transition to other foods for HIV-exposed and HIV-positive infants alike. Breastfeeding messages for HIV-negative mothers remained consistent with exclusive breastfeeding for six months, complementary feeding from the six food groups, and continued breastfeeding for at least two years. The current messages do not consider the key AFASS criteria for replacement feeding (i.e., is replacement feeding **a**cceptable, **f**easible, **a**ffordable, **s**afe, and **s**ustainable?). The variations in messages may be due to the changing WHO breastfeeding standards in the context of HIV. For example, in 2009 as WHO was drafting its revised breastfeeding standards, the MOH revised its policy concurrently to reflect these updates and disseminated the information to all DHMT members, even training 300 trainers. However, the updated information on breastfeeding in the context of HIV has not trickled down to health professionals and HSAs dealing with patients on a daily basis. It is important to note that the ENA pilot as reviewed in Phalombe includes technically sound breastfeeding information within its materials, but the proper messages have not yet been disseminated.

Furthermore, HSAs, volunteers, and other clinicians correctly promote complementary feeding messages at six months, but these messages seem limited to feeding from the six food groups (i.e., food diversity). Cooking demonstrations target the malnourished only. As a preventive measure, cooking demonstrations and recipes should be expanded to the non-malnourished, which would

reinforce the service delivery nutrition package. The ENA pilot program, although in its infancy, strongly emphasizes complementary feeding, with cooking demonstrations during the MFSG using locally available and affordable foods from markets and home gardens. The ENA program also takes into consideration essential feeding elements such as **f**requency, **a**mount, **d**ensity, **u**tilization, and **a**ctive feeding (FADUA). This program focuses on nutrition management of the sick child, including nutrition during and up to two weeks after illness.

Although IMCI capacity-building covers nutrition management of the sick child, this seems to be neglected at health facilities across the board, and at the village clinics in all districts. The consultant visited various wards, including the cholera ward in Chikwawa, pediatric wards in Chikwawa, Kasungu, and Salima, and malaria wards in Chikwawa and Salima. The counseling messages focused on drug compliance (frequency and completion), taking medications with food, and targeted health education (e.g., for prevention of seasonal cholera, malaria, diarrhea, or malnutrition). However, feeding during illness and for two weeks after illness for catch-up growth was not mentioned. Such messages must be included systematically with other medical advice at sick visits and upon discharge from hospitals and health centers.

Moreover, the referral system shows gaps in terms of caregivers' knowledge of danger signs, early health-care-seeking, and transportation constraints (private, public, and hospital), both for patients and medical personnel at the health facility level. These gaps contribute to medical complications and some mortality due to delays and inefficiencies. To strengthen the referral system, the community must be able to recognize danger signs and take action regardless of cultural beliefs. Without addressing delays in care-seeking practices, medical care cannot be as effective as it should be. It is important to note that communities in the ENA pilot area of Phalombe seem very well-sensitized and aware of danger signs and appropriate care-seeking practices. The late care-seeking seems to be more problematic in the other BASICS districts, where CTC is the only intervention, and there are limited preventive nutrition interventions.

Reliable and affordable transportation must be made available for patients so as not to undermine medical assistants' and HSAs' referrals and recommendations. A number of HSAs report referring patients for additional care, but caregivers are unable to follow through due to a lack of reliable and affordable transportation. In some districts, HSAs' requests for ambulance services for severe malnutrition cases have been denied. One case stood out during an evaluation visit to a CTC center where the HSA had correctly referred a marasmic child of HIV-positive, unemployed parents to the district hospital, and had tried to arrange transportation, but because "malnutrition is not an emergency," the caregiver was told she would have to wait for other priority emergencies in order to hitch a ride on the ambulance, space permitting. In addition, the roundtrip fare from the health center to the district hospital in question is estimated at 900[3] mk, very costly for an unemployed or even low-income couple whose income is probably less than $1 per day. (The distance is such that it takes a car about one hour to get there, or numerous hours on foot.) Needless to say, such a caregiver will not be able to get her sick child to the hospital in a timely manner without some assistance. The MOH's *Integrated Management of Childhood Illness: Caring for Newborns and Children in the Community: Manual for Health Surveillance Assistants* encourages HSAs to arrange for transportation to support their referrals, but many lack the support to do so. One HSA mentioned that he sometimes takes patients to the hospital on his 11-year-old bike out of the kindness of his heart. Such a solution is untenable as the HSA has to be available for other patients, not to mention the likelihood that he will become exhausted from too many trips to and from the hospital.

[3] At this writing, US$1=150 Malawi kwacha (mk). The 900 mk represents an estimated US$6.

e) Effectiveness of BASICS's organizational structure in achieving program objectives (relationship of Lilongwe central team and District Coordinators, and links with district and national MOH staff and other stakeholders)

The BASICS organizational structure has been instrumental in achieving program objectives. Three staff members work on the nutrition component of the project—the Nutrition Officer, the Community Nutrition and Health Advisor, and the Zinc Technical Officer. Each staff member is responsible for the CTC, ENA, and zinc programs respectively, and each has a unique relationship with the district and national MOH staff as well as with stakeholders. Stakeholders, the MOH, the BASICS Lilongwe central team, and District Coordinators participate in the quarterly Nutrition Technical Working Group and the District Targeted Nutrition Program (TNP) meetings. It is during these meetings that members showcase their success stories, seek solutions to nutrition issues, develop and provide technical inputs to materials, disseminate reports, communicate ideas and messages, and make action plans. Stakeholders also support and develop action plans as well as supporting the District Implementation Plan activities. These relationships foster cohesion among group members and emphasize their common goals of improving nutrition status and reducing mortality.

In the same vein, stakeholders complement one another with their interventions. Organizationally, the various partners are geographically distributed over several districts. In districts where overlapping interventions would be a problem, typically one NGO will take the lead. For example, COOPI and Concern Worldwide are responsible for the nutrition CTC intervention in Salima and Nsanje Districts respectively. BASICS plans to cover Nsanje District when Concern Worldwide exits in December 2010, thus providing intervention continuity in the BASICS target zone. Other symbiotic relationships between stakeholders include some that provide services while others provide inputs. For example, in selected areas where BASICS provides technical assistance to reinforce NRU programs, the United Nation's Children's Fund (UNICEF) provides F-75 and F-100 therapeutic milk as well as four essential antibiotics to participating district and CHAM hospitals. The World Food Programme provides oil, corn-soy blend, and pulses for the Supplemental Feeding Program, while the Clinton Foundation focuses on the Chiponde (plumpynut) for outpatient services, thus avoiding duplication of intervention efforts. According to BASICS's Chief of Party, the Canadian International Development Agency (CIDA) will take over when the Clinton Foundation exits in December 2010. The World Health Organization (WHO), UNICEF, and BASICS have contributed funds and technical assistance in building HSA and volunteer capacity in CMAM and mother-father support groups respectively. In addition, BASICS and other stakeholders support the MOH's biannual Child Health Days by providing fuel and transportation, and mobilizing the community. All these approaches complement and support one another in achieving common objectives. It should be noted that because all the components are integrated with each other, issues in one can affect performance and outcomes of another.

One challenge that has surfaced is the (BASICS) Lilongwe Community Health and Nutrition Advisor's responsibilities and the time spent between community activity implementation and her role as a technical advisor to the MOH. The innovative ENA intervention mix requiring quality materials development and translation, and intensive training and mentoring, combined with the fact that few staff possess nutrition skills at the project level, has required the Community Health and Nutrition Advisor's expertise in Phalombe and Zomba Districts to ensure proper implementation of the pilot project before scale-up. Typically, project coordination or management occurs near the project site, while a technical advisor is more likely to sit at the central level in the capital city. Fundamentally, the BASICS organizational structure with dual responsibilities for the Community Health and Nutrition Advisor position (as originally designed during the initial proposal development) seems to have caused a misunderstanding whereby MOH had expected the Advisor to provide more technical expertise and collaboration at the central level. As a result, the balance between these two types of responsibilities has been challenging given results expected by BASICS on the one hand, and the MOH's needs and expectations on the other. The plan is to redress this

issue by collaborating more closely with the MOH, in particular, to complete the MOH's Growth Monitoring and Promotion Manual in an effort to standardize materials for the country. BASICS may wish to consider hiring a technical assistant to support the Community Health and Nutrition Advisor in implementing the ENA program during the rest of the project period.

f) Progress toward achieving nutrition-related monitoring and evaluation goals and targets

At mid-term, BASICS has exceeded its nutrition targets. Most nutrition indicators are scheduled to meet end-of-project targets. CTC, CMAM, and SFP programs have been scaled up progressively given the existing structures (policy, facilities, staff). The districts in conjunction with CTC Advisory Services (CAS) are able to collect and analyze data, which is then shared with BASICS. Enrollment in CTC programs has been decreasing, from before the BASICS project was initiated to today. This is consistent with anecdotal data suggesting declining trends for severe acute malnutrition.

Overall, the CTC/CMAM programs are running quite well. Most of the indicators are within the sphere standards. Nonetheless, there exist pockets of populations and health centers where indicators are above the standards, and these need close attention. Despite challenges, deaths due to acute malnutrition have declined with the improvement of malnutrition management and referral skills, as well as consistent foodstuffs and medications to rehabilitate the malnourished.

As for the Outpatient Therapeutic Program (OTP) and supplementary programs, earlier and better detection due to improved skills and community awareness has increased enrollment in the outpatient and supplementary feeding programs where U.S.-supported activities serve the more moderately malnourished. Enrollment variations may be explained by seasonal effects such as food insecurities during the pre-harvest season, and late referrals due to cultural beliefs. Overall, the management of the SFP is showing good results that are also well within the sphere standards. One challenge regarding default rates is that once a child is doing better after the second visit, a guardian often does not return for subsequent visits.

As for the ENA program, neither baseline nor quantitative data exist to measure progress for a number of reasons. The program was collecting data for process rather than impact indicators. Following the assessment of July 2009, the consultant recommended that BASICS cease collecting such data and instead redesign and strengthen its M&E system to reflect the newly designed results framework indicators. In the future, data will be collected on the following indicators: Growth trends of children 6–23 months, namely percentage with increasing weight; percentage with static weight; and percentage with decreasing weight, as well as prevalence of acute malnutrition disaggregated into four categories—severe, moderate, mild, and normal (as measured by MUAC). The objective is to measure improved nutritional status. Considering that BASICS did not collect baseline nutritional status data, once training on growth monitoring is completed, these data will serve as a baseline for the project, and subsequently as the final assessment for the project. According to the BASICS M&E Specialist, the plan is to collect nutrition status data through growth monitoring data (i.e., underweight (weight-for-age) and MUAC measurements) for children 18 months and younger, followed by a six-month assessment when the oldest of those children will have turned 24 months old, and every six months after that until the project ends. In addition, the recommendations issued from the Essential Nutrition Actions assessment are in progress, although delayed due to work on materials development and translation and the process of laying ground work for a resource-intensive, innovative program with only one specialist in nutrition. (For more detailed, information, see Annex F.)

The table below summarizes BASICS's progress to date against current end-of-project indicators. Following this are tables comparing findings by district of community therapeutic care and supplemental feeding programs.

TABLE 3: BASICS'S PROGRESS TO DATE AGAINST CURRENT END-OF-PROJECT INDICATORS		
Indicators	**Total Achievement (FY 2009)**	**End-of-Project Target**
Number of children reached by U.S. Government-supported nutrition activities (CTC)	7,438	15,100
Number of children who received Vitamin A	1,545,634	3,800,000
Number of mother-father support groups	396	-

TABLE 4: COMMUNITY-BASED THERAPEUTIC CARE OTP INDICATORS						
Indicators by districts	**Balaka %**	**Chikwawa %**	**Kasungu %**	**Mangochi %**	**Phalombe %**	**Zomba %**
Cure rate January 2008	84.2	73.3	No Program	73.3	No Program	No Program
Cure rate December 2009	93.8	90.6	78.6	85.5	83.3	86.7
Death rate January 2008	4.2	10.0	No Program	7.9	No Program	No Program
Death rate December 2009	3.1	0.0	10.7	3.1	8.3	1.3
Default rate January 2008	8.4	16.7	No Program	16.8	No Program	No Program
Default rate December 2009	2.1	9.4	10.7	10.7	8.3	12.0
Non-response rate January 2008	3.2	0	No Program	2.0	No Program	No Program
Non-response rate December 2009	1.0	0	0	0.8	0	0.0

TABLE 5: SUPPLEMENTAL FEEDING PROGRAM INDICATORS						
Indicators by districts	**Balaka %**	**Chikwawa %**	**Kasungu %**	**Mangochi %**	**Phalombe %**	**Zomba %**
Cure rate			Data[4] Unavailable			
Cure rate December 2009	90.4	91.7		84.4	95.8	64.4
Death rate			Data Unavailable			
Death rate 2009	0	0		1	0.8	0.7
Default rate			Data Unavailable			
Default rate December 2009	4.8	4.6		6.9	0	28.5
Non-response rate			Data Unavailable			
Non-response rate 2009	1.4	1.8		4.1	3.4	4.6

Conclusions

In sum, the BASICS nutrition interventions appear to be on track and progressing well. They have contributed to significant health systems-strengthening with respect to improved skills in acute malnutrition detection and management, as well as in reducing child mortality. Likewise, the Essential Nutrition Actions pilot has begun to show positive qualitative impacts and has significant promise. Its innovative program design combines nutrition preventive interventions that are technically sound, proven, detailed, and comprehensive—the combination of increased male involvement, care of the fetus (through antenatal care), and a continuum of nutritional care through the mother-infant pair (MIP) until age two seems likely to end the cycle of malnutrition (stunting and acute malnutrition alike) that has persisted from generation to generation.

Nonetheless, factors including lack of transportation, certain cultural beliefs, shortages in qualified staff and nutritionists, misinformation, delayed capacity-building due to funding issues, shortages of insecticide-treated nets and drugs for malaria treatment—combined with high rates of malaria, pneumonia, HIV, and diarrhea—threaten access to quality health care and to significant nutrition impacts. Without proper management of illness (with necessary drugs and increased feeding/nutrition during these vulnerable times), frequent relapses will compromise any nutritional

[4] Data for that district and year were managed by another organization.

improvements once gained. It is therefore critical to combat malnutrition both with curative and preventive services, while simultaneously strengthening linkages with various sectors, including the Ministries of Agriculture and Gender, to address other extraneous issues and provide an environment conducive to even more promising results.

MALARIA FINDINGS AND CONCLUSIONS

a) Progress made through BASICS and subpartners to improve malaria health systems and services management at the district level

It is truly impressive what the small BASICS staff (two program officers and one administrative/financial officer) has been able to accomplish in implementing a grants program that mobilizes existing community-based networks of NGOs to engage in behavior change communication (BCC) campaigns. These campaigns urge specific malaria prevention practices (including net use and intermittent preventive treatment in pregnancy (IPTp)), increase knowledge of malaria symptoms and the urgency of treatment, and heighten public awareness of the new drug policy (SP to LA) and the importance of compliance.

Overall, the malaria grants program appears to be both well-administered and well-implemented. BASICS has established a sound grants-making methodology, consisting of the development of a grants manual, calling for concept pieces, applying standardized criteria for rating proposals, using an assessment tool to determine an applicant's financial and programmatic capacity to undertake the proposed activity, and a proposal-writing workshop for those applicants selected to proceed to the proposal stage.

In designing the grants program, BASICS has given priority to activities that maximize the number of people reached with core malaria messages. Monitoring of the program is therefore designed to ensure that planned activities take place and projected numbers of target audiences reached. In this regard the project's M&E plan differs from that advocated in the 2010–2015 Malaria Communication Strategy for Malawi, which establishes behavior change as the basis for malaria communication M&E.

In its first cycle (June 2008–August 2009) BASICS awarded grants to six NGOs operating in seven districts, all of whom exceeded their goals in reaching people with core malaria messages. Two of these six grants were not renewed; in one case the grantee's parent organization reportedly determined that the malaria communication activities lay outside its core mission, and in the second case, BASICS and the DHMT in Blantyre District determined that the grantee's strength lay in reaching an urban population, whereas the greater need was in the rural areas of the district.

In its second cycle (August 2009–July 2010) BASICS awarded an additional four grants to four NGOs. In its third cycle (April 2010–May 2011) BASICS is making an additional seven grants covering 12 districts. In 2010 the program will have 12 grantees performing activities in 20 districts. (See Annex: Malaria Grants Program: Malaria Grants Recipient Chart.)

According to BASICS's design of the program, all grantees are accountable to DHMTs because all the activities are addressing the needs of the district. In this regard, a DHMT plans coverage strategy with the grantees. The DHMT and the grantee determine when activities within a given Traditional Authority (TA) are complete and when the grantee will hand over the communication activities to direct DHO supervision. Within a district, grantees collaborate with the DHMT to determine priorities in targeting TAs with BCC campaigns. For instance, in Zomba District the District Malaria Committee requested that the grantee, Development Aid from People to People (DAPP), invest its cycle-three resources exclusively in three TAs that the committee considered to be malaria hotspots. The committee is to take over operations of BCC activities in the TAs where DAPP is now operating. The committee's request to shift activities to the three hotspots reportedly is based on the demand for malaria services as recorded by the District Health Information Services. The committee said, however, that it wished that the grantee had greater resources so that it could continue

operating in the TAs where DAPP is currently working. The committee believes that three to five years of activities are required to ensure that desired behaviors take root. Behavior change research findings would be a valuable aid to the DHMTs and grantees in determining district communication priorities.

Ideally, an evaluation of the impact of malaria programs should include both intermediate objectives (knowledge, attitude, perceived norms, and efficacy) as well as behaviors, such as the appropriate use of bed nets in homes. At the least, it would be useful if BASICS, the grantees, the DHMT, and other stakeholders were to establish behavior change criteria for graduating TAs and districts from the grantee-supervised programs. Current goal-setting for grantees is based on numbers of people reached with core messages, typically a minimum of 80% of the people in a district. All stakeholders should start asking, "What are the behavior change objectives, and have they been achieved? How are these measured?" In assessing the progress made in a given district, it would be helpful to commission BCC baseline and follow-on research capable of measuring the behavior change that is taking place. BASICS should also consider using the findings of the National Malaria Control Program's (NMCP) Malaria Cluster Indicator Survey (to be undertaken beginning April 2010) to see if it can tease out data indicating the grants program's impact.

The BASICS grants manual establishes behavior change indicators, as does the National Malaria Communication Strategy, and these could also be used to generate evidence of effectiveness and to determine when desired behavior regarding malaria treatment and prevention is reflecting a change in social norms. Perhaps these behavior change indicators can also be used as the criteria for signaling when the grantees' intensified malaria communication activities can be scaled down and handed over to the DHO. The use of indicators as criteria would serve to objectify the decision to scale down grantee activity.

Informants in the six districts visited were fairly confident that the BCC activities are highly successful, for instance, in creating demand for bed nets, care-seeking for feverish children, and seeking IPTp services. Indeed, the reported shortfalls in malaria commodities at the local level may in part be explained by increased demand for nets and the frontline treatment, LA. Behavior change research is critical to achieving a fuller evidence-based appreciation of the effectiveness of this well-managed project. It should also be noted that although the project's core messaging includes PLWHAs as a priority for bed net use, grantees appear not to include this group when conveying messages. The unavailability of free nets for this target group appears to have influenced the decision not to include PLWHAs as a priority group.

BASICS acknowledges that it has yet to establish exit strategies for the grants project. This is a complex and dynamic issue, made even more so by the anticipated implementation of a universal bed net usage policy and the roll-out of indoor residual spraying, both of which will require sustained BCC activities around malaria prevention. With their experience, the program grantees would be well-positioned to take on these new communication issues. With approximately 18 months left in the BASICS project, it is advisable that the malaria partners, including government and donors, devise a strategy for post-BASICS malaria communications, giving consideration to continuation of the grantee program.

The NMCP recognizes the importance and success of the communication work undertaken through the grantee program even without the benefit of behavior change data needed to determine impact more conclusively. During the team's meeting, the NMCP advocated for an expansion of the grantee program to every district in the country, considering the program to be currently underfunded in each district for the tasks at hand, especially for undertaking the formative research, baseline research, and BCC indicator surveys. (Some grantees also reported that the size of their grants had proven inadequate for meeting their targets, leaving them to dip into other funding sources to reach malaria goals; one grantee, the Red Cross in Kasungu, reported that the size of the grant was inadequate for the labor-intensive reporting requirements.)

The NMCP also suggested that a minimum of three years of intensified BCC activities in a given district is likely necessary to achieve desired BCC outcomes, although these outcomes have yet to be clearly defined. The NMCP believes that the DHOs lack both the resources and the capacity to take over the intensified BCC activities carried out by the grantees, implying that the grantee program should be sustained. The NMCP also expressed concern at what it considers to be the slow start-up of the grantee program, and one grantee noted a lengthy delay from being chosen as a grantee and the receipt of funding. Certainly, as the grantee program expands to the goal of 20 districts, greater demands will be placed on BASICS central malaria staff, and consideration should be given to increasing the size of malaria management staff for BASICS and that of its follow-on project.

A hallmark of BASICS's management of the grants program is its responsiveness to grantee feedback and its willingness to apply lessons learned. For example, in response to grantee suggestions BASICS has developed in conjunction with the MOH a malaria job-aid flip chart to be distributed to HSAs and volunteers. Some grantees said they would like more sharing of experiences and networking among grantees.

b) Progress in malaria-related health promotion and BCC at the community level, and strengths and weaknesses of this approach

With some noteworthy variations, the grantees employ similar BCC methodologies, consisting of volunteers engaging in door-to-door interpersonal communication (IPC) and community talks. HSAs supervise the work of the volunteers. Grantee staff members collaborate with volunteers, HSAs, District Malaria Officers, and other stakeholder to publicize and organize community rallies or campaigns that typically feature a variety of activities, including performances of local drama groups, statements by chiefs and/or headmen, poetry presentations, talks by District Malaria Officers, and other activities. A grantee will also usually provide orientation for chiefs and headmen in order to gain their support for community mobilization activities. Grantee reporting on the numbers of individuals, TAs, and villages reached suggest robust activities by the grantees, who are required to reach at least 80% of a district's population.

From district to district, there exist common beliefs and constraints that act as barriers to the target audiences' ability to adopt the actions and behaviors suggested in the core messages. The most common belief barriers include concerns about sexual impotency and infertility that work against the sustained use of bed nets; a pregnant woman's fear of having her fetus stolen by witches means that she will delay going to ANC for IPTp so as not to attract attention to her pregnancy; and in some districts when a child has a fever, the belief in mauka means that a traditional healer may treat the mother for the child's fever, especially if the mother has an abnormally discolored vaginal discharge.

The team recorded many other beliefs that act as barriers but that are too numerous for this report.

In their training, the volunteers learn arguments to counter such beliefs, and during interviews, volunteers explained that they counter them largely by explaining the science of malaria and offering biomedical explanations for illness. Shortfalls in commodities (nets and LA) also act as barriers to behavior change, as do transportation difficulties, for example, in promptly getting a feverish child to a clinic. Volunteers also reported that the poor attitude of ANC clinicians toward clients discouraged pregnant women from returning for their second dose of SP and that clinicians often did an inadequate job of explaining bed net use and care. Specifically, some volunteers reported that the appearance of rashes on bed net users was a strong barrier to bed net use. The volunteers counsel pregnant women in particular to air out bed nets for a couple of days before sleeping under them. These volunteers believed that if ANC clinicians could give practical advice like this when distributing nets, this would help ensure consistent and proper bed net use.

It may be worthwhile to explore how to employ positive, rather than merely reactive, messaging to promote behavior change and new social norms. For instance, how can local communicators appeal to established values—African traditional (e.g., proverbs), Christian, and Muslim—to promote desired behaviors? (UNICEF's forthcoming publications on Christian and Muslim values regarding

child health may be an important tool in deliberate outreach to churches and mosques.) The Zomba District Malaria Committee advocated with the evaluation team for greater outreach to imams and pastors. Making churches and mosques committed allies in malaria prevention and treatment will help ensure the sustainability of behavior change, as religious institutions constitute one of the important pillars of civil society in Malawi.

The fact that malaria season also coincides with farming seasons means that malaria can take a big toll on a family's and village's well-being through food insecurity and loss of income, so highlighting the costs to household and community of apathy, fatalism, and inaction may also be an effective way to promote behavior change. Some grantees use such a cost-benefit argument in their IPC. Illustrating the costs of inaction can be a powerful motivator to behavior change and self-efficacy. A theatre performance during a community rally in Balaka District made such a point, the performance contrasting a better dressed and well-mannered couple who used bed nets with a boorish, poorly dressed, and aggressive couple whose husband did not want to use bed nets. The impact of these positive reinforcements and role models would likely be magnified if the national malaria branding strategy were implemented, thus complementing the local BCC efforts with nationwide messaging. For instance, the national branding strategy underscores the importance of disseminating prosperity and development messages. Likewise, a national health literacy campaign would work to reinforce local-level efforts to promote popular understanding of a scientific interpretation of malaria.

Grantees had accumulated considerable BCC experience in areas such as HIV/AIDS and TB even prior to this project, which has been valuable in establishing strategies around malaria communication and in ensuring the availability of qualified personnel. Moreover, in the absence of formative research on malaria communication, which is recognized standard procedure in BCC initiatives, the experience of the malaria grantees could be considered a valuable laboratory for best practices in malaria communication. In this regard, BASICS management has proposed the creation of a grantee conference in which grantees could showcase their accomplishments and create an environment for sharing best practices. (One grantee suggested that BASICS launch a newsletter to further networking among grantees.) Such sharing and discussion may be a practical way to overcome the lack of formative BCC research. Some of these best practices may include direct outreach by grantees to imams and pastors as a way to mobilize congregations and their women's groups; direct outreach to traditional healers to enlist them as allies in the roll-back malaria effort by making speedier referrals to health facilities; describing to chiefs and headmen the ways in which their counterparts in other TAs are influencing their subjects to follow the core messages; and incorporating the adoption of community action plans into the agenda of community talks and rallies, e.g., finding community solutions to transporting feverish children to health facilities. (See Annex: Malaria Grantee Program—Collection of Apparent Best Practices.) Nonetheless, it is not too late for BASICS to commission formative research in order to learn the best ways to promote behavior change among key audiences. From data gathered during a focus group discussion conducted by the team with 12 traditional healers in Salima District, the team concluded that it was important for the healers to feel respected in order for them to change their practices so as to promote best practices in malaria treatment. Measures that convey respect would help ensure that the traditional healers are allies in this important malaria control and treatment effort.

At least two grantees use radio broadcasts and listener clubs as part of their behavior change promotion—the Red Cross in Kasungu District and the Development Communication Trust in Chiradzulu District. The Trust methodology appears to be particularly innovative and effective. The listener clubs record local community informational meetings, which are then edited for broadcast and carried on the national network of the popular and independent Zodiak radio—the malaria programs reach an estimated weekly audience of 750,000 listeners. The grantee, Cooperazione Internazionale (COOPI), in Salima District reported sizeable listenership to the Trust's malaria programming broadcast on Zodiak. Broadcasting the voices of ordinary Malawians discussing issues surrounding malaria prevention and treatment is potentially a very empowering force in an environment where health messaging is typically top-down. The Trust's management believes that

the broadcasting of programs in which members of the community meet with and are able to question health officials helps to overcome the twin challenges of fatalism and apathy, thus promoting a sense of self-efficacy and empowering individuals to communicate better with service providers. In this way, the format of the medium is the message.

c) Effectiveness of service delivery packages in malaria and capacity-building (technical, training, administration, management, financial)

Service Delivery Problems Stalk Malaria Communication

Stock-outs of bed nets and LA are undermining the BCC effort. Project volunteers reported that their credibility as communicators is undermined when pregnant women report to ANC and find that nets are unavailable. One volunteer in Mulanje explained, "I tell the women who do not get nets not to lose heart. I tell them that at their next ANC visit to let the doctor know that she did not get a net the last time." Except for Balaka, stakeholders in the districts visited reported net stock-outs on a monthly basis. Likewise, except for Balaka, volunteers, HSAs, and even District Malaria Committee members reported widespread LA stock-outs. According to them, this undermines their efforts to improve care-seeking for feverish child and in prompting LA compliance. NMCP provided assurances that the commodity stock-outs experienced in the waning months of 2009 are no longer occurring, but testimonies on the ground tell a different story. BASICS might consider making stock-out reporting part of the grantee data collection; this could provide an alternative, independent channel for reporting of identifiable supply problems to central health authorities and other partners. The impact of stock-outs on the communication initiative underscores the importance of BCC research, as the best-run program may not achieve the desired behavior change because of factors beyond its control. The national malaria effort may benefit from the establishment of an independent ombudsman who could hear concerns at the local level and translate them into troubleshooting and problem-solving at all levels of the public health system.

Trainings and Orientations

Overall, grantees have established a sound policy regarding training and orientations, and BASICS has provided strong support to these efforts, creating adequate levels of supervision, producing supervision guides, checklists and forms, and designing a generic curriculum.

Grantees typically provide a one-day workshop on malaria communication to HSAs, who assume the role of supervising the activities of community volunteers. Grantee staff and the District Malaria Officer/Coordinator typically conduct this training, which includes instruction in the supervision of volunteers and on reporting requirements. As noted above, the BASICS malaria team is also finalizing a malaria flip chart for use by HSAs and volunteers.

BASICS has established a generic curriculum for a 2.5-day training that grantees conduct for community health workers. These workers are volunteers; the training focuses on developing core, interpersonal communication skills with community members, HSAs, and other community stakeholders, and on data collection and reporting. BASICS has also developed a malaria training manual in Cicewa that can be used for HSAs and volunteer training. Both BASICS staff and grantees conduct randomized supervision of volunteers' performances, using standardized forms developed by BASICS to assess competency in communicating core messages.

Maintaining volunteers' motivation is critical to the success of the grantee programs as they are the foot soldiers of the malaria communication effort, and it would serve grantees, the DHMT, and BASICS well to enact policies and make gestures to promote the spirit of volunteerism. Regular supervision of volunteers by grantee staff appears to help maintain volunteer morale and commitment. During interviews, volunteers said that commodity stock-outs undercut their effort. They (and grantees) also stated that the lack of IEC leaflets detracts from a volunteer's credibility within the community. Volunteers said that they are discouraged by having to pay out of pocket for transportation to meetings and events. Many volunteers said that a bicycle would greatly facilitate their work in making the rounds to villages. (Volunteers have other personal and livelihood

responsibilities, and grantee support that reduces the time they spend in traveling would be greatly appreciated.) In addition, giving volunteers caps and T-shirts would be an encouragement. It may also be advisable to provide culturally appropriate forms of community recognition to volunteers for their public service. Grantees should consider both creating line items in their budgets to reimburse volunteers for transportation, and developing a policy on the accessibility of volunteers to bicycles. These two measures may go a long way in ensuring that volunteers remain eager and strong supporters of the BCC effort over the long haul.

Grantees also conduct orientation of district leaders, including chiefs and headmen, members of the District Assembly, the District Executive Committee, and the District Development Committee, in a bid to mobilize their support. Orientation of chiefs and headmen is critical because of the influence and authority that they wield in the communities. Reportedly in some TAs, the chiefs and headmen will fine those who misuse nets for fishing and for keeping pests out of gardens. The regular sharing among grantees of such best practices and success stories may be useful in furthering community responsibility vis-à-vis malaria prevention and treatment. In general, the more a community is engaged in malaria prevention and treatment, the greater the likelihood that individuals and community will make the effort to adhere to malaria prevention and treatment advice that arrive as foreign cultural concepts.

BASICS also orients grantees in implementation and reporting requirements, which has led to a considerable skills transfer from BASICS/MSH to grantees. For instance, the Sue Ryder Foundation noted that as a result of BASICS training, the Foundation has improved its overall handling of receipts and payments for all its activities, and has also praised BASICS for its practice of making prompt cost reimbursements.

BASICS also uses quarterly review meetings to evaluate grantee performance, especially in the area of grant administration. Some grantees lamented the fact that the last quarterly review meeting did not occur, reportedly because BASICS staff were preoccupied with processing the third cycle of grantees, thus underscoring the need for additional staff to manage the project. A greater emphasis during these meetings on sharing of communications best practices should also be considered, with an emphasis on applying the principles and approaches outlined in the BASICS BCC strategy document. In general, the grantee program would likely benefit from BASICS's exercise of greater authority in the area of BCC best practices to optimize grantee performance, and it is recommended that BASICS exercise more technical communication leadership to promote best practices, lessons learned, and the commission of formative research. One grantee said that it would welcome the inclusion of more information on communications methodologies in the training manual.

The MOH Health Education Unit has also trained local theatre groups in interactive developmental techniques, as occurred in Balaka District.

d) Effectiveness of BASICS organizational structure in achieving program objectives (relationship of Lilongwe central team and District Coordinators, and links with district and national MOH staff and other stakeholders)

The BASICS central malaria team appears to enjoy very strong working relationships involving mutual respect and trust with all stakeholders—at the central level in Lilongwe (NMCP, HEU, UNICEF, etc.), with DHMTs (especially the District Malaria Coordinators), the District Malaria Committee, and the grantees. The evaluation team heard praise for BASICS's contributions to malaria BCC from all quarters. BASICS includes NMCP and HEU personnel in its grant-making activities, and it encourages grantees to sustain close relationships with MOH structures at the district level to help guarantee sustainability of the malaria communication activity in the post-grant phase.

e) Progress toward achieving malaria communication monitoring and evaluation goals and targets in malaria

In first cycle of grants (June 2008–August 2009) grantees exceeded their goals of total number of people reached with core messages. The target was 1,679,485, and BASICS reports that a grand total of 2,155,548 individuals were reached—an excess of nearly 500,000 individuals reached. Figures for the second cycle will be reported in July 2010.

BASICS compiles these data on a data and indicator performance tracking form. BASICS has also implemented an activity implementation tracking form to assess whether a grantee is fulfilling its goals on the events taking place. BASICS staff use both these tracking mechanisms to determine if a grantee is on track to achieve its performance and activity goals. The staff use these criteria to troubleshoot performance issues with grantees and elicit mid-course corrections, if required.

In the second cycle of the project (August 2009–July 2010) BASICS implemented a mapping requirement for its grantees. This allows BASICS to visualize in which area of a district activities are taking place and provides BASICS with a better sense of demographic and/or geographic distribution of activities, allowing BASICS to raise questions about perceived geographic lapses in activities. The six grantees visited as part of this evaluation all had copies of these maps on their office walls, illustrating with push pins and by other means the villages and TAs where activities are taking place.

BASICS has also developed a tool to assess the quality of messages, and admits that it could do a better job of gathering success stories, which is a good way to measure impact in the absence of behavior change indicator research.

Malaria Grantee Program—Collection of Apparent Best Practices

The following represents a listing of some grantee practices that may be worth emulating. The list is by no means comprehensive, but is included to assist in the sharing of information among grantees.

COOPI–Cooperazione Internazionale

- Writes core messages on house walls, trying to put a malaria message on every house.
- Community reception is reportedly good.
- Each community meeting reportedly ends with an agreed-upon plan of action, thus helping to ensure community commitment and action on key items. (Consider including transport solutions in these action plans.)
- Volunteers have spontaneously used community fertilizer meetings to communicate malaria messages.
- Promoters go door-to-door to see if bed nets are hung up and properly used. This is a form of both communication and BCC M&E.
- HSAs will travel to health facilities to learn of fever diagnosis and follow up on SP use by pregnant women.

Development Communication Trust–Chiradzulu District

- Includes pastors and imam in its listener clubs as a way mobilizing churches and mosques.
- Uses a cost/benefit argument: Since malaria season coincides with farming season, malaria undermines household and village output and income.
- Collects success stories (personal testimonials) to illustrate effectiveness.

DAPP–Development Aid From People to People, Zomba District

- Raises money on its own by selling used clothing and shoes.
- Promotes the message that not dealing with malaria costs families more money.
- Chiefs will fine individuals who misuse nets.

Project Hope, Mulanje District

- Conducted its own research on local traditional practices and beliefs that pose barriers, and came up with messages to counter them.
- Met with healers to explain the real cause of mauka.
- Reached out to shopkeepers regarding medication policies.
- Volunteers follow up with patients to make sure they are recovering and complying with medication instructions.
- Volunteers follow up to make sure that young children are able to ingest LA.

DHMT would like the BASICS project to approach churches and mosques directly, which would reinforce this outreach.

IV. RECOMMENDATIONS

CHILD HEALTH

CCM

- Work with village health committees to access funding from District Assemblies for support for HSA/VHC housing. Also work with the committees to develop transportation plans for pediatric emergencies.
- Explore ways to include VHC diagnosis and treatment information in patient passports.
- Evaluate drug supply system options in light of new demands from expanding VHCs. If drugs are short at health centers, HC staff will not give drugs to the VHCs, which results in more referrals.
- Monitor options for maintaining drug boxes. As in Phalombe, the two-key system may become too cumbersome. Review what is being monitored.

Facility IMCI

- Assess the possibility of extending course length to include more practical sessions.
- Assess whether charts can be streamlined or be more targeted. Explore alternatives for health workers with large patient loads.
- Explore cross-supervision tools/training for DHMTs to allow one or two members to review all areas when making health center visits.
- In order to strengthen the continuity of care between emergency care and case management, pursue combining IMCI with ETAT training at the health center level. This will also support referral and supervision systems. Options for limited staffing at health centers also need to be considered. Can some education and counseling functions be done with waiting groups?
- Work with districts to address transportation management for pediatric emergencies.

ETAT

- Pursue development of a five-year strategic plan that includes links to PHI and IMCI. Will assist donors to address gaps/needs and plan for future support.
- Continue training hospital staff with a focus on pediatric wards.
- Continue quarterly review meetings, using them as opportunities for training updates and system-strengthening.

BCC

- Pursue development of UNICEF ACSD flip chart. May consider selecting and printing those sections specific to CCM for VHCs.
- Consider developing a low-cost, one-page instruction sheet for low-literate parents that illustrates home care of sick children with malaria, diarrhea, and ARI.
- Pursue more donor funding for zinc launch. Need more than five radio spots per week to have impact; otherwise may want to consider other options such as local radios.

Other administrative, technical capacity-building

- Begin planning exit strategy with the MOH and district partners regarding handover of meetings, procurement, trainings, and other support tasks supported by BASICS.
- USAID should consider using the same flexible model of support to MOH programs for future procurements.

BASICS organizational structure

- BASICS and the family planning program should work together to develop a consolidated monthly report format.
- The central MOH and the donor community need to agree on which areas and activities will be covered by which donors in each district.
- Need support from MOH and USAID to address health facility staffing issues, including funding for training of new health workers at colleges. Explore PEPFAR funding.

M&E

- Pursue planned training of district and health center staff on the importance of M&E data collection. Staff needs to understand how to use their data to make decisions regarding services, staffing, supplies, etc.

HIV

PMTCT

- Consider applying the guardian support model as soon as a pregnant woman tests positive, rather than after she delivers. Attempt to engage guardians in all antenatal and post-natal visits to help ensure that an HIV-positive mother understands her counseling and when to return for follow-up visits.
- Consider a campaign to enlist husbands/fathers in a guardian role (using messages about men as protectors of their families?)
- Provide more health worker trainings on breastfeeding and nutrition counseling for HIV-positive, HIV-negative, and unknown HIV-status mothers.
- Help distribute the new MOH (printed by UNICEF) feeding job aid as quickly as possible. Perhaps BASICS could fund reprinting of more copies of this important resource.
- Continue working toward the goal of training all facility-based health workers in PMTCT, combination regimens, and accurate breastfeeding guidelines.
- Include all HIV-positive mothers in any food distribution programs, regardless of CD4 count or arm circumference, to help keep mothers alive.
- Add food supplements as an incentive to bring mothers with babies on ART back to the clinic.

Pediatric HIV services

- Where possible, schedule adult and pediatric ART on the same day so the mother must only visit the clinic once.
- Where possible, offer nutrition supplements for mothers and/or infants at a pediatric ART clinic as motivation for their return.

- Every district hospital reportedly has a cooking demonstration area; consider ways to use these better on behalf of HIV-positive mothers and HIV-exposed children.
- Provide trainings (can BASICS also provide support for equipment (hemacues, reagents, cuvets?) to support expansion of ART outreach health center sites that will allow patients to initiate ART at the district level, and then be followed up by health facilities closer to remote areas. This maintains facility-based ART services, but places them closer to where patients live.
- Consider multiple roles for expert patients, who can promote testing of sick children, help HIV-positive mothers or babies access CPT/ART, and link infants with exposed infant follow-up.
- Think about introducing nutrition education into Wednesday pediatric ART clinics.
- Consider adding HIV testing in Under 5 clinics. Could offer the rapid test to children known to be exposed and perhaps for children with ETAT referrals, with PCR follow-up for positives.
- Enlist local Peace Corps volunteers to facilitate HIV-positive teen support groups at ART clinics.

HTC

- Provide refresher trainings for HTC counselors on PMTCT, ART, CD4 and PCR tests, and couples counseling.
- Strengthen referral mechanisms to existing psychosocial services in each target district. Engage HSAs to identify support services near their locations and send information to BASICS offices for compilation and distribution to DHMT. Make support services referral lists available to patients in HTC, PMTCT, L&D (labor and delivery), exposed infant follow-up, and NRU clinics.
- MSH should consider comparing village-to-village testing (BASICS) and home testing (FP CBDAs strategies in terms of how well people who test positive are being linked to facility-based CPT/ART services.
- Where possible, continue to strengthen capacity for CD4 and/or PCR testing.
- Where possible, implement PCR at Under 5 clinics, as well as exposed baby follow-up clinics.
- Expand the village-to-village testing model, which has been proved to be a successful testing strategy.
- For village-to-village testing, review how supply estimates of test kits are made, to mitigate running out of them.
- Since the MSH FP project CDBAs are also conducting home-to-home testing in the same two districts (Salima and Chikwawa), this provides a useful opportunity to compare the two strategies in terms of how many people tested were successfully linked with ART (village-to-village family testing model includes clinical staging, whereas home-to-home testing does not).
- Increase HTC for infants and children through pediatric wards and Under 5 clinics.
- Where possible, increase district hospital and health center capacity for CD4 and PCR testing of children. Continue to support transportation of samples, and expand this support if possible.

Community-based services

- Sensitize communities to the fact that ANC services include HIV testing. Husbands need to know this, as this will encourage couples testing.
- Commission a feasibility study to expand the MFSG model.

- Consider facilitating community-level participatory meetings to address patient transportation challenges. Perhaps this could be added as a follow-on at village-to-village testing sites.

For Project overall

- Consider study tours for neighboring target District Coordinators to learn how other districts are addressing PMTCT, MIP follow-up, male involvement, outreach ART, and outreach HCT.

- Explore other ways to engage Peace Corps volunteers as partners to fill gaps in HIV support services (e.g., facilitate support groups for HIV-positive mothers).

For USAID

- The Dignitas PMTCT model includes HBC workers who locate ART defaulters and support HIV-positive mothers and HIV-exposed/positive babies through home visits. USAID should consider ways to replicate this model, with a focus on whole family support, through district-wide partnerships between clinical services systems-strengthening partners and psychosocial services-implementing partners.

- lan the gradual transition of technical assistance support to be provided directly by MSH/BASICS from outside the MOH for developing protocols, policies, services packages, and training packages. At the zonal level, provide technical assistance support for the roll-out of programs and services once they are designed at the national level.

MALARIA COMMUNICATIONS RECOMMENDATIONS

- BASICS, the grantees, the District Malaria Committee, the NMCP, and other stakeholders should establish criteria for reducing or ending intensified BCC activities in a TA and a district. Everyone should have a clear idea of what success means in term of adopting malaria-healthy behaviors and how behavior change outcomes are measured.

- Work with stakeholders to decide what a transfer of responsibility for malaria communications from a grantee to the DHO would entail, and create strategies to achieve sustainability and adequate mobilization of resources.

- Conduct research in cycle-three districts to establish current behavior and practices baselines, even if funds allow for only reduced sampling. This will help set the stage for determining whether the communication activities are achieving desired behavioral outcomes. Conduct research to measure the changes that have occurred since the baseline, perhaps on an annual basis.

- Use the findings of the forthcoming NMCP behavior indicator survey to help determine whether the grantee program is having its desired impact. It may be possible, for instance, to compare behavior indicator responses in districts with and without the BASICS grant program.

- The national malaria effort should consider the establishment of an independent ombudsman who could hear concerns at the local level and translate them into troubleshooting and problem-solving at all levels of the public health system. This could be a mechanism for ensuring that commodity stock-outs do not undermine the malaria control and treatment effort.

- Clarify the messaging on the use of bed nets for PLWHAs, considering the current unavailability of free nets for PLWHAs, as volunteers seem confused about this.

- Sensitize grantees, HSAs, and volunteers about the policy of having HSAs in remote areas administer LA. There appears to be a lot of confusion on the ground regarding this policy.

- Enlarge the BASICS grants program team to ensure that there is adequate staff to oversee the rapid expansion of the program, and also to ensure that the team has sufficient BCC expertise. The program would benefit greatly if BASICS demonstrated greater leadership in ensuring that grantees adopt best BCC practices. In this regard, hold a grantee conference to share best practices, understanding target audiences, and lessons learned.

- Conduct formative research among key groups such as religious leaders and traditional healers to learn how best to make them strong allies of the roll-back malaria initiative.

- Conduct formative research in the new cycle-three districts.

- Share among grantees best practices in mobilizing the support of chiefs and headmen.

- Budget to provide incentives for the volunteer forces and develop inexpensive ways to bestow recognition on the volunteers for their services. Incentives may include reimbursement for transportation costs and provision of items such as T-shirts, caps, and IEC materials. A policy should be developed on the provision of bicycles, as advocated by some grantees.

- BASICS should add the availability of bed nets and LA at local levels to its grantee reporting systems, so that BASICS can inform higher-level public health authorities about continuing barriers to behavior change due to stock outs.

NUTRITION RECOMMENDATIONS

For BASICS

- Hire an additional Nutrition Specialist to assist the Community Health and Nutrition Advisor in expediting and accomplishing remaining objectives and tasks.

- Collaborate with Ministry of Agriculture extension workers to promote less labor-intensive agriculture methods for HIV-infected/positive individuals and ensure that they benefit from fertilizer and seed programs.

- Consider outreach OTP services to increase access to health services.

- Collaborate with the Ministry of Agriculture to establish cooking demonstrations in hospital wards for non-malnourished children as a means to prevent malnutrition and promote nutrition.

- Send the BASICS M&E Officer or other District Coordinators to Mangochi and Zomba Districts.

For MOH and BASICS

- Remind/orient all clinicians, health facility staff, HSAs (and hospital attendants attending patients in the NRUs) at village clinics, health centers, and district hospitals to **systematically emphasize at each and every sick visit** the importance of breastfeeding and feeding more in frequency and quantity during illness, and especially for two weeks after illness (when appetite has returned) for catch-up growth and to regain weight which may have been lost.

- Since HSAs will be receiving new bikes, refurbish and repair old HSA bikes with spare parts, and make these available to village health committees for guardians and patients to use for referral compliance and medication acquisition.

- Extend the opportunity to volunteers to purchase a subsidized bike for improved transportation to do their tasks and as an incentive, as well as a token of appreciation for their commitment to their communities.

- Consider piloting a shuttle service using ambulance motorbikes patrolling village clinics daily (or twice a week) to provide transportation of emergency and non-emergency referrals on a regular basis to health centers and district hospitals when necessary.

- Inventory all hospital attendants monitoring the malnourished in Nutrition Rehabilitation Units and ensure that they receive capacity-building for proper management of acute malnutrition, considering that a number of them are caretakers in the NRUs due to the shortage of clinical staff.

- Revise guidelines regarding supplemental feeding to include all HIV-positive women and children regardless of CD4 count and nutritional status (MUAC).

- Consider collaborating with traditional healers/herbalists to address malnutrition issues and assist with CCM.

For MOH/DHO

- Re-disseminate the updated breastfeeding policy and clarify breastfeeding messages within the context of HIV, assessing whether replacement feeding is AFASS.

- Consider informing, counseling, and assisting HIV-infected and HIV-positive mothers who have ceased breastfeeding (and where AFASS is not met) with re-lactation (if they wish to resume breastfeeding).

- Update the IMCI policy to include the treatment of diarrhea with zinc.

- Prioritize and provide a clear policy for addressing chronic malnutrition and stunting so as to begin reversing the cycle.

- Revise the Under 1 and Under 5 registers in order to be able to follow up each child over time.

- Ensure that all women with children under five years of age have health passports by replacing all growth monitoring notebooks with health passports, transferring information, and plotting growth patterns.

- Consider providing selected drugs (paracetamol, LA, albendazol) at growth monitoring clinics.

- Mend or replace defective mosquito nets at hospital wards to prevent transmission of malaria from the malaria ward to other wards.

- Provide refresher or additional trainings in growth monitoring.

- Expedite the printing and distribution of the MOH nutrition counseling cards (funded by UNICEF) at the facility level.

- Consider adding condoms and nutrition-related drugs to the drug box such as albendazole, Vitamin A, and iron tablets in order to target those who missed the Child Health Days campaign, lack community-based distributors of family planning methods in their catchment areas, or are pregnant and need iron tablets.

- Sensitize all hospital staff (receptionists, ETAT staff, security, hospital attendants) to respect, recognize, and assist in dispatching emergency transportation for referrals of severe malnutrition to minimize mortality at the hospital level due to late arrivals.

- Write a memorandum of understanding (MOU) between the districts for follow-up of children in other districts and to minimize possible conflicts between HSAs. Chikwawa District is one example.

- Mobilize the community to donate seeds for the health center garden. Consider opening an ARV clinic in Mfera in Chikwawa District.
- Collaborate with traditional healers and train them in CCM and prevention of malnutrition as well as nutrition management of the sick child.
- Promote growth of artemisia as a mosquito repellent.

For BASICS and the community

- Sensitize the community and raise awareness of the importance of growth monitoring until age five, and the necessity for booster immunizations and Vitamin A supplements beyond age one and throughout one's life.
- Collaborate with Muslim religious leaders to address misinformation and mistrust of government programs that are intended for improved nutrition (i.e., Vitamin A supplementation/deworming), but are perceived to curtail reproduction.

For communities in BASICS target districts

- Establish a transportation system within the village health committee, whereby patients and clients can borrow/rent a bicycle at an affordable price for health purposes (i.e., preventive and curative services as well as referrals for emergency and non-emergency conditions and for the purchase of medications).
- Build a community shelter to ensure that meetings and MFSG sessions are not disrupted due to inclement weather.

RECOMMENDATIONS FOR OTHER FUNDING OPPORTUNITIES BEYOND BASICS

For USAID and other donors/partners

- Prioritize and seek funding for a motorbike ambulance (with spare parts) for each village (priority), and each health center for emergencies and referrals.
- Purchase new motorbikes and spare parts for senior HSA transportation for supervisory visits.
- Provide one or two bikes to village health committees as a means of transportation for patients to seek health care (preventive and curative services including CTC/CMAM/SFP) and to purchase medicines.
- Include a line item in subsequent project budgets and provide useful incentives to volunteers as a token of appreciation for their work. Selected requests include uniforms, umbrellas, rubber boots, flashlights(torches) and bicycles to perform duties.
- Consider scaling up the ENA package in an effort to decrease the high malnutrition rate. As there are shortages of nutritionists in Malawi, this may necessitate periodic, short-term nutrition consultants (or a team of nutritionists) to assist simultaneously with scale-up and mentoring.
- Consider working in an entire district (rather than in a few villages in each district) in order to have a stronger, more meaningful, and more measurable intervention impact.
- Consider dividing the Community Health and Nutrition Advisor position into two positions—one to implement activities at the community level, and the other with a technical advisory role to strengthen the MOH at the central level.

- Ensure that baseline surveys are conducted to assess the quantitative impact of USAID interventions and programs.
- Expedite the funding and capacity-building of HSAs in hard-to-reach areas so that they are eligible to treat malaria patients at the community level with LA (aka ART).
- Purchase new height boards for health facilities with old ones that need replacement, and for outreach and growth monitoring clinics. Weight-for height boards should be distributed for use at each village clinic and outreach clinic to assist in screening and detecting stunted children in hard-to-reach areas.
- Provide scales to all villages and hard-to-reach village clinics for outreach and growth-monitoring activities.
- Consider seeking funds to repair leaks in hospital roofs.
- Consider establishing a Nutrition Rehabilitation Unit at the Kalembo health center to increase access to health care given the large catchment area, the high demand for services, the long distance, and the high cost of transportation to the Balaka District Hospital.
- Consider soliciting contributions/funding to erect the Phalombe District Hospital.
- Consider erecting a dispensary in areas where the catchment area is large (Phalombe, Kalembo (Balaka)).

GENERAL RECOMMENDATIONS (LESS URGENT)

1. BASICS plans to collaborate with such sectors as the Ministry of Gender, the Ministry of Agriculture, and other NGOs. BASICS has not yet set a date as to when this will begin.
2. The IEC Officer plans to launch activities such as drama, songs, poems, etc., to mobilize communities. He is currently in the process of identifying and preparing magnet theatre groups for this purpose.
3. At this time the mother-father support group will remain the main approach to increase men's involvement.

APPENDIX A. METHODOLOGY

At the request of USAID/Malawi, a four person team was recruited by the Global Health Technical Assistance Project (GH Tech) to conduct a final evaluation of the BASICS project. The team brought expertise in Child Health, Nutrition, HIV/AIDS, and Malaria communication, capacity building, management and evaluation. Prior to arrival in Malawi, the team reviewed relevant project and other documents and materials provided to them by GH Tech and USAID/Malawi.

After arrival in Malawi on February 17th, the team received an initial briefing from the USAID Health Team on the key issues to be explored. The team received a briefing from the MSH staff about the BASICS project activities. The USAID Child Health specialist and BASICS staff assisted the team in compiling a list of relevant stakeholders, planning field visits, and arranging meetings with local groups and organizations. The team developed a questionnaire used as a basis for interviews and focus group discussions with stakeholders (Annex). In total, between February 25th and March 6th, the team visited six of the eight project districts (Salima, Kasungu, Mulanje, Chikwawa, Phalombe and Balaka). Visits included interviews with District Hospital staffs, Health facility staffs, Health Surveillance Assistants, Village Health Clinics, Village Health Committees, Community Based Organizations (CBOs), radio listening groups, NGO collaborating partners, traditional healers and others. Upon return to Lilongwe, the team met with several MOH officers at the CHSU, the Nutrition Section, the Health Education Unit and the HIV/AIDS Unit. Finally, mid review and final debriefings were conducted with the USAID Health Team and Mission Director and Deputy to gain their perspective on the history and performance of the project. The team's schedule is located in the Annex.

CONSTRAINTS

Because this is a mid-term review the end of project survey has not yet been conducted so the evaluators were unable to compare and analyze their qualitative project findings with quantitative survey findings. The evaluation was limited to documentation in reports, self reported behaviors, observation and key informant interviews.

The turnover of staff on the project as well as with collaborating partners has meant that many of the individuals interviewed did not have enough experience with the project to thoroughly answer the evaluation questions. As a result, some of the staff interviewed were not able to answer questions about project history in a region or reasons for changes in project direction. However, to assist with this, the COP and other BASICS staff accompanied the team on field visits to the districts and also made themselves very available during the evaluation period to answer questions and clarify issues.

Because the MTE occurred during the rainy season, the review was sometimes hampered by difficult road conditions during field visits. Some of the scheduled visits to hard-to- reach-villages had to be cancelled due to impassable roads. Other visits had to be rushed and cut short because the meeting areas were rained out.

Despite limited time with the project's key individuals and organizations, the evaluators completed a comprehensive evaluation. However, these constraints may have resulted in some misunderstandings of the project, such as appropriate roles of key organizations or project accomplishments, which the evaluators were unable to discover or verify. The evaluation team also organized the interviews and focus groups to include as much participation as possible in accord with the availability of project partners and stakeholders.

APPENDIX B. PERSONS CONTACTED

U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID)

Alisa Cameron, HPN Team Leader USAID mission Malawi
Catherine Chiphazi, Child Health Specialist, USAID Malawi
Violet Orchardson, Nutrition Specialist
Matthew Barnhart, HIV/AIDS Advisor
Katherine Wolf, Malaria Advisor

BASICS – MSH

Rudi Thetard Chief of Party
Timothy Kachule - Child Health Officer
Enoch Kajawo - HIV/AIDS Officer
Johnes Moyenda, - Malaria Program Officer
Weston Njamwaha - Asst Malaria Officer
Joe Kumadzulo - Grants Manager
Allison Aakaliya -
Chancy Mauluka - Behavior Change and Communication Officer
Thoko Bema
Margaret Khonje, Nutrition Officer
Mwate Chintu, Community Health and Nutrition Advisor
Mpumulo Jawati, Zinc Technical Officer
Lawrence Mululu, District Coordinator, Balaka
Doreen Machinjiri, District Coordinator, Phalombe
Geometry Kachepas, Community Nutrition Officer, Phalombe
Joyce Wachepa - District Coordinator, Chikwawa
Erick Schouten, - TA, Ministry of Health HIV/AIDS Unit

OFFICE OF THE PRESIDENT AND CABINET

Catherine Kangama, Director of Nutrition and HIV

MINISTRY OF HEALTH

Dalitso Kang'ombe, Head, Nutrition Unit, Clinical Services
Tapiwa Ngulube, Coordinator Infant and Young Child Feeding, Nutrition Unit, Clinical Services
Janet Guta, Principal Nutritionist, Nutrition Unit, Clinical Services
Godffry Kadeweli (SP?), Deputy Director, Pharmaceutical Services
Francis Chafulumira, Head, Central Medial Stores
Daniel Maseka, Health Education Unit
Doreen Ali, Executive Director, National Malaria Control Program
Mr. Kadewere, Deputy Director of Pharmaceuticals, Office of Permanent Secretary for Health
Mr Chafulumira, Acting Director of Central Medical Stores

UNICEF

Rosemary Wellington, Chief, Communication for Development
Ketema Aschanki Bizueh, Health Manager
Mr. Ketemah Bizuneh and Texas Zamasiya, UNICEF
Follow up meeting with Mr. Kondwani Ngoma, PMTCT Officer, UNICEF

WHO

Susan Kambale, Sr. Health Officer

ELIZABETH GLASER

Patricia Mbetu, Country Director, Elizabeth Glaser Pediatric AIDS Foundation
Dr. Ratzima, Dignitas, Zomba District

BAYLOR INTERNATIONAL, MALAWI

Dr. Peter Kazembe, Director, Baylor International, Malawi

JHPIEGO MCHIP

Tambudzai Rashidi, Country Director and Chief of Party and
Aleisha Roazario, Deputy Country Director

BALAKA DISTRICT HOSPITAL

Doris Kayambo, District Health Office
Susan Phiri, Nutrition
Kitty Khanga, Nurse-in-Charge, NRU
Moffat Chiutsi, Volunteer
Patricia Zamasia, ETAT Trainer
Robert Bwaluzi, IMCI Coordinator
Richard Makwiza, Kwitanda Health Center nurse mid-wife
Thomas Biliwita, Nailuwa Village Clinic HSA

PHALOMBE DISTRICT

Raphael L. Piringu, District Health Officer, Phalombe
Eraton Matik, Group Village Headman, Nyambaro/Phalombe
Cottana Mtembo, FP District Coordinator, Phalombe District
Mary Lujere- IMCI Coordinator

PALOMBE VILLAGE CLINIC

Madalitsu Mamsucha, HSA
Langtom Mwachande, HSA Supervisor
Lingston Chiangana, Village Chairman

CHIKWAWA DISTRICT HOSPITAL

Joyce Wachepa, District Coordinator
John Mugawa, IMCI and CTC Coordinator
Daina Vinyo, nurse, NRU

Ronald Nachipo, Registered Nurse, Pediatric Ward
Peter Gundampanda, Senior HSA, Cholera Ward
Edith Kazembe, ETAT Team

CHICKWAWA DISTRICT

Andrew Gideon, HAS, Mtombolola Village clinic
Dalitso Banda, Kakomo Health Center

MFERA HEALTH CENTER, CHIKWAWA DISTRICT

Rex Bwanausi, Officer-in Charge/Medical Assistant
Henry Lizi, Medical Assistant
Grant Mpembelera, Senior HSA
Medson Faila, HSA

MWALIJA VILLAGE CLINIC, CHIKWAWA DISTRICT

Alexander Chiwanda, Health Surveillance Assistant

NTUWANA VILLAGE, CHIKWAWA DISTRICT

Alfred Kampaundi, Traditional Healer

SALIMA DISTRICT

Etwon Garcela, Deputy DHO Salima
Rodvich Kaliafi, ETAT Coordinator
Packson Tsiku, IMCI Coordinator
Artwell Ndakala, HTC Coordinator, Salima District
Blessings Makono, Chimphanga Village Clinic, Salima
Hope Kathumba, Medical Assistant In-Charge, Mchoka Health Center, Salima District
Jefferson Nkhata, HSA, Mpunga Village Clinic, Salima District
Chadza Fisi, Village Headman, Mpunga Village, Salima District
Benson Bulla, Chair, Village Clinic Committee
Rogers Cyrus, Volunteer, COOP
Joyce Zeki, Volunteer, COOPI
Traditional Healers Association, Salima District

KASUNGU DISTRICT HOSPITAL

DHO, Mr. Albert Mbowe
Deputy DHO, Mr. Joster Banda
DEHO, Mr. Ketwin Kondowe
PHSA, Mr. Ziba
DNO, Mrs. Margaret Chipeta
H. Centre Incharge, Mr. Wetson Kawelama (Chamwabvi)
HTC Counselor (Chamwabvi)
ETAT Coordinator, Stalire Kapila
Malaria Co-coordinator, Rodgers Kumwenda
IMCI Co-coordinator, Obvious Mtambo

HTC Counsellors (KDH), Goodson Thwala
HTC Counsellor, Gibson Nyirenda
HTC Counsellor, Harry Sandram
IEC Officer, Mrs. Catherine Yoweli
NRU Nurse, Mrs. Tiyezge Dhlamini
Family Planning Coordinator, Mrs. Esther Kazonde

DEVELOPMENT AID FROM PEOPLE TO PEOPLE (DAPP)

Nervous Nsansaula, Programs' Coordinator

WORLD FOOD PROGRAMME (WFP)

Anna Tallant, Nutrition Focal Point

MINISTRY OF AGRICULTURE AND FOOD SECURITY

Stella Kankwamba, Nutrition, HIV and AIDS Unit

RED CROSS, KUSUNGU DISTRICT

Theatrical Group Kusungu District

COOPI, SALIMA DISTRICT

Taonga Malfumbo
Jesse Dimo
Church meeting with HSAs and COOPI Malaria Communication Volunteers

PSI, BLANTYRE

Rick Oxford, Resident Director
Charles Yuma

DEVELOPMENT COMMUNICATION TRUST, BLANTYRE-CHIRADZULU DISTRICT

Lusunga Dzinkambani and staff

MALAWI TELEVISION NETWORK

Bright Malopa, Executive Director, Malawi National Broadcasting Authority

PROJECT HOPE, MULANJE DISTRICT

Chimwenwe Chamangwaana
Innocent Chanvinda, District IEC, Mulanje

DAPP, ZOMBA DISTRICT

Frank Nsumza and staff

DISTRICT MALARIA COMMITTEE, ZOMBA

Ella Chamanga
Henry Tsekeleza
Tracy Chinula

SUE RYDER FOUNDATION, BALAKA DISTRICT

Kibble Ngalauka, Executive Director

COMMUNITY RALLY, BALAKA DISTRICT

Chief and Headmen

Theatrical Group

BAOBAB HEALTH

Sabine Joukes

PARTNERSHIP DEVELOPMENT

Robin Stecklye

FRONTLINESMS: MEDIC

Isaac Holeman, Clinical Programs Director

MPHUNGA VILLAGE HEALTH CLINIC COMMITTEE, SALIMA

Benson Bulla, Chair

Chanza Fisi, vice-Chair

Jefferson Nkhata, HAS

Hope Katumba, member at large

Roger Cyrus, volunteer

Joyce Zeke, volunteer

APPENDIX C. MALAWI BASICS MID-TERM EVALUATION SCHEDULE

FEBRUARY 17 – MARCH 24, 2010

DATE	TIME	VENUE	CONTACT/ACTIVITY	CONTACT DETAILS	COMMENTS
WEEK 1 & 2					
Wednesday 17	16.00	Kumbali Lodge	C. Chiphazi	01 772 455 Ext 5310 0888 870 954	Arrival all. Review of documents and tool development.
Thursday 18	9.30 – 12.00 14.00-15.30	Office USAID	Consultant team meeting HPN – In-brief		Catherine, Kate, Matthew, Violet and Archanjel. Evaluation schedule review
	16 – 17.30	BASICS	Rudi Thertard	0999 964 109 01753652 01756111	Briefing / Q & A
Friday 19	9.00	Courtesy call to PS	Mr Kadewere, Deputy Director of Pharmaceuticals and Mr Chafulumira, Acting Director of Central Medical Stores.	01 789 400	Confirmed
	11.00-12.00 13.00-18.00	BASICS	Individual meetings with BASICS Projects Staff	01753652 01756111	Briefing cont/ schedule
Saturday 20	8 – 17.00	Office			Office work- prepare tools
Sunday 21	Off duty				
Monday 22	9.00	MSH	Mwate	01753652 01756111	Kim Confirmed
	9.00	Baylor International, KCH	Director Dr. Peter Kazembe	01750 877	Deborah Confirmed
	10.30	Ministry of Information	??	??	Greg Confirmed
	10.30	CHAM	Director & Health Coordinator Mrs. Rose Kumwenda	0888 869305 01 755 180 02	Sandra Confirmed

DATE	TIME	VENUE	CONTACT/ACTIVITY	CONTACT DETAILS	COMMENTS
WEEK 1 & 2					
				088855134-Secretary	
	11.30	USAID	Violet	01772455	Kim Confirmed
	14.00	UNICEF	Ketemah Bizuneh Texas Zamasiya	01 770 781/099 9964211/09 964 663	All Confirmed
	16.00	MSH-BASICS	Rudi and staff		
Tuesday 23	9.00	WHO	Susan Kambale, Mr Dodoli	0888852638	Sandra, Greg and Kim Confirmed
	10.00	MOH – CHSU	IMCI Coordinator, Mr. Humphreys Nsona	0999 510 272	Sandra, Kim Confirmed
	14.00	MSH	Mexon Nyirongo	01753652 01756111	Sandra Confirmed
	16.00	MOH	Mr. Nkhono, PHC Manager (HSAs)	0888 895 073	All Confirmed
Wednesday 24					
	8.30	EGPAF	Patricia Mbetu	A/13 Green Heritage 1st Floor 0999134537	Deborah and Kim Confirmed
	10.00	CHSU	Mr. Norman Lufesi, ARI	0888 714 961	Sandra Confirmed
	10.30	UNICEF	EE or and Kondwani	099958210	Deborah Confirmed
	14.00	MOH	Erick Schouten	01789400 0888340151	Deborah Confirmed
	14.00	BASICS	Alison		Kim Confirmed

DATE	TIME	VENUE	CONTACT/ACTIVITY	CONTACT DETAILS	COMMENTS
WEEK 1 & 2					
	16.00	USAID/DELIVER	Jane Waweru	01 752 030/0999 809 314	Sandra, Kim, Deborah Confirmed
Thursday 25	6.30	Kasungu & back	Site visit - district hospital, health center, community	01753652 01756111	All Confirmed
		Red Cross	Leonard Maganga	01753652 01756111	Greg Confirmed
Friday 26	7.30	Salima & back	Site visit – district hospital, health center and community	01753652 01756111	All Confirmed
		Health Education Unit	Dan Maseko		Greg, Kim Confirmed
		COOPI	Tawonga Mwenefumbo		Greg Confirmed
Saturday 27	8-17.00	Write-ups			
Sunday 28	13.00	Travel to Blantyre			Ryalls Hotel
March Monday 1	7.30	Travel to Chikwawa & back	DHMT, site visit		Sandra, Kim, Deborah Confirmed
	7.15	PSI/Malawi	Rick Orford,	01874139 rorford@psimalawi.org 0888879400	Greg Confirmed
	10:00	Malawi TV/Radio	Bright Malopa	01 872 676	Greg
		Chiradzulu, Development Community trust	Lusungu Dzinkambani		Greg Confirmed
Tuesday 2	7.00	Travel to Phalombe & back	DHMT, site visit		All

DATE	TIME	VENUE	CONTACT/ACTIVITY	CONTACT DETAILS	COMMENTS
WEEK 1 & 2					
		Project Hope, Mulanje	Rodrick Nalikungwi/Chimwemwe Chamangwana	0999691937	Greg Confirmed
Wednesday 3	Public holiday- Write Notes				
	09.00	Malawi Broadcasting Corporation-Blanntyre			Kim Confirmed
	10.00	Zodiak Broadcasting Corporation-Blantyre, Pilirani Tambala			Kim Confirmed
	10:30 Lusungu Dzinkambani 1:30 PSI				Greg
Thursday 4	8.30	College of Medicine (COM)	Prof. Molyneux	0888844517 01871911	All Confirmed
	10.30	Travel to Zomba			
	14.00	Dignitas	COP, Dignitas?? Zomba Central Hospital, HTCs, DHTC		Debora, Kim
	15.30	DAPP	Meeting with DAPP Florence Longwe	0999413028	Greg, Kim
		Zomba District Malaria Committee			Greg, Kim,
		Night in Zomba			Masongola Hotel
Friday 5	7.30	Leave for Lilongwe via Balaka			
	8.30	Sue Ryder Foundation	Kibbo Ngalauka/Edward	088830100 kibblengalauka@sueryd ermw.org	Greg Confirmed
		DHMT, site visit	Balaka		Confirmed
	15.00	Travel to Lilongwe	Kumbali lodge		

DATE	TIME	VENUE	CONTACT/ACTIVITY	CONTACT DETAILS	COMMENTS
WEEK 1 & 2					
Saturday 6		Write-up			
Sunday 7	Off				
Monday 8		Report outline due			
	10.30	ACCESS (MCHIP) Jhpiego - an affiliate of Johns Hopkins University Malawi Country Office	Tambudzai Rashidi Chief of Party (MCHIP) Country Director (Jhpiego) and Aleisha Rozario, Deputy Country Director	0888 201 838/01 776 414 ARWA House, 1st Floor	All Confirmed
	9:30	BASICS	Chancey Mauluka, , IEC officer		Greg
	14.30	NMCP - CHSU	Director, Doreen Ali/Sande/Kaunda	01759935	Greg, Kim Confirmed
		Preparation for stakeholder meeting			All
Tuesday 9					
	8.30	Malawi College of Health Sciences	Mr. T. Masache/Mrs. I. Chirwa, Executive Director and Principal, respectively	01 756 777	Sandra Confirmed
	9.00	Ministry of Agriculture and Food Security	Person responsible for nutrition Stella Kamkwamba	01789033 0999220088	Kim Confirmed
	10.00	BAOBAB	The Executive Director	01751413	Greg Confirmed
	10.30	MOH	Mr. Frank Kumbanga, Planning Unit	0888 688 008/01 789 400	Sandra Not confirmed
	16.00	OPC, Nutrition section	Mrs. Catherine Mkangama	01-771-374 0888-890-913	Kim Confirmed
	15.00	BASICS	Alison Zakaria - M & E Officer for BASICS	01756 111	Greg Confirmed

DATE	TIME	VENUE	CONTACT/ACTIVITY	CONTACT DETAILS	COMMENTS
WEEK 1 & 2					
Wednesday 10			Prepare for debriefs		All
	11.00	MOH-CHSU	Phillip Moses	09953533900	Deborah Confirmed
	15.00	USAID	Catherine Chiphazi	01 772 455 Ext 5310 0888 870 954	Confirmed
Thursday 11			Prepare for debriefs		All
	11.30	MOH, Nutrition section	Dalitso Kang'ombe	01789400 0999212565	Kim Confirmed
	14.00	CRS-WALLA	Julitta Nsanjama	0995757482 jnsanjama@walamalawi.org julitansanjama@yahoo.com	Kim Communication by e-mail
	14:00	BASICS	Rudi Thethard		Greg
Friday 12			Write-up		All
	11.00	UNICEF	Benson Kazembe	01770780/781	Kim Not confirmed
Saturday 13			Write-up		All
	14:00	Kumbali	Joe Kumadzulo	BASICS Malaria Team	Greg
Sunday 14	Off				
Monday 15			Write-up		All
	9:00	BASICS	Joe Kumadzulo	BASICS Malaria Team	Greg
	9.00	WFP	Anna Talent	01774291/666	Kim Confirmed
Tuesday 16			Write-up		All

DATE	TIME	VENUE	CONTACT/ACTIVITY	CONTACT DETAILS	COMMENTS
WEEK 1 & 2					
		Field trip Salima	Kuzemba Mulenga	0999 471 939.	Kim and Greg Confirmed
Wednesday 17			Write-up		All
Thursday 18	10 -11.30 14.00	USAID USAID	Debrief HPN Debrief Mission Director	01 772 455 Ext 5310 0888 870 954	Confirmed
Friday 19	9.00 – 11.30	MOH	Debrief stakeholders		All Confirmed
Saturday 20 -24		Office	Write-ups and submission of draft report		All

Districts to visit: Salima, Chikwawa, Kasungu, and Phalombe

Notes:

- Field visit detailed schedule to be provided by BASICS.
- For Kasungu and Salima site visits, all vehicles to meet at Salima Turn-off at 08.30 for both days.
- For Field visits, three vehicles will be provided, one from BASICS, one hired and one from USAID which will be used by Catherine.
- One person from MSH and Catherine from USAID will accompany the consultants to Blantyre.
- The team will split into groups when doing field visits.
- Joe Kumadzulo of BASICS will go with Greg.
- For the trip to Blantyre, there will be two hired vehicles, 1 from BASICS, 1 from USAID.
- Much as Kim wanted to meet with Clinton Hunter Foundation, it has not been possible to make appointment so too for the Liaison officer for transport in the MOH.
- There is a separate list of all people met by the consultants during the evaluation.

APPENDIX D. MALAWI BASICS TRAINING DATA BY QUARTER – FROM OCTOBER 2007 TO DECEMBER 2009

FY			FY 08					FY 09					FY 10	
No	**Training**	**Definition**	**Qrtr 1**	**Qrtr 2**	**Qrtr 3**	**Qrtr 4**	**Total**	**Qrtr 1**	**Qrtr 2**	**Qrtr 3**	**Qrtr 4**	**Total**	**Qrtr 1**	**Total**
	Accelerated Child Survival and development (ACSD)													
1	HSAs trained in CCM	Full package of training related to CCM – major childhood diseases – fever, pneumonia, diarrhea, malnutrition. Includes theory and practical components (review of symptoms and signs related to important childhood diseases).	0	0	54	28	82	99	67	20	49	235	78	**395**
2	HAS Supervisors trained in CCM		0	0	0	0	0	0	0	0	0	0	32	**32**
3	Health Workers trained in Facility-based IMCI	District level health staff trained to provide mentoring support to facility level staff in management of childhood illnesses	0	0	0	0	0	0	0	38	0	38	0	**38**
4	HSAs trained in M&E	Training aimed at introducing providers to the components of data collection for CCM – completion of register, compilation of data.	0	0	0	0	0	19	0	0	0	19	100	**119**
5	HSAs trained in drug management	As above – emphasis on implementation of logistics system and drug management within the village clinic – storage, First In – First Out principles, etc.	0	0	0	0	0	39	0	0	20	59	0	**59**

FY			FY 08					FY 09					FY 10	
No	**Training**	**Definition**	**Qrtr 1**	**Qrtr 2**	**Qrtr 3**	**Qrtr 4**	**Total**	**Qrtr 1**	**Qrtr 2**	**Qrtr 3**	**Qrtr 4**	**Total**	**Qrtr 1**	**Total**
6	HSAs trained in HII for ACSD	High Impact Interventions cover the 12 child health interventions defined in the Lancet some years ago. This includes CCM but also aspects such as nutrition, use of ITNs, etc.	0	0	24	30	54	90	0	0	0	90	0	**144**
7	Health workers trained as trainers in ACSD	Trainer of Trainer model whereby in each district a cadre of HWs trained to conduct district level training. Follows IMCI model.	0	0	40	12	52	36	0	0	0	36	0	**88**
8	Health Centre Officers in charge trained in ACSD	This training important in terms of exposing Health Centre providers to the new developments in child survival as well helping them understand their own responsibility in terms of providing supervisory support, providing drugs and other support (receipt of referred children).	0	0	62	0	62	15	74	0	0	89	0	**151**
	Pediatric Hospital Initiative													
9	Health workers trained as trainers in PHI	Trainer of Trainer model – whereby TOTs trained in ETAT.	0	0	11	0	11	0	0	0	0	0	0	**11**
10	Health workers trained in PHI	HWs trained to provide emergency care as well as implement triaging system. Program has substantial practical focus.	0	0	30	89	119	62	209	29	52	352	293	**764**
	Community Based Management of Acute Malnutrition (CMAM)													
11	Nurses and clinicians trained in CTC	HWs trained to implement the CTC program at facility level – identification of malnourished children per defined criteria, identification of children with	0	33	0	0	33	79	55	0	15	149	0	**182**

FY			FY 08					FY 09					FY 10	
No	**Training**	**Definition**	**Qrtr 1**	**Qrtr 2**	**Qrtr 3**	**Qrtr 4**	**Total**	**Qrtr 1**	**Qrtr 2**	**Qrtr 3**	**Qrtr 4**	**Total**	**Qrtr 1**	**Total**
		complications related to the malnutrition as well as the provision of care for these children.												
12	Extension Workers and HSAs trained in CTC	As above – aspects relevant to extension workers and HSAs (most of the follow up care at facility level).	25	0	70	0	95	46	36	76	11	169	20	**284**
13	Volunteers trained in CTC	As above – aspects relevant to volunteers(community level screening and follow up).	0	51	0	0	51	201	194	0	60	455	60	**566**
14	Health workers and program coordinators trained in Nutrition M&E		0	0	0	0	0	0	0	0	0	0	170	**170**
15	Refresher - Volunteers	To refresh volunteer knowledge and skills for quality of services	0	75	0	0	75		62			62	87	**224**
	ART and Palliative Care (Excluding TB/HIV)													
16	Health Workers trained to deliver Cotrimoxazole	HWs trained to provide CPT to HIV Positive persons including the documentation procedure.	0	0	0	0	0	20	124	218	102	464	129	**593**
	Pediatric HIV Capacity Enhanced													
17	Number of health workers oriented in Pediatric HIV/AIDS	This is an training based on providing non-providers of HIV services (those not doing PMTCT or ART service provision) with a brief but comprehensive overview of important aspects of HIV service provision).	0	0	56	0	56		42	117	66	225	148	**429**
18	Number health workers oriented on new ART		0	0	0	0	0	0	0	14	31	45	389	**434**

FY			FY 08					FY 09					FY 10	
No	**Training**	**Definition**	**Qrtr 1**	**Qrtr 2**	**Qrtr 3**	**Qrtr 4**	**Total**	**Qrtr 1**	**Qrtr 2**	**Qrtr 3**	**Qrtr 4**	**Total**	**Qrtr 1**	**Total**
	guidelines													
	Essential Nutrition Actions (ENA)													
19	Community Members trained as MFSG facilitators	MFSG facilitators have been trained to implement ENA at the community level – this includes a broad range of topics – GMP, nutrition and the sick child, aspects of maternal health and PMTCT.	0	0	12	185	197	127	0	98	0	225	0	**396**
20	# HWs trained on new ANC and maternity registers			0	0	0	0	0	0	0	0	0	3,002	**3002**

ANNEX E-1. CATCHMENT AREAS FOR POPULATION COVERED OF CHILDREN UNDER 5 IN 8 BASICS DISTRICTS

District & Village Clinic		Catchment Population	Pregnant Women	Children Population		No. of Villages	No. of HouseHolds	Catchment Area has up-to-date:		No. of Active Village:	
				Under 5	Under 1			Map	Monitoring tool	Health Committees	Development Committee
Chikwawa											
Dulasanje		2123	106	137	56	4	646	Yes	Yes	2	0
Kabwatika-Chithumba		1062	53	180	53	6	212	No	No	5	1
Kazimbi		2797	130	622	132	5	566	No	Yes	1	5
Mpheza-Chipwaila		6218	310	1057	310	15	918	No	No	9	2
Pende		2064	750	326	62	6	500	No	No	6	6
	Kasungu										
	Kaphaizi	4718	236	803	236	44	617	No	Yes	19	6
	Khakama	1399	70	238	70	19	334	Yes	Yes	3	0
	Mazi	3112	156	529	156	16	442	Yes	No	3	1
	Mitula	2461	152	557	152	63	580	Yes	No	14	1
	Mwezi	1495	75	254	75	31	NA	Yes	No	3	0
	Mangochi										
	Namaso-Bay	998	59	197	59	4	196	Yes	No	1	1
	Phalombe										
	Maholiya	2581	129	439	129	1	408	No	Yes	1	0
	Manyamba	1833	92	312	92	4	306	NA	Yes	2	0
	Mpata	3900	195	663	195	3	650	Yes	Yes	2	0
	Njobvo	1687	84	277	84	3	672	Yes	Yes	1	0
	Yohane	2410	120	410	120	3	274	No	Yes	1	1
	Total Villages	40858	2717	7001	1981						

District & Village Clinic		Catchment Population	Pregnant Women	Children Population		No. of Villages	No. of HouseHolds	Catchment Area has up-to-date:		No. of Active Village:	
				Under 5	Under 1			Map	Monitoring tool	Health Committees	Development Committee
	(16)										
	Av/pop per village	2150	143	368	104						
	Pop Under 5 covered by 518 village clinics			190,869							
	Pop Under 5 - 8 districts			778,029							
	% Children covered			25%							
	X Note - removed clinics where data incomplete. Still a few errors but reasonable approximation.										

Annex 2: Beneficiary population in project districts (drawn from BASICS DIP 2008).

	Balaka	**Chikwawa**	**Kasungu**	**Mangochi**	**Nsanje**	**Phalombe**	**Salima**	**Zomba**	**Total**		
Total population	**314,733**	**450,609**	**629,278**	**755,039**	**234,218**	**300,451**	**331,308**	**699,186**	**3714822**		
Population < 1	**14,437**	**19,858**	**30,709**	**33,344**	**10,595**	**14,913**	**20,805**	**30,437**	**175,098**		
Population < 5	**65,362**	**88,126**	**131,267**	**151,945**	**40,933**	**67,606**	**93,937**	**138,853**	**778,029**		
Women 15-49	**76,042**	**102,560**	**138,656**	**161,316**	**56,210**	**70,728**	**119,682**	**171,742**	**896,936**		

ANNEX E-2. HIV/AIDS

SUMMARY OF PMTCT AND HIV TA MENTORSHIP CONTRIBUTIONS AT MINISTRY LEVEL

Primary Activities of HIV Coordinator

1. Strengthen Ministry's coordination of health sector response to HIV/AIDS

Supports MoH in organizing regular technical coordination meetings, including TWG for HIV and AIDS, and subgroup for HIV Care and Treatment.

2. Support drug procurement for national HIV program

Responsible for ARV drug procurement quantification and supplies orders, conducting review of supply management system for HIV commodities (will present a reviewed plan in April 2010).

3. Support the ART program

From March 2008 to March 2009, supported roll out and management of national ART program. Ensured that quarterly supervision took place, reports were submitted in time, and ART and OI guidelines were reviewed and approved. Led review of 5-day ART training curriculum and implementation of a rapid feasibility appraisal of introduction of revised ART guidelines.

By end of December 2009, over 198,000 people on treatment in over 300 health facilities providing ART services in country.)

4. Support Head of HIV and AIDS Unit in MoH

Providing support on ongoing basis, by preparing presentations for meetings, reviewing and advising on proposals, organizing meetings, preparing reports and budgets.

5. Prepare long term plans and reports on state of HIV epidemic and the health sector response

Part of the core group that prepared the successful $375 million GFATM Rolling Continuation Channel proposal, member of team that negotiated the grant with FATM and reviewed proposal and budget after FATM requested 10T efficiency savings. Supported development of new National Action Framework, especially Care and Treatment Component. In 2009, worked on National Strategic Application (NSA) proposal to GFATM, especially on care and treatment component and budget. Coordinates preparations of reports to NAC, MoH, and GFATM.

6. Support Increased MoH capacity in supply management

This year the total value of HIV supplies will exceed US $35 million. Management of supplies is increasingly complicated and time consuming. Existing staff in the HIV Unit need to be strengthened with one dedicated staff for HIV supply management.

7. Challenges

Although number of staff in HIV Unit has increased (currently 15), 7 are non MoH staff (TAs and fellows), and all MoH staff are on secondment from other units, districts and hospitals, as the Unit has not yet been formally established.

Primary Activities of PMTCT Coordinator

1. **Provided strategic direction to achieve national PMTCT coverage, provision of comprehensive PMTCT, inclusion of pediatric HIV services to national PMTCT program and improvement of data collection through following activities:**

   - Authored Six Month PMTCT Scale Up Plan for April to September 2007 and the 15 Month PMTCT Acceleration Plan for April 2007 to June 2008. These plans were implemented simultaneously.
   - Authored first draft of PMTCT Guidelines in July 2007, revised them to incorporate comments from PMTCT and Pediatric HIV Care Sub-Group.
   - Devised a PMTCT service data collection system and form in the absence of national monitoring tools and system. BASICS staff assisted the MoH to collect and enter quarterly data. Data shared with NAC, UNICEF, CDC and partners who requested it.
   - Procured from UNICEF vehicles, computers, printers and LCD projectors for the HIV unit.
   - Revised and edited the Five Year Scale Up Plan for 2008-2018 initially written by a Washington, CD based BASICS consultant, and incorporated comments from the PMTCT and Pediatric HIV Care Sub-Group. Obtained funding from the Clinton Foundation to print copies of the plan.
   - In 2007, suggested HIV indicators to be included in the revised ANC and Maternity Registers and Women's Health Passport.
   - Developed partnership with UNICEF on expansion of PMTCT program to achieve national coverage. Obtained funds from UNICEF, formed partnership between MoH, BASICS, MSH and UNICEF. Agreement developed between UNICEF and MSH for the latter to coordinate national training of service providers to roll out PMTCT services. Partners worked together to implement and monitor the quality of simultaneous trainings held in zones.
   - Applied and advocated to utilize the total quality management (zonal training strategy) approach to train 1,800 health workers in eight months to expand PMTCT services in the country. The same approach is used to train service providers to roll out combination regimen and capacity building of PMTCT and Safe Motherhood Coordinators through mentorship meetings.
   - Contributed to the Early Infant Diagnosis (EID) pilot in north and central regions, and advocated use of lessons learnt from these regions to start rolling out EID in south region rather than continue with the pilot.
   - Obtained funds from UNICEF for combination regimen training.
   - Provided TA to develop the PMTCT refresher training package.
   - Contributed to development and editing of Pediatric HIV Care Manual for frontline health workers. Most of the content in this manual has been included in the revised pediatric HIV care module in the refresher training package.
   - Provided TA during development of DMPA policy document and training manual by RHU and MSH. Edited the DMPA policy document.
   - Contributed to technical policy decisions by the FP Sub-Group, RH TWG, and Maternal Audit Committee at RHU.
   - Reviewed research and funding proposals for USAID.

- Advocated for establishment of district level samples transportation system for CD4 and DBS samples for HIV positive pregnant women and exposed and infected infants/children.
- Developed pediatric HIV Care scale up plan 2009-2013; this is an addendum to the Five Year PMTCT Scale Up Plan 2008-2010.

2. Provided management support to former Head of HIV and AIDS Unit and national PMTCT Coordinator through meetings, information sharing on working with cooperating partners' systems, and lobbying on important interventions and management issues. Key results include:

- Placement of M&E TA in HIV and AIDS Unit to improve data collection, establishment of an integrated database for HTC, PMTCT, ART, and later STI indicators.
- Acceptance of the Fellowship Program in the Unit.
- Assistance with MOUs for Clinton Foundation, M2M and EGPAF. Originally, MOUs were approved by the Treasury; through successful lobbying, they are now approved by MoH.

ANNEX E-3. MALAWI BASICS PROJECT HIV RELATED STRENGTHS, CHALLENGES AND RECOMMENDATIONS

(See report section for overall Strengths and challenges)

STRENGTHS BY DISTRICT:

Kasungu

Has excellent relationship with BASICS: "BASICS has been central in leading our achievements in child health services."
Male championship program encourages men to accompany wives to ANC clinic; we observed 4 or 5 husbands waiting outside, and 2 inside waiting for couples counseling and testing.
3 HTCs at hospital; third counselor focuses on testing children in Under 5 clinic and pediatric ward.
Under 5 clinic has excellent ETAT system; triage provider stamps child passport and circles needs for priority attention.
PMTCT program at Chamwabvi Community Health Center gives food supplements for HIV exposed babies until they are 18 months old and get a rapid test.
Quality control visits taking place for accuracy of HIV rapid test results.

Salima

23 PMTCT sites in district, doing CD4 counts for positive mothers, fast turnaround for CD4 testing.
BASICS supports PMTCT review meetings, pediatric HIV services review.
Facility based testing strong in this district (1,600 males tested, 15% positive; 7,190 females tested, 12% positive).
Village to village testing going extremely well. Have conducted testing at 30 villages, other villages are asking to be included; are encouraging whole families, adults and children, to test together.
ANC clinic located next to Under 5 clinic for good cross referrals.
Hospital has an HTC room in every clinic! except for Under 5 clinic, but HTC room well situated to accommodated both ANC and Under 5 clinics.
Changing over to combination therapy for HIV positive pregnant women.
PITC is happening in this hospital; they are also testing patients in the wards, including pediatric ward.
5 health centers in this district are also providing ART.
Sick patients being referred to a nearby palliative care program that supports 200 pts including 10 children. (This palliative care program is well known and highly regarded in Africa.)

Chikwawa

Project has oriented 128 health workers on CPT guidelines at 16 health facilities (all but private or CHAM facilities). Also provided CPT cards and registries for same number of facilities.
Strong community sensitization has yielded increased uptake of HTC for children (however has not been sustained).
Hospital tracks HIV exposed children through NRU; keeping good records, starting nutrition cooking classes for mothers.
Providing PCR testing for HIV exposed children.
M2M support group at NRU clinic meeting twice a month.
Reportedly positive support groups exist in district, one facilitated by hospital with over 40 members at nearby primary school, but no apparent list of these groups for patient referral.
District is using combination therapy for PMTCT.
District is seeing a higher adult ART return rate.
District is using revised women's health passports.
District is engaging HSAs to assist with ART and pediatric ART defaulter follow up.
Hospital is conducting mobile HTC services; are testing adults and children.
3rd HTC counselor is working in ART clinic, different from other hospital testing set ups. People are coming both to test and initiate ART.
ANC/FP/HTC/Under 5/ETAT all happening in same location, very good cross referrals.

Phalombe

Strong focus on MIP follow up and nutritional counseling, promoting a continuum of care up to 2 years of age at both health facility and community levels (MFSG).
Support groups for positive mothers based on age of infants has good attendance (this model is different from M2M, each mother asked to bring guardian on 2nd visit).
WFP is distributing food supplements to HIV positive women and women on ART, linked with support groups for positive mothers.
District using combination regimen for PMTCT.
District accesses PCR test due to proximity to Blantyre (Queen Elizabeth Hospital), takes samples weekly.
ANC/PMTCT/HTC rooms are side by side in same building for easy cross referral.
ART outreach is happening at 3 sites.

Balaka

DHMT pleased with collaboration with BASICS in planning the DIP.
Using combination therapy for PMTCT.
This district having better success rate with mothers returning with children on pediatric ART; use HSAs and M2M mentors to find women who don't return.
They are doing pediatric ART outreach.
Doing CD4 counts for children at 18 months.

Providing RUTF for malnourished mothers.
Adults initiating ART first get group education session.
Reportedly people in district fairly open about HIV status, have been many community sensitizations and coordination among NGOs.
ANC/PMTCT/Under 5 clinics next to each other for easy cross referral and tracking.
Kalemba Health Center reports that most positive eligible mothers start ART, also reports a good return rate for pediatric ART. (BASICS provided trainings on pediatric ART guidelines and also a pediatric ART orientation module. Baylor has also providing mentoring.)

CHALLENGES BY DISTRICT:

Kasungu

Hospital has encouraged women to deliver babies in hospital rather than with TBA; 17 beds in L&D, about 50 women waiting to deliver, many lying on floor (this doesn't directly pertain to BASICS activities, but has implications for ability to test infants of known HIV pos mothers if they decide not to come to hospital because of too few beds).
Only 1 provider managing multiple clinics at Chamwabvi Health Center.

Salima

ART is happening in the TB ward due to lack of space. Hospital needs a separate ART space.
Seeing cervical cancer and KS in HIV positive people. Limited ability to treat.
HIV positive mothers may return at 6 weeks for immunizations but not for PCR. (If these services are integrated, more likely to catch these infants for testing when they are at clinic).
Reportedly Khombedza health center staff includes 2 medical assistants and 4 nurses, but at our visit all were absent except for 1 nurse.
Nurse tell us that of 40 to 60 pregnant women, maybe 20 to 25 will go for HTC (different from what we heard at hospital, where 95% of women were agreeing to be tested)
Health center experiences stock outs of CPT and pediatric syrups.
At Kajoli Village to Village counselors had run out of test kits; testing delayed while they returned to health center for more. May need assistance in estimating # of kits to take for entire day of testing.

Chikwawa

Rapid test kits stock outs.
Geographic constraints (game reserves, large river) create supervisory site visit challenges in the north.
No visible list of support groups for positive patients. Positive teens are asking for a support group.
Not much couples testing happening yet.
Many pediatric ART children not coming back.
No food services, other than NRU, to help positive mothers.

Phalombe

Confusion about breastfeeding messages, positive mothers are starting mixed feeding right away.
Mothers in communities have heard 'stop breastfeeding' messages so mothers who don't know their status are stopping, mothers of babies who are already positive have been told to stop breastfeeding.
One old CD4 machine keeps breaking down, can't meet test needs, relying largely on clinical staging.

Balaka

No PCR capability, shortage of rapid test kits.
Male involvement with PMTCT not yet happening although being encouraged.

ANNEX E-4. MALARIA GRANT RECIPIENT CHART

	Grant Recipient	Grant Cycle	Location	Grant Period	Remarks
1	CCAP Livingstonia Synod- Health Department	Cycle 1	Chitipa District	June 2008-August 2009	Includes three months no cost extension
2	World Medical Fund	Cycle 1	Nkhotakota District	June 2008-August 2009	
3	Malawi Red Cross Society	Cycle 1	Dowa District	June 2008-August 2009	
4	Development Aid from People to People (DAPP)	Cycle 1	Zomba District	June 2008-August 2009	
5	St John Ambulance malawi	Cycle 1	Blantyre Urban -poor communities	June 2008-August 2009	
6	Project Hope malawi	Cycle 1	Mulanje District	June 2008-August 2009	
		Cycle 1	Phalombe District	June 2008-August 2009	
7	COOPI	Cycle 2	Salima District	August 2009- July 2010	
8	Sue Ryder Foundation Malawi	Cycle 2	Balaka District	August 2009- July 2010	
9	Development communication Trust- (DCT)	Cycle 2	Chiradzulu District	August 2009- July 2010	
10	Malawi Red Cross Society	Cycle 2	Kasungu District	August 2009- July 2010	
11	CCAP Livingstonia Synod- Health Department	Cycle 1 Extension	Chitipa District	January 2010-December 2010	
12	Malawi Red Cross Society	Cycle 1 Extension	Dowa District	January 2010-December 2010	
13	Development Aid from People to People (DAPP)	Cycle 1 Extension	Zomba District	January 2010-December 2010	
14	Project Hope malawi	Cycle 1 Extension	Mulanje District	January 2010-December 2010	

Evangelical Lutheran Development Service	Cycle 3	Dedza, Karonga Districts	April 2010 - May 2011	
Circle for Community Development	Cycle 3	Ntchisi District	April 2010 - May 2011	
COOPI	Cycle 3	Lilongwe District	April 2010 - May 2011	
Anglican Diocese of Southern Malawi	Cycle 3	Chikhwawa, Nsanje Districts	April 2010 - May 2011	
Development Aid from People to People	Cycle 3	Blantyre, Thyolo Districts	April 2010 - May 2011	
CPAR Malawi	Cycle 3	Nkhata Bay, Likoma District	April 2010 - May 2011	
Nauzikambe	Cycle 3	Mwanza, Nemo Districts	April 2010 - May 2011	
COOPI	Cycle 2 extension	Salima District	August 2010 - July 2011	Subject to satisfactory performance & need
Sue Ryder Foundation Malawi	Cycle 2 extension	Balaka District	August 2010 - July 2011	
Development communication Trust-(DCT)	Cycle 2 extension	Chiradzulu District	August 2010 - July 2011	
Malawi Red Cross Society	Cycle 2 extension	Kasungu District	August 2010 - July 2011	

ANNEX E-5. IMPLEMENTATION STATUS OF THE RECOMMENDATIONS FROM THE 2009 ESSENTIAL NUTRITION ASSESSMENT

Most of the recommendations from the Essential Nutrition Action Assessment of August 2009 are either in progress or planned for completion at the writing of this evaluation. Below is the status of each recommendation:

1. a. BASICS provided weighing scales to all 31 villages in program area per the recommendation. The project also provided an additional x scales in xx district above and beyond the recommendation. In an effort to resolve the stockouts of health passports, BASICS has procured health passports which are now stored at the district office. They will be distributed to each child who does not have one shortly after BASICS has completed the mentoring training. It is scheduled for March 22 through April 1st.

b. BASICS has completed the design of its community counseling cards and the pre-test will be completed by April 2010. In an effort to standardize materials used by NGOs in Malawi, the MOH will review the BASICS and WALA community counseling cards and will decide which of the two will be selected as the national community counseling cards.

c. The re-design of the Monitoring and Evaluation System to include proposed key indicators as specified in the ENA Assessment is currently in progress. BASICS plans to complete the M and E system by the end of May 2010.

d. One meeting was held on Dec 10-11, 2009 to orient stakeholders at the central and district levels for their input on the design of the community-based tools and approaches for ENA.

e. Training/pre-test on the utilization of the above mentioned counseling cards and tools is scheduled to begin on March 22 through mid-April 1, 2010. Facilitators and HSAs from the 19 villages of the program area will be targeted for this training to implement the changes to strengthen the program.

2. Jessica Tilahun has been contracted as a short-term external consultant to provide continuous support over the next two years in the areas of technical input for the counseling materials and scaling up the program. She began on March 15, 2010 until April 27, 2010 and will be coming on a needs basis until end of project.

3. Inventory of existing outreach clinics and volunteers that assist HSAs with growth monitoring has been completed. There are 84 outreach sites and 4000??? volunteers in Phalombe and 52 outreach clinics in Zomba with XXXX volunteers.

MEDIUM PRIORITY

1. The planning tool to prioritize home visits based on nutritional risk will be introduced to facilitators and HSAs beginning March 22, 2010 with the role out of the training.

2. The orientation of health facility staff and facilitators to a strengthened system of referrals and counter referrals will also take place beginning March 22, 2010.

3. Supportive supervision has been designed at this time and will be introduced for the DHO to use with HSAs and for HSAs to use with facilitators working in nutrition beginning March 22, 2010.

4. Dissemination workshops took place at three levels: in November 2009 at the district level (dhmt, facilitators, village head and hsa) and on January 21st, 2010 to disseminate the *Assessment*

of USAID/BASICS' Community Essential Nutrition Actions Program in Malawi at the national level. The goal was to inform and advocate the MOH and UNICEF to effectively quantify and provide vitamin A and iron/folic acid micronutrients to health facilities to eliminate stock outs. To date, health facilities utilized the balance of vitamin A remaining from the Child Health Days (which targets children) campaign to supplement post-natal mothers at the facility level. As this was done ad-hoc, stock outs were commonplace.

5. March 2010 was the period when all the above program improvements were scheduled to have been implemented. As specified, most of the improvements are commencing beginning March 22, 2010. The delays can be explained by: a) the time needed to design and develop counseling and community-based training tools for growth monitoring and promotion and ENA; b) the translation of the materials in local language; and the MOH's request that NGOs not develop their individual manuals because WHO and the MOH are currently in the process of adapting a standard manual for use by all actors, agents and NGOs conducting community-based activities in the country.

6. Also in March 2010, after assessment of implementation results from above recommendation (if found to have a positive impact on weight gain and nutritional status), BASICS plans to scale up to the entire district of Phalombe District and the catchment area of Bimbi health center (52 villages). The reason of limiting to this catchment area to see impact in the intervention zone and the non-intervention zones. However, due to the delays resulting from materials development and consequently capacity building and implementation, there are no quantitative results available to assess the impact of the ENA program at the time of the mid-term evaluation (also taking place from February17 through March 23, 2010).

LONG-TERM EXPANSION PHASE IN PHALOMBE AND ZOMBA (APRIL 2010-JUNE 2011)

1. As mentioned earlier, the delays incurred may also have a domino effect on the long-term expansion phase recommendations. Most activities related to scale up are not on schedule to take place at the writing of this evaluation. Revisions to update the HSA Community ENA Training Manual and the Facilitator's Guide with the new tools and program changes have not yet taken place and are planned for after materials and trainings are completed.

2. An evidenced-based necessity for expansion phase has not yet been determined due to delays in implementation. Hence new volunteers and HSAs have yet to be identified and trained.

3. Maternal and infant and young child nutrition counseling corners have not been established in the health centers to be identified for expansion.

4. The follow-up of all mother-infant pairs across the continuum from pregnancy through two years of age (to better address infant feeding advice and the special needs of HIV infected mothers and exposed children) has not been implemented. At this time, only the HIV-infected are followed up.

5. At the writing of this evaluation, health centers and HSAs still utilize the two existing registers namely a) Under one children register and b) under 5 children registers. According to the BASICS Community Health and Nutrition Advisor, the revision of the registers is the Ministry of Health's responsibility. However, BASICS plans to develop a community register for the project which can serve as a pilot and the results can be utilized to advocate for the modification of the under 1 and under 5 registers.

6. The policy dialogue with MOH to target and focus on weighing children under two years of age (rather than all children under 5) will take place after results from the recommendation above (number 5) shows the critical importance of weighing under twos where a difference can be made in growth and nutritional status.

For more information, please visit
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Global Health Technical Assistance Project
1250 Eye St., NW, Suite 1100
Washington, DC 20005
Tel: (202) 521-1900
Fax: (202) 521-1901
www.ghtechproject.com