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Mid-term Evaluation of Chifundo Project

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Project Delivered by:
EMMS International
Palliative Care Association of Malawi
Palliative Care Support Trust
Mulanje Mission Hospital
Nkhoma Mission Hospital
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Purpose of the report

The purpose of this report is to measure the mid-term indicators of Chifundo's intended Impact, Outcome and 4 Outputs, to compare these with Chifundo's baseline survey indicators and 3-year targets, and to write a report including recommendations of any changes needed to achieve these 3-year targets.

Biography of author

Jonathan Mbuna

Jonathan Mbuna is a Management Development Consultant who is currently working with Pakachere IHDC supporting the Advocacy and Training Unit. Holding a Masters Degree in Health Administration and a Bachelor's degree in Social Sciences, Jonathan has worked with the Ministry of Health in Malawi as a Health Administator and Health Planner. He also worked with Malawi Institute of Management (MIM), Malawi's premier institution in training senior civil servants, as a Management Development Consultant.

He has conducted various consultancies in Malawi, Tanzania, South Africa and DRC with both local and international NGOs. He is a facilitator and lecturer.

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Executive Summary

With a budget of £994,095, Chifundo is a 3-year project implemented in 28 districts of Malawi from mid-2018 to mid-2021. It is funded by the UK's Department for International Development (DFID) which contributes £846,248 and UK trusts (True Colours and 4 more) which contribute the remaining £147,847. The 5 Malawian partners are: Palliative Care Suport Trust (PCST), Palliative Care Association of Malawi (PACAM), David Gordon Memorial Hospital (DGMH), Nkhoma Mission Hospital (NMH) and Mulanje Mission Hospital (MMH). This project was designed to address the needs of poor families in hard-to-reach, rural Malawi, served by poorly resourced health facilities, but increasingly needing palliative care due to increased incidence of cancer and other life-limiting diseases at this stage in the AIDS epidemic, and due to projected increases in Non-Communicable Diseases (NCDs). Chifundo is to reach 9,965 families (59,790 people) in catchments of 26 mainly rural or hard-to-reach health facilities and all 4 Central Hospitals of Malawi. Beneficiaries are to receive holistic palliative care and be referred to relevant help with food provision. The project's goal is in line with the Malawian government's strategic frameworks including the Health Sector Strategic Plan and National Palliative Care Policy. Both AIDS and NCDs eventually require palliative care, a holistic intervention providing pain relief, symptom treatment, and psycho-social and spiritual support to whole families, preparation for a dignified death and bereavement services. Chifundo is designed to spread such care to hard-to-reach and rural areas, adding an emphasis on nutrition. A mid-term evaluation was commissioned in 2020 to measure mid-term indicators of Chifundo's intended Impact, Outcome and 4 Outputs and compare them with the baseline survey and 3-year targets.

By March 2020, the project had reached 7,288 palliative care patients: 3,965 female (54%), 3,323 male (46%), against the June 2020 Year 2 target of 7,425, in catchment areas of 26 rural or hard-to-reach health facilities and 4 Central Hospitals. This Year 2 target is therefore almost achieved already. The project has supported 20 health facilities evenly spread over Malawi to pass APCA. The target for June 2020 is 22 and so progress is on target. Thus 20 health facilities are providing good quality, free palliative care by adequately trained staff offering all needed drugs 90% of the time and adequate psychosocial care to all families in need in their catchment areas. These 20 facilities include all 4 Central Hospitals. 14 of the 26 mentee facilities are running demonstration agriculture training to improve nutrition & food security; the Year 2 target by June 2020 is 10, and therefore is already exceeded.

The evaluation identified some matters requiring strengthening or attention:-

a. Weak project and data management by DGMH; very low DGMH patient recruitment
b. Rural patient numbers sparead over several facilities - pay attention to continue growth
c. Risk: government recruiting staff for COVID-19 may drain palliative care-trained staff
d. Weak use of participation tools by mentees

The evaluation recommended the following:-

1. Strengthen project management in DGMH area; emphasise DGMH patient enrolment
2. Encourage mentees to use Community Health Action Groups to reach more patients
3. Continue to train health workers by completing clinical attachments of those trained
4. Encourage mentee facilities to conduct interviews with clients, during and after care
5. Strengthen data and information management in all facilities.

Introduction

Project background

With a budget of £994,095, Chifundo is a 3-year project implemented in 28 districts of Malawi from mid-2018 to mid-2021. It is funded by the UK's Department for International Development (DFID - £846,248) and UK trusts (True Colours and 4 more - £147,847). The 5 Malawian partners are: Palliative Care Suport Trust (PCST), Palliative Care Association of Malawi (PACAM), David Gordon Memorial Hospital (DGMH), Nkhoma Mission Hospital (NMH) and Mulanje Mission Hospital (MMH). Chifundo is to address needs of poor families in hard-to-reach, rural Malawi, served by poorly resourced health facilities, increasingly needing palliative care due to increased incidence of cancer and other life-limiting diseases at this stage in the AIDS epidemic, and due to projected increases in Non-Communicable Diseases (NCDs). Chifundo is to reach 9,965 families (59,790 people) in catchments of 26 mainly rural or hard-to-reach health facilities and all 4 Central Hospitals of Malawi. Beneficiaries are to receive holistic palliative care and be referred to relevant help with food and agriculture. Chifundo's goal is in line with the Malawian government's strategic frameworks including the Health Sector Strategic Plan and National Palliative Care Policy. Both AIDS and NCDs eventually require palliative care: pain relief, symptom treatment, and psycho-social and spiritual support to whole families, preparation for a dignified death and bereavement services. Chifundo adds an emphasis on nutrition.

Chifundo targets both demand for palliative care (patients) and supply (providers). PCST's role is to mentor 3 government Central Hospitals to Level 3 (tertiary or specialist) and 4 CHAM facilities to Level 1 (primary) or Level 2 (intermediary). Central hospitals are: Mzuzu Central Hospital (MCH) in the North, Kamuzu Central Hospital (KHC) in the Centre and Zomba Central Hospital (ZHC) in the South. PCST is based in Queen Elizabeth Central Hospital (QECH) in the South, which it long ago mentored to Level 3. PCST mentors CHAM facilities Utale Health Centre in Machinga, Malamulo Mission Hospital in Thyolo, Tsangano Health centre in Ntcheu and Lulanga Health Centre in Mangochi. PCST also trains all health and social providers in Chifundo, including arranging clinical attachments for health workers.

PACAM audits all new facilities and conducts national and district advocacy. Since most facilities in Chifundo are CHAM facilities, PACAM engages in advocacy with District Health Offices (DHOs) and MoH to resource these facilities and have DHOs' Service Level Agreements (SLA) include palliative care. PACAM thus contributes to sustainability.

DGMH, NMH and MMH are 'hubs' to mentor selected health centres or community hospitals to Level 1, support mentee facilities in agriculture training, upgrade their palliative care rooms and provide their own model service. DGMH in Rumphi mentors 3 CHAM facilities in the North: Atupele in Karonga, Chilambwe in Nkhata Bay and Kaseye in Chitipa. Thus in the North, 4 districts have a CHAM facility with palliative care, Mzimba has Mzuzu Central Hospital mentored by PCST and PCST has trained Likoma staff, totalling 6 districts.

NMH, in Lilongwe District, mentors 6 facilities: Mtendere Community Hospital in Dedza, Mvera Health Centre in Dowa, Chinthembwe Health Centre in Ntchisi, Liwaladzi Health Centre in Nkhotakota, Kapiri in Mchinji, and Nkhamenya Health Centre in Kasungu. In Central Region, PCST also mentors Kamuzu Central Hospital and St. Gabriel in Lilongwe District, Tsangano in Ntcheu and Ndi Moyo in Salima, thus covering 9 Central districts.

MMH mentors 6 facilities: Makapwa Health Centre in Thyolo, Thambani Health Centre in Mwanza, Trinity Mission Hospital in Nsanje, Montfort Mission Hospital in Chikwawa, Chilinga Health Centre in Phalombe and St. Luke's Mission Hospital in Zomba. Between MMH and PCST, all 13 Southern districts are covered.

Country Background

Malawi's population is 18 million (13 million in 2008) (2018 Population and Housing Census). The growing population brings many challenges in all social sectors. Most socio-economic indictators demonstrate clearly that the country is among the poorest in the world. Life expectancy at birth is 64 (2018 Population and Housing Census) while the national poverty rate increased slightly from 51% in 2010 to 52% in 2016, although extreme national poverty decreased from 24% in 2010/11 to 20% in 2017. Almost every year since 2017, the government has announced increases in financial allocations to health, but on the ground there is usually a decrease. In 2019, government allocated a budget of K101 billion, 13% higher than the 2018/19 approved figure of K90 billion. K26 billion was allocated to procurement of drugs, of which K11 billion for central and K15 billion for District Hospitals. But by the time of this mid-term review, K11 billion was disbursed for other recurrent transactions (ORT) and K26 billion fell to K13 billion. Budgeted construction of the Military Hospital, Blantyre District Hospital, Balaka Referral Hospital and Mponela Community Hospital had not started and Phalombe District Hospital was far from complete. Thus the health sector faces critical challenges ranging from provision of quality services to access to healthcare. The system continues to experience shortages of essential medical products and technologies. The Health Sector Strategic Plan II attributes this mainly to inadequate funding, weak supply chain management and irrational use, leakage and theft of medicines. While the Constitution of the Republic of Malawi states that the State is obliged "*to provide adequate health care, commensurate with the health needs of Malawian society and international standards of health care*", access remains a challenge. While Malawi was developing the current HSSP in 2017, only 90% of the population lived within an 8km radius of a health facility, indicating an underserved proportion of the population living in rural and hard-to-reach areas. 56% of Malawian women cite distance to health facility as a key barrier to healthcare. *Universal Health Coverage* is a key theme in the 2017-2022 HSSP, but challenges accessing basic healthcare are critical for patients on palliative care. 11% of Malawians (1.8 million) live with HIV[1], which aggravates incidence of cancers such as cervical and Kaposi sarcoma[2]. Recent increases in these plus oesophagal cancer contribute to over 8,151 new cases of cancer in Malawi annually: incidence of cancer increased between 2002 and 2010 in women from 29 per 100,000 population to 69, and in men from 31 to 56.[3] The WHO estimates that 1% of Africans need palliative care, such that by 2021, amongst the 18 million population of Malawi, 180,000 patients and families will need this care. With 80-85% of the population being rural, about 153,000 of these patients live in rural areas. Including family members, 918,000 rural Malawians will need palliative care by 2021. These are amongst the poorest people in the world: living in a poor country (170th of 188 countries by living standards[4]), impoverished by disease[5], lacking access to relief during food crises, and cut off from basic healthcare. Food crises affect palliative care families badly because patients need food for medicines to work, poverty worsens their food status, and anecdotal evidence indicates that such families miss out on food distributions, unable to attend distribution sites and lacking social capital to appear on beneficiary lists.

[1] Office Malawi National Statistical: Demographic Health Survey 2010 National Statistical Office: Zomba; 2011.

[2] Cancer affecting skin and organs: http://www.nhs.uk/conditions/Kaposis-sarcoma/Pages/Introduction.aspx

[3] https://bmcresnotes.biomedcentral.com/articles/10.1186/1756-0500-5-149

[4] http://hdr.undp.org/en/countries

[5] EMMS mid-term report of its previous palliative care project in Malawi, METHOD

Purpose and scope of the mid-term evaluation

The purpose of the mid-term evaluation is:-

a. To establish the status of Chifundo's indicators halfway through the project,
b. To compare these with the baseline survey and 3-year targets
c. To recommend changes to achieve these targets

Scope and deliverables

The scope is to measure the mid-term indicators of Chifundo's intended Outcome and 4 Outputs, to compare these with Chifundo's baseline survey indicators and 3-year targets, and to write a report including recommendations of changes needed to achieve the 3-year targets.

Methodology and limitations

The evaluation used complementary methods of data collection for generating evidence. These methods were meant to collect quantitative and qualitative data. The data was collected from various sites and respondents based on the sampled population. Using a purposeful sampling technique, the evaluation was to visit three types of sites: health centres, community hospitals and Central Hospitals. However, due to COVID this did not materialise.

Sampling:

The sampling design was purposive based on the project design. From the TOR, the evaluation was to target all 5 implementing partners and visit at least 5 health facilities, view all premises relevant to palliative care, interview and hold discussions with staff working in palliative care, talk to patients, family members, home-based care volunteers and others relevant to palliative care, such as Traditional Authorities, spiritual leaders and social workers and assess the facility's status against Chifundo baseline and target indicators. Since the health facilities ranged from Level 1 on African Palliative Care Association (APCA) standards to Level 3, a decision was made that the facilities had to be representative of these levels. Secondly because these facilties are across the 3 regions of Malawi, attempts were made to have every region represented. That meant that the sampling had to be purposeful.

Evaluation sites

The evaluation was conducted in 6 districts (Rumphi, Karonga, Lilongwe, Dedza, Mulanje and Phalombe) but only 3 health facilities. The plan was to visit 6 sites (the TOR said 5), to ensure that every category of health facility was represented: 2 health centres (Chilinga (Phalombe) and Tsangano (Ntcheu)), 2 community hospitals (Atupere (Karonga) and Mtendere (Dedza)), and Zomba Central Hospital plus St. Luke's Hospital, also in Zomba. However, what eventually happened was that in Karonga the visit was made to Atupele Community Hospital (DGMH's mentee), which had just started offering palliative care services, in Dedza the visit was made to Mtendere Community Hospital which had been offering services for some time (NMH mentee), and in Phalombe a visit was made to Chilinga Health centre (MMH mentee). Tsangano and Zomba Central Hospital (PCST mentees) and St. Luke's (MMH) were not visited, due to the risk of spreading COVID-19.

The table below summaries the evaluation sites sampled in the 6 districts:

CATEGORY	SITES	SAMPLED	% REPRESENTATION	VISITED
Health centres	13	1	7%	1
Community hospital	3	2	66%	2
Central Hospital	3	0	0	0
Mission Hospital	1	0	0	

Components of the evaluation

This evaluation had 2 components: quantitative and qualitative. The quantitative component was to compare the targets at mid-term point with the baseline survey and 3-year targets and focused on a literature review and logframe indicators:

a. **Interviews with service providers,** to determine services they are offering, when they started these, client flow and what has been done to make the community aware of services offered (including community mobilisation). The interviews also sought views on perceptions of clients and community and challenges faced in implementing activities and what can be done differently to enhance project impact.
b. **Project managers/Coordinators,** to determine how they are managing the resources, using service data to inform services and what role they play in linking palliative care services with the DHO to make them sustainable.
c. **Interviews with social workers and community workers**, the link with the community, operating within the health facility, to determine what they do, how they facilitate and support community mobilisation, whether they keep records and data of their work, and their role in setting up demonstration conservation gardens.

The qualitative component focused on semi-structured interviews to help identify recommendations of changes and gain deeper understanding of factors behind indictators:

a. Clients' interviews to determine satisfaction with services, in their homes and ideally exit interviews with clients leaving the health facility.
b. Religious and traditional leaders and social workers, to ask them their role in ensuring the community knows of services and their view of offering quality services.

Data collection methods

Quantitative data were collected through face-to-face structured interviews and examination of project reports and registers. Qualitative data was collected using semi-structured questionnaire and observations. The table below presents a summary of methods used:

RESPONDENT	METHOD	PLANNED TARGET	ACTUAL	REMARKS
Health Providers	Structured questionnaire	5	5	Target met
Project Administrators/ Managers	Structured questionnaire	5	5	Target met
Social workers	Structured questionnaire	5	2	Target not met
Health Centre Management Committee	Structured questionnaire	1	1	Target met
Patients	Unstructured	10	2	Not met as at 2 sites patients did not come.
Traditional leaders/Religious leaders	Unstructured	5	2	Target not met
Community members	Unstructured	5	3	Target not met

Limitations

Corona Virus Disease (COVID-19) restrictions began in Malawi in March. Therefore:

- Of 36 clients scheduled for interviews, only 2 were interviewed, nowhere near saturation point in qualitative data, and the number of traditional leaders and religious leaders was inadequate. Visits to health facilities were planned for clinic days, but 2 facilities visited on clinic days had no patients.
- 3 of 5 health facilities were visited, omitting 1 hard-to-reach and 1 Central Hospital.

In this 3-year project, DFID requires annual targets, and therefore the mid-term evaluation, conducted to March 2020, shows achievement after 21 months, but is compared against Year 2 targets of 24 months.

DGMH started to learn palliative care from Chifundo's start in July 2018, reached Level 2 by June 2019, and began to mentor health centres from July 2019, all as planned. Therefore:

- The mid-term evaluation in the North conducted in March 2020 was only 3 months after the sampled districts had begun to deliver care in December 2019;
- New senior staff at DGMH could not provide timely information and struggled to understand what a mid-term evaluation is.

Context analysis

In designing Chifundo, there was analysis of political, economic, social, environmental and legal factors that would affect the project. These continue to shape and affect implementation. Chifundo commenced when the country's population was 18 million and using WHO estimates that 1% of Africans need palliative care and estimates that 80-85% of the population is rural, Chifundo's target of helping 9,965 mainly rural patients (59,790 including patients' family members) compares to a total rural need of 153,000 patients by 2021.

Several changes have occurred in the past 2 years both at national and district level, affecting provision of health services. The ministry of health, (MOH) adopted the current Health Sector Strategic Plan II (HSSP), 2017 to 2022. The HSPP main theme is to move the country towards Universal Health Coverage (UHC). WHO defines UHC as meaning that all people and communities can use the promotive, preventative, curative, rehabilitative and palliative *health* services they need, of sufficient quality to be effective, while ensuring that use of these services does not expose the user to *financial* hardship. In Malawi, health services are free to all those in need and the largest provider of health services according to UNICEF Facility mapping (2016) is government with about 60% while all non-state actors account for 40% and of these non-state actors CHAM is the largest provider, of 29-30%. However according to CHAM secretariat, CHAM facilities account for 37% of healthcare.

Some surveys have pointed out that in some districts CHAM is the largest provider of the health services. In Mangochi, out of 25 health facilities in 2016, 12 were run by government and 13 by CHAM. Of 16 training institutions, 11 are under CHAM. Unlike other non-state actors who charge for all services, CHAM health facilities do not charge fees for the Essential Health Package (EHP). This is because CHAM facilities and MOH have Service Level Agreements (SLAs). These are agreements between CHAM facilities and District Health Offices (DHOs) of the Malawi government, whereby the CHAM facility agrees to provide critical care services free of charge to communities that would otherwise not be able to access critical health services. Government pays CHAM health facilities costs incurred in providing these services. In 2018, the SLAs had within two years helped CHAM facilities increase those accessing health care from 200,000 to 800,000: https://mbc.mw/q-a/item/8285-malawi-takes-stock-of-universal-health-coverage . From 2016 to 2019 MOH fast tracked signing of SLAs with CHAM facilities. However, while the expectation was that government

would continue to roll out SLAs to include other ailments, there was reluctance to extend them to NCDs, most of which account for palliative care needs. The main reason cited was indaquate funding: https://www.manaonline.gov.mw/index.php/national/health/item/9370-cham-services-will-not-be-extended-to-non-communicable-diseases . While government has attributed its failure to extend SLAs to cover NCDs and other conditions within the EHP to limited finances, in some instances, SLAs have been hampered by lack of clarity to address non-payment by DHOs, lack of performance monitoring and sometimes lack of trust. Some DHOs claim that some CHAM facilities submitted wrong or incomplete documentation. Some leadership changed at District Council Management. These frustrate the process in some facilities, in turn leading to end users being affected.

From 2018 to 2019, the health sector in Malawi has been one of the first 3 priority sectors to get a lion's share of the national budget. The country allocated K87 billion to the health sector in 2018 making it the third largest recipient of government funding, after Agriculture and Education. However, despite increases of funding to public health services, there have been reports of poor delivery at all levels from primary, secondary to tertiary level.

For all that Malawi talks about UHC, 10% of the population does not live within 8 kms of a facility that provides the minimum package of services free. Although SLAs signed with CHAM facilities have closed some gaps (mostly for mother and child health), a number of problems primarily insufficient funding affects the viability of this initiative and many vulnerable communities still do not have access to health services. Added to this is shortage of essential drugs and medical supplies in the health facilities. A quantification study conducted earlier this financial year by MoH showed a massive gap in funding for essential medicines, characterised by low funding and delayed onset of second phase of the DFID drug procurement programme. Related to this is the issue of drug management in health facilities, a huge challenge resulting in reports of drug pilfering. This has created common occurrences of patients being sent home without being given even basic painkillers like paracetamol.

The issue of staff shortages is another challenge that has affected both public sector and CHAM. Most CHAM health personnel are paid by the government and in most cases CHAM facilities have to seek authority to fill their establishment. The issue of staff shortage and high staff turnover has been with the health sector for a long time. The MOH lacks personnel of all cadres: Doctors, Nurses, Pharmacists, Laboratory Technicians, Medical Engineers. While plans were developed to address these gaps through recruiting from the College of Medicine, Kamuzu College of Nursing, Mzuzu University CHAM training institutions and other recognized institutions in Malawi, for the past 2 years government could not recruit them. The MOH embarked on a Functional Review hoping that this would help increase and upgrade posts in health facilities. This also caused challenges in deployment of staff in hard-to-reach areas where some health facilities remain closed due to lack of staff: https://www.health.gov.mw/index.php/78-demo/slides/74-health-challenges

Within the period 2018 to 2020, Malawi has made tremendous progress in decentralisation. District Councils have been given authority to start recruiting personnel at district level, including health personnel, in line with rolling out Programme-Based Budgeting (PBB). PBB is an opportunity for District Councils to improve comprehensiveness of local budgets, ensuring programme, economic, functional and administrative classification, as required by international practice. It contributes to improved visibility of budget lines on critical social sector programme areas such as health. In the past, most social sector budgets were allocated and spent at central level, with very little going to sub-national level but with the PBB, most financial resources are *supposed* to go to the district. These changes have come with change of authority in district personnel. The head of health services in the District is the Director of Health and Social Services (DHSS) and the incumbent is based at the District Council. The DHSS is overall in charge of all health and social services in the

district. The District Health Officer (DHO) heads the District Hospital and is based at the health facility. These changes have meant that the overall administration of health services is coordinated in the office of the District Commissioner. However, despite decentralisation including recruitment of health personnel at District level, by 2019, most nurses and clinical staff who had graduated in 2018 and 2017 were not employed by MOH. Government cited financial challenges over its failure to recruit the graduates. As a result, most were employed as temporay employees earning less than K80,000/month ($109). While newly qualified health workers were finding it difficult to enter the job market, health workers who were qualified were being poached from NGOs or CHAM facilities to join government - but not as government employees but as NGO employees. Due to government's financial challenges and recognising the huge workload of health facilities, government started partnerships with some NGOs, e.g. Elizabeth Glasser Foundation (EGPAF), JPHIENGO, Medicins Sans Frontieres. These NGOs were recruiting health workers and paying them higher salaries than government employees and then seconding them to work in government health facilities.

Further, under Decentralization, District Hospitals are funded through District Assemblies. Funds are pooled under one operating account and MOH observed that this has an impact on the health budget such that mismatch of priorities has negatively affected day to day operations at District Hospitals. Almost all District Hospitals have faced challenges in paying for utility bills and food for patients. To patients on palliative care, food is essential as most have financial challenges.

From 2019 to date, the country has passed through much political and social instability. The country had its general elections in May 2019, and the period preceding this was characterised by community mobilisation affecting development. For instance, prior to elections is a tendency to change key district management staff like District Commissioner (DC), Director of Planning and Development and sometimes the DHO. Dedza witnessed change of 3 DCs within a year and change of DHO. Politicians use this period to move loyal District heads to areas where they can best use them and politicians sell themselves to the electorate, making promises and spending lots of money on campaigns. In most constituencies issues of health, food security and education take centre stage. Aspiring MPs provide ambulances to woo voters, but once the elections are over these ambulances are withdrawn if the owner loses the elections. For the first time in Malawi after the elections were claims of rigging the presidential elections. The results were heavily disputed and the country witnessed demonstrations by human rights groups and citizens. These in some instances became violent and led to loss of life and property. Businesses were closed and some people were injured. The country has witnessed a level of lawlessness where people are now taking the law into their own hands. This continued from July 2019 to February 2020 when the High Court of Malawi sitting as the Constitutional Court ruled that the elections were marred by massive irregularities and there was need to conduct fresh elections. The government has to fund these elections to the tune of over K32 billion, and must pay the huge legal costs of losing this case. There is strong possibility that budgets will be cut to fund this.

On 30th January, 2020, World Health Organization (WHO) declared Corona Virus Dieases-19 (COVID-19) a Public Health Emergency of International Concern. Nation states including Malawi undertook measures to protect their citizens. From late February, MoH started issuing guidelines to partners and communities on threats of COVID-19 and how to limit the spread. Some guidelines issued in February and March required social distancing and halt of non-essential services. On 10th March, 2020, the President appointed a Special Cabinet Committee on COVID-19. Some mild restrictions were issued to prepare the country for COVID-19. Although no one had tested positive to COVID-19, it was clear from official statements that Malawians had to brace themselves for difficult days ahead. People were

advised to avoid non-essential travels and meetings. On 2nd April, 2020 the president announced that 1 Malawian had tested positive and announced several restrictions.

On 8 April, the government launched the National Covid-19 Preparedness and Response Plan, with a budget of US$213 million (MWK157 billion). The main objective was to prevent, rapidly detect and effectively respond to any COVID-19 outbreak thereby reducing morbidity and mortality in Malawi. Several restrictions were again announced including probably lockdown. Health workers across the country went on strike demanding that they be provided with adequate Personal Protective Equipment (PPE) if they were to assist in containing COVID-19. They demanded adequate risk allowance if they were to be considered front line soldiers. The risk allowance for these workers was last raised 17 years ago and the workers demanded an increment from about K1,700/month to K60,000 for some cadres. Nurses and clinicians which government had recruited on a temporary basis and who were paid about K80,000/month demanded that they be recruited to established positions. In view of fighting COVID-19, government made concessions and promised to recruit 2,000 health workers. These developments may trigger an effect on workers in other sectors who may also demand risk allowances with the advent of COVID-19.

On 14th April, 2020, the President announced a 21-day nationwide lockdown from Saturday, 18th April, 2020. Following that announcement some citizens, religious leaders and human rights groups took government to court demanding that government clarify the lockdown and list measures to provide safety nets to the vulnerable and ensure people's rights to economic participation. On 28th April, the Judge ruled that the lockdown infringed some constitutional provisions and granted that the lockdown be on hold until the constitutional court determined the way forward.

Findings

Findings are presented based on the logframe and ranked from achievement of outcome down to outputs. In assessing how the project achieved its outputs, reference is made to supporting activities in the analysis of each output indicator. From the TORs, the evaluation assessed how project partners had delivered on the outcome and outputs and the summary matrix below shows the situation at baseline compared with mid-term.

Summary of comparison between baseline and mid-term:

Descriptor	Baseline indicator	Year 2 indicator (Jun.2020)	March 2020 achieved
Outcome: By mid-2021, 9,965 families (59,790 people) needing palliative care in catchment areas of 26 rural and/or hard-to-reach health facilities and the 4 Central Hospitals of Malawi, have access to good quality, holistic palliative care and are referred to relevant nutritional support. (Hard-to-reach = >10km from road or from health facility on a road.)	3,600	7,425	7,288
Output 1: By June, 2012, 30 health facilities, evenly spread over Malawi, have passed APCA, and half are certified to host clinical attachments.	2	22	20
Output 2: By 2021 June, all 26 participating rural &/or hard-to-reach CHAM facilities, plus all 4 Central Hospitals provide good quality, free palliative care, by adequately trained staff, offer all needed drugs most of the time, and provide adequate psychosocial care, all for free, to all 9,965 families in need in their catchment areas.	1	18	20
Output 3: 23 participating CHAM palliative care services are following the example of 3 CHAM demonstration agriculture support services to improve nutrition & food security.	0	10	14

The project is on course in all core indicators from outcome to output.

Assessment of performance of project outcome

The project outcome is that by mid-2021, 9,965 families (59,790 people) needing palliative care in catchment areas of 26 rural and/or hard-to-reach health facilities and the 4 Central Hospitals of Malawi, have access to good quality, holistic palliative care and are referred to relevant nutritional support. This outcome has three indicators.

The first outcome indictor is that that there will be 9,965 patients in catchment areas of 26 rural and hard-to-reach health facilities and of all 4 Central Hospitals (together covering all 28 districts) enrolled for free care as in the National Palliative Care Policy and who have therefore received free counselling on their disease, social needs assessment and monthly nutrition assessments. The 2-year target by June 2020 is 7,425 patients. Data from the May quarterly partners' meeting showed that Chifundo project had seen 7,288 patients. Thus by March (the 21-month point), this target is only 137 clients short of the June, 24-month target. Of these, 3,965 are female (54% of total), and 3,323 are male (46%), while 1,644 (22%) are under 18 years old, against a target of 17%.

Several factors account for these successes. Firstly, there has been continued commitment by key partners PCST and PACAM to support the other three mentors MMH, DGMH and NMH. PCST and PACAM have each made over 6 visits to each partner. Every quarter partners have been visited by either PCST or PACAM, with a record kept of each visit and minutes circulated. Secondly, PCST, PACAM, MMH, NMH and DGMH have established cordial relationships with the DHOs so that they support CHAM facilities in their catchment areas to implement palliative care services. During the visit, Chilinga was in discussion with Phalombe over arrangements for supplies and the Phalombe Palliative Care Coordinator was that week planning to visit the facility to discuss record-keeping and how the facility can transmit its records to the DHO. In addition, finance and material resources like smart phones, DVD and furniture that the facilities have been provided with, especially those mentored by PCST, MMH and NMH, has contributed to the successes. Finally, every facility implementing palliative care has at least 2 trained providers who attended the 5-day training.

As expected, these patient numbers come mainly from Central Hospitals and established facilities Mulanje Mission Hospital and Nkhoma Mission Hospital. The figures from David Gordon Mission Hospital and health facilities in the north are low, due to their recent starts in palliative care. Some health facilities like Thambani in the South and Makapwa also began their palliative care services recently, as the original plan was for MMH and NMH to mentor each facility for 1 year only, and thus each mentor 2 faciliteis in Year 1, 2 in Year 2 and 2 in Year 3, but DGMH was to mentor 1 facility in Year 2 and 2 in Year 3, and so its mentees are meant to be later in building up caseloads. Following a Mannion Daniels supervision visit, this changed to have all mentors mentor all their mentees from January 2020. The table below indicates what DGMH and its 3 mentees contributed to the total number of patients:

Number of patients (cumulative to March 2020)	DGMH	Atupele Community Hospital	Kaseye Health Centre	Chilambwe Health Centre	Total
Females	33	9	4 (one died)	2	48
Males	33	10	5	5	53
TOTAL					**101**

By June 2020, DGMH is to achieve 416 patients (cumulative), and to have mentored 1 Level 1 to a caseload of 35. Instead, it had achieved by March only 66 patients (cumulative), while its 3 mentee facilities had achieved a cumulative caseload of 35, following the change from mentoring 1 to mentoring all 3 from January 2020. Thus DGMH achieved its mentee facilities' caseload through mentoring 3 at once rather than delaying 2 until Year 3. However, its own number of patients is far below target, with 350 patients to be added in only the April to June 2020 quarter. Respondents from DGMH, Atupele and Kasaghe said that when they were oriented into the project, DGMH did not tell them that palliative care patients are to access services free of charge. DGMH is three-quarters of the way through its first year of mentoring, and its mentees have managed to secure informal arrangements with their DHOs which enable the DHOs to give drugs to these health centres for free. This is normally only possible after the palliative care room and staff training are complete and after someone has paid for the first patients' drugs, enabling patients to be enrolled and hence become part of the DHO's caseload. Fortunately DGMH mentees have taken the initiative and are now treating all patients free of charge, although Kaseye's patients remain unofficial as far as the DHO is concerned, and DGMH needs to check that all patients needing drugs are getting

them, and if not, supplement them from its Chifundo budget. NMH and MMH are, as intended, further advanced in these informal arrangements of mentees with DHOs, since NMH and MMH started as Level 2 facilities able to mentor from the very start of Chifundo, such that their mentee facilities are providing reliably comprehensive free services and are linked to DHOs for free supplies, or, where DHOs cannot provide free services, getting drugs free from MMH and NMH. For example, MMH provides drugs to Chilinga health centre from the EMMS budget, and Chilinga had treated 51 patients by March 2020, almost as many as DGMH's 66. However, DGMH was to build up a much larger caseload. DGMH did indeed achieve Level 2 within Year 1 from a standing start, but has achieved very few patients, in spite of extra support: an ambulance, attendance at all-partner meetings and a significant budget, which it has largely underspent. DGMH's under-performance in achieving patient numbers is largely due to staff changes in DGMH causing unfamiliarity with the project, lack of direction and financial management problems. The EMMS-DGMH Project Agreement and the proposal narrative under risk management are clear that EMMS cannot disburse funds to DGMH if its audited accounts are out of date, and DGMH was indeed late; EMMS gave partners repeated advice on timetabling an audit, in person from its Director of Finance, and by email from its Director of International Programmes. However, this is not the only problem: DGMH underspent funds that EMMS did send it. Since 2 key staff left in mid- to late 2019, DGMH management is very weak.
In spite of this, PCST has provided training to DGMH mentees such that all have 2 or 3 staff trained and 2 have had a clinical attachment. DGMH mentees started offering services in December 2019, which is not late, as DGMH's mentee facilities were to be mentored in Year 2 (as DGMH itself had to be mentored in Year 1). MMH's mentee Chilinga similarly began seeing patients in the third quarter of its mentorship, which for them was in Year 1, and achieved 18 patients by the end of Year 1, similar to DGMH mentee Atupele's achievement of 19 after the first 3 quarters of mentorship. NMH mentee Mtendere Community Hospital and MMH mentee Chilinga both raised inadequate community mobilisation as a challenge causing low enrolment, since by March 2020, after 2 years of mentorship, Mtendere had treated 38 patients (cumulative since start of Chifundo). Either the targets of 35 new patients/ year for newly mentored facilities is unrealistic, as facilities cannot start enrolling patients until the final quarter of their first mentorship year, or the facilities would benefit from increased communitiy mobilisation. No health staff interviewed had heard of Community Health Action Groups (CHAGs), a key community health structure recognised by government and key in community moblisation. If this project is to live up to its name of *Chifundo*, more rural and vulnerable people must access palliative care in hard to reach areas, and use of CHAGs may help in community mobilisation. Nevertheless, the change to mentor all facilities at once since January 2020, has enabled Level 1 targets of patients to be met.

This project outcome indicator also has qualitative attributes besides the quantitative numbers. Palliative care patients are supposed to receive free counselling on their disease, a social needs assessment and monthly nutrition assessments. The 2 palliative care patients interviewed in Dedza and Phalombe confirmed that the health facility team visits them, with the husband of a cancer patient in Dedza saying:

> The doctors do come to visit my wife. In fact last week they were here and visited her and I think they also last came last month. However, on providing us with nutrition support, that I am not aware of. Maybe because I have adequate food supply here. Of course I have heard that others do get food supplements.

From interviews with Project coordinators in all the three implementing sites visited and in MMH and NMH, it was evident that palliative care patients are benefiting from nutrition support. NMH had made about 53 contacts in one month with those requiring nutritional support and MMH had made 188 contacts with patients on palliative care during the previous month. While the 2 hubs or mentors could provide records of how many patients they made contact with, the situation was quite different at DGMH and its 3 mentee facilities, where health workers had challenges in getting the data right at their finger tips. This was the same at Mtendere, where the data from NMH on how many patients were active at Mtendere was different from the data that Mtendere gave at first. It appears that health workers and coordinators are not very concerned with data. PACAM therefore confirms all data on the government MIS, which is reliable, being formed from data submitted to and then by DHOs.

The second project outcome indicator was the proportion of enrolled patients whose facility had at least 1 Level 1 (aspirin, paracetamol, ibuprofen, diclofenac), at least 1 Level 2 (codeine, tramadol) and at least 1 Level 3 (liquid / oral morphine) pain control medications in stock over the last 3 months. Amongst the 3 facilities visited, Chilinga, Atupele and Mtendere, only one had reported stock-out of drugs: oral morphine. However, since the sample needed at least 5 health facilities to have a meaningful picture, two other health facilities were contacted by telephone interview: Kaseghe and Chilambwe. Both reported that they have had no incidences of stock-outs. The facility that reported stock-out was Chilinga Health centre and taking the sample of 5, this shows that 20% of the sampled implementing health facilities reported stock-outs. Chilambwe does not prescribe morphine or codeine, which its patients access straight from the District Hospital. All 3 mentors, MMH, NMH and DGMH reported no stock-outs in the previous 3 months, and none in the previous quarter, but noted that they have had instances where government supplies were erratic and they cushion that with their own drug supply. Thus Chilinga Health Centre could have requested oral morphine and MMH would have provided it in time. At Chilinga Health Centre, it was learnt that the stock-out was due to handover problems between 2 providers who normally assist palliative care patients: the one on duty that week had assumed that there were adequate supplies of oral morphine.

The third project outcome indicator is proportion of families of enrolled patients who have received non-medical support (legal depending on need and / or spiritual at least quarterly). Of the sample population of 5, all confirmed that all patients on palliative care are provided with spiritual support either through the chaplain's office or through health providers. All facilities start with some form of morning devotion and transmitting spiritual support to patients is done as part of their daily and routine work. One social worker said:

> In fact the in-charge, the sister's office is always open and the chaplain is also active. I am yet to witness a situation where any patient's spiritual needs (not just palliative care patients) have been overlooked. However, the legal aspect is tricky since those needs are not directly expressed by the patient. Culturally you cannot just raise issues of legal support without the patient himself or herself requesting.

Those sentiments were shared by most health workers interviewed. However, in Mtendere, the social workers claimed that though they were trained, they feel under-utilised:

> We were trained in social work and issues about legal or wills were part of the training. We were also trained on how to moblise communities. However, here

> we are not properly utilised. Sometimes we just learn that people have gone for home visits but we are not involved.

This situation was also prevalent in Atupere where the Health Centre Management Committee confessed that they are mainly involved with issues of demonstration garden but would love also to be involved in learning to support others with legal advice. When pressed if they had raised these issues with their leaders, the respondents did not provide a conclusive answer. The finding indicated that some health facilities have various key players who form a palliative care team but are not properly coordinating their work.

Thus 100% of facilities offer spiritual support but none of the 5 sampled has cautiously offered legal support depending on need. However, we must recognise that issues of legal advice and wills are not easy for anyone to raise with palliative care patients.

The fourth outcome indicator was percentage of enrolled patients who had the weight expected for their disease, and the target by June 2020 is 30%. Since this indicator requires reliable data-collection, it is now measured for the 4 mentor facilities only, who achieved as follows by March: PCST 580/673 (86%); DGMH 55/55 (100%), MMH (268/268 (100%), and NMH 78/287 (27%). The intent is that nutritional support to malnourished patients increases these percentages, and NMH expects to improve, having gathered its data reliably.

Overall therefore it can argued that the project is on course to achieve its Year 3 outcome of reaching by mid-2021, 9,965 families (59,790 people) needing palliative care in catchment areas of 26 rural and/or hard-to-reach health facilities and the 4 Central Hospitals of Malawi, with access to good quality, holistic palliative care and referred to relevant nutritional support. The June 2020 target of 7,425 patients is nearly achieved by March 2020. However, no respondent conducts exit interviews or post-visit with clients to get client feedback.

Assessment of performance of project outputs

Outputs are to achieve the outcome. The first output is that by June 2021, 30 health facilities, evenly spread over Malawi, have passed APCA (Level I, II or III), and half are certified to host clinical attachments. All 3 facilities visited and 2 interviewed by phone were at Level I.

Trained Palliative care team and in the background furniture supplied by the project

The first output indicator is number of health facilities who were audited at APCA-level and passed. Auditing is the main role of PACAM, whjile PCST, NMH, DGMH and MMH

mentor their respective mentee facilities. By the time of the mid-term evaluation PACAM had done all 3 audits of Central Hospitals (Mzuzu, Zomba and Kamuzu), while Queen's, where PCST is based, long ago passed Level III. All 3 achieved Level III by March 2020. These audits are significant for Central Hospitals because it means they are recognised to offer tertiary services, including receiving referrals, and specialised services and host attachments. This is key because already ZHC has 2 health workers who are undergoing Bachelor's degree at Makerere and once they return they must put into use the skills and knowledge they have gained. For this, they must be in a facility operating at a higher level. These 3 Central Hospitals are to host attachments by June 2020 and the project achieved **4**, which is the full 3-year target.

The other output indicator is that 6 mentored health facilities would reach level 2. By March 2020, 6 CHAM facilities and 1 NGO (total = **7**) had achieved level 2: St. Gabriel, St. Joseph, St. Luke's, Ndi Moyo, DGMH, NMH which passed right at the start of Chifundo, and MMH which passed before Chifundo. This is due to St. Luke's being found capable of achieving Level 2, after achieving Level 1 in Year 1, and St. Joseph both being found capable of moving straight to Level II, with Malamulo also to be audited against Level II once travel permits. 7 Level II facilities means that Chifundo has already exceeded this Year 3 indicator too.

The third indicator is that there would be 20 CHAM facilities at Level I providing palliative care services by June 2021. With 2 expected Level 1s haveing movied to Level 2, this indicator is now that 18 facilities will be Level 1. The project had anticipated that by June 2020, there would be 13 additional CHAM units at level I, providing basic clinical and supportive care services while relying heavily on referral of patients and their families to level 2 and level 3 service providers for more advanced and specialised services. By March 2020, 16 CHAM facilities were operating at Level I and providing services (and of these **9** had passed APCA Level 1), while 2 were about to roll out services. The table below lists these facilities:

PCST	DGMH	MMH	NMH
1. Utale 2. Mpiri 3. Lulanga 4. Tsangano 5. Malamulo	1. Chilambwe 2. Atupere 3. Kasaghe	1. Trinity 2. St. Lukes 3. Chilinga 4. Makapwa 5. Thambani	1. Mvera 2. Liwalazi 3. Nkhamenya 4. Kapiri 5. Mtendere

Note: The ones in yellow were just starting implementation

Thus the target of 13 additional ones has also been surpassed, but audits become difficult, due to COVID-19, and so 4 fewer than target had passed an APCA audit. The success in providing services is due to collaboration with DHOs which gave guidance and suggestions. One DHO asked why CHAM facilities are included, which is discussed later in this report.

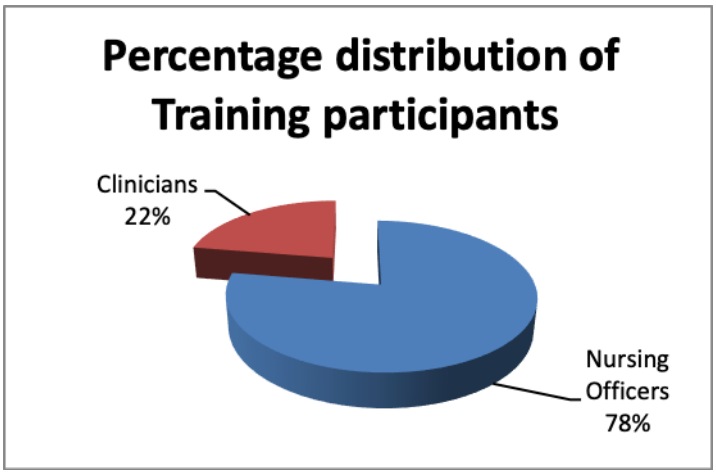
Thus the project is on track to achieve 30 health facilities, evenly spread over Malawi, which would have passed APCA, had COVID-19 not caused an interruption in audits. In spite of COVID-19, by March 2020 the project has achieved 20 facilities which have passed APCA: 4 at Level III, 7 at Level II, and 9 at Level I, against a June 2020 target of 22.

The second output is that all 26 participating rural or hard-to-reach CHAM facilities and the 4 Central Hospitals provide good quality, free palliative care, by adequately trained staff, offer

all needed drugs most of the time, and provide adequate psychosocial care, all for free, to all 9,965 families in need in their catchment areas. It is critical that all facilities have trained health and social workers. The term health workers refers to be all people engaged in actions whose primary intent is to enhance health. All 5 health facilities interviewed have more than 2 providers offering palliative care. Of the 2 trained, deliberate efforts were made to train a clinician and nurse. This output had three indicators which the evaluation assessed.

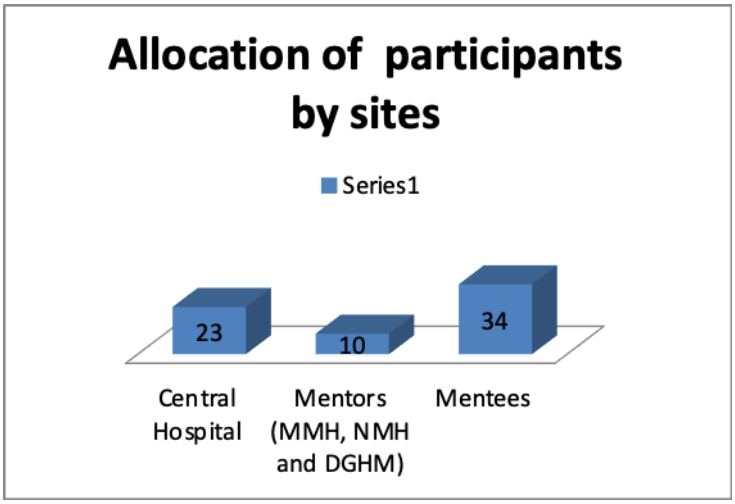
The first indicator had five components with the first part stating the 4 Central Hospitals will have at least 1 person with B.Sc. in palliative care. In all of KCH, ZCH and MCH, are nurses and clinicians studying for or with a B.Sc. in palliative care. ZCH has 2 staff members studying at Makerere, MCH has 2 staff studying and a PCST staff member based there with BSc, and KCH has more than 1 staff member with BSc in palliative care. Chifundo is supporting some staff members with their studies. The second part is that all facilities have and prescribe all drugs for free. 2 facilities visited were not aware of this. The others are providing free drugs. The third part of the indicator was that facilities would play a DVD on legal services to all patients and refer via Memorandum of Understanding to the local Legal Aid Bureau. Through the efforts of PACAM, all partners were given the DVD and literature to guide them on how to access legal aid, and through the efforts of PCST, all partners were given a DVD player. The fourth part was that these facilities should have over 10 churches nearby using Inspiring Hope. The 5 facilities said that they had the materials, that they are near churches, and that they have trained chaplains or member of clergy either stationed at the health facility or living nearby. The last part was that the facilities have trained pyscho-social workers who were trained for 2 days. All 5 facilities interviewed said they had psycho-social staff who had been trained, being utilized differently depending on the facilities.

The second output indicator was that there would be 95 staff trained on 5-day training and placed on 2-week attachment. By March 2020, the project had trained 67 health workers but facilities had the required combined 95 staff trained appropriately, including from outside Chifundo, although 30 staff have still to have their 2-week clinical attachment. Staff trained in Chifundo include both clinicians and nurses. The graph below shows approximate ratios of each. 15 clinicians (including 3 doctors) and 52 nurses were trained.



Source: PCST training and clinical placement report form

The other important observation is the type of location they came from, shown in this graph:



Source: PCST training reports

Most training participants, 87% of trainees, came from mentees and Central Hospitals. However, during visits, 1 health worker at Atupere Community Hospital and 1 at Chilinga Health centre expressed concern that they had not done their clinical placements yet.

The other indicator was that all participating CHAM/non-denominational not-for-profit facilities will have over 5 staff trained in palliative care. Of the 5 sampled, 2 community hospitals and 3 health centres, the 2 community hospitals Atupere and Mtendere had 3 and 4 trained health staff respectively. Mtendere lost 1 trained provider who resigned. Resignations and frequent change of jobs by health staff was raised by PCST staff, who observed that when the project began, they planned to train more staff than needed for each facility:

> We had planned that implementing partners should have a minimum number of 2 health personnel and that is why in our training we invited partners to send at least 2 health workers. If any facility has less than the required number it's due to the recurring challenges in the health sector of resignations.

All 3 sampled Health Centres have adequate staffing with none having less than 2 trained staff. All Central Hospitals have the required number of trained staff, and all have 2 or so staff studying for B.Sc. in palliative care, while some have staff who already have a BSc.

The third indicator was that by June, 3 participating CHAM/non-denominational not-for-profit facilities will have signed revised CHAM-DHO SLA including palliative care. This is work in progress but in this financial year, 4 DHOs made commitments that they would have no problems signing SLAs: Chitipa, Karonga, Phalombe and Ntchisi. Already Chitipa and Karonga DHOs are supplying Kaseghe and Atupere with Home Based care drugs and kits and committed to supply the drugs for palliative care patients as a short term measure. Nkhata Bay DHO said they had already budgeted for the coming financial year and it would be challenging to include SLAs. This DHO was the one which raised concerns about the project including Chilambwe Health Centre. There is a chance that some districts may include palliative care in their SLAs with these facilities next year, but meantime all have an informal arrangement with the trained facilities, and provide drugs for free. Some DHOs do not understand the project.

Overall assessment of this output is that the project is on track to achieve this output in the remaining time, but some areas require improvement.

The third output is that 23 participating CHAM palliative care services will by 2012 be following the example of 3 demonstration agriculture support services and will have their own, to improve nutrition & food security. This is to ensure that patients on palliative care are supported in nutritional status. The demonstration gardens are to demonstrate conservation agriculture, growing food in areas of uncertain rainfall. This output too has three indicators.

The first indicator is that by June 2020, 50% of families enrolled are adopting more than 1 practice taught to them by the 3 hubs: DGMH, MMH, NMH. The 3 hubs have demonstration gardens, but NMH and DGMH only started their gardens over the course of Year 1. Nevertheless, 91% of 55 families taught by DGMH have adopted at least 1 practice, 61% of 208 families trained by MMH have adopted at least 1 practice, and 70% of 310 families trained by NMH have adopted at least 1 practice. Thus the 3 hubs surpassed this indicator.

The demonstration garden in Chilinga

The second indicator was that by June, 2020, 38% of CHAM/non-denominational not-for-profit services have developed referral pathways to agricultural support. NMH and DGMH attended an open day in MMH in December before helping their mentees to develop their gardens. NMH started this in January and DGMH in February. Mtendere Community Hospital already had such a garden. All 3 health facilities visited had fences around their demonstration gardens. The 2 interviewed by phone confirmed that they are developing demonstration gardens. Mvera and Nkhamenya said they too had started demonstration gardens. Quarterly monitoring confirmed that 14 out of 20 facilities which are practising palliative care have referral pathways to agricultural training. Therefore 70% of practising facilities have operating demonstration gardens with referral pathways to this for patients.

The third indicator is that by June 2020, 8,165 families of 19 CHAM/non-denominational not-for-profit facilities are referred to facilities' agriculture training services. There is a mistake in this indicator, as by June 2020, the target is only 7,425 families, and clearly more than this cannot be referred to any part of the service. Further, Central Hospitals families are not to be referred, as they likely live far from the Central Hospital, and so we can assume that the target was intended to be that all 3,625 families which are targeted to be enrolled in CHAM mentee facilities by June 2020 were to be referred to their facility's agricultural

training. The 14 CHAM facilities with demonstration gardens have not provided figures of how many families they have referred to agriculture training, but since the 3 hubs have referred 550 families, this means that these other 11 CHAM facilities with demonstration gardens would have had to refer 3,075 families. 21 non-hub CHAM facilities have enrolled 4,084 patients so far, and it is unlikely that 11 of them had 3,075 enrolled families.

Overall, this third output did not perform as expected. The 3 hubs could by now have helped all 23 mentee CHAM facilities to develop agriculture demonstration gardens, but have helped only 11 to this stage. The concept of the demonstration gardens is to train families by letting them appreciate the benefit of the demonstration garden, but even the demonstration gardens did not have anything during the mid-term evaluation. Atupere and Chilambwe thought that the concept was that people will volunteer to take care of the demonstration gardens, and had not understood that they are to pay labourers with produce. They also had not understood that the garden's purpose is to demonstrate conservation agriculture, to save water. Staff can appreciate a garden but if they do not know its purpose, will not demonstrate it well.

Changes in emotional, economical and spiritual status of clients

Changes in emotional status of clients helped

Chifundo has reached 7,288 families with palliative care. As defined by the Global Palliative Care Atlas, this is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, psychosocial and spiritual. Most patients on palliative care and their families face emotional stress. The project has managed to relieve this, as shown by the 2 cases below. First is one that PACAM reported in its February 2020 quarterly report:

On 12th February PACAM staff (Lameck and Glenda) visited Chinthembwe health centre in Ntchisi district and met a palliative care patient with cancer of the skin (Kaposi's Sarcoma) who had been receiving palliative care services at Ntchisi District Hospital for 4 years. The patient was referred to Chinthembwe health centre to continue his palliative care. The patient's home is 40 KM from Ntchisi District Hospital and 2 KM from Chinthembwe health centre. Chifundo project has brought palliative care services closer to the patients and so reduced patients' costs and time travelling long distances.

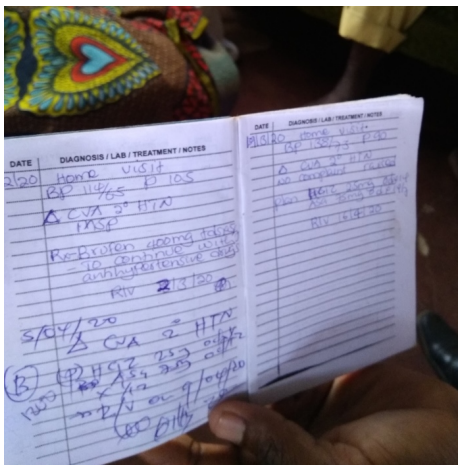
Thus not only costs and time have been saved. This family had in the past 4 years been travelling long distances and the stress of travelling that distance with a patient cannot be ignored. The emotional stress that goes with traveling that long distance knowing that what you will get will only relieve the pain is too much to bear for both patient and guardians. By bringing the service closer to the family, their finances, time and stress are relieved.

The second case is that of Mai "Nangozo" based in Dedza, Mtendere:

Mai "Nangozo" is a woman aged over 60 and has cancer. She lives 4 kilometres from Mtendere Community Hospital and is cared for by her husband. Since last year, she has not been able to move and is in pain. She requires support and sometimes has to be bathed and fed by her husband. The Palliative Care Team at Mtendere visits her regularly and administers drugs to her. When asked what his views are on the current situation of his wife and the home visits by the team, he responded,

"This issue of caring for my wife has caused many challenges to me. I can't do my regular farming and business and caring for her single-handed is stressful. At first her relatives would assist but now I am doing it alone. These visits the team makes though once in a while relieve stress for me and make me realise that I have friends in the hospital who still remember that they have a patient here"

That observation speaks volumes about what the project has done for emotional status.



Patient passport showing the home visit the palliative care team made

Changes in spiritual status

All health facilities interviewed face to face or by phone said patients served by their facility are all ministered spiritually unless they say that they do not want this. A guardian in Phalombe, Chilinga cements this position:

Mai Mwachande who looks after Mai "Lipoto", a patient on palliative care, noted that the Health Providers have visited but not regularly. She noted that what the family appreciates from the visit is spiritual counselling and nutritional support they have received previously (though they could not relate if the nutritional support came from Chilinga).

"The spiritual counseling was appreciated because you know caring for patient on palliative care is part of Christian service and requires spiritual support" (Kusamala odwala matenda amgonagona ndi nchito za chifundo zofunika mapemphero)

Changes in economic status

Chifundo's contributions in changing the socio-economic status of clients is demonstrated by PACAM's case study and by bringing palliative care closer to where patients are. The costs to the family of travelling with the patient 40 kms is great. Village transport is difficult and given mobility problems of most patients on palliative care without Chifundo, families must hire a cart or car and provide at least 2 guardians who therefore cannot work at home.

Compliance with EMMS overall operational framework

EMMS's strategic statements point to issues of Christian conduct, purpose and practice as expressed in vision, mission and values. The vision is *a just world in which all people have access to good quality and dignified healthcare.* To achieve this vision EMMS exists to *'Following the example of Jesus Christ, we work with partners in some of the poorest communities of the world to transform lives through compassionate, effective and sustainable healthcare.'* The values guiding EMMS international are Christian and include faithful, encouraging, empowering and accountable.

EMMS uses a Rights-Based Approach which in essence is that people and communities **should** be fully supported to participate in development of policy and practices which affect their lives and to claim **rights** where necessary. Issues of inclusion include sex-equality, disability and the vulnerable. Participation and ensuring partners involve clients and protect clients' interest are also key. EMMS cares about the environment and wishes to ensure that partners have social responsibility on issues to do with climate. The final major component is sustainability, defined as ensuring that the work continues.

Key instruments that demonstrate that facilities are adhering to EMMS framework is availability and implementation of policies and procedures. The 5 mentee facilities are under CHAM. Atupere, Kaseye, Chilinga and Mtendere belong to the Catholic Church and Chilambwe to the Anglican. They do not all have strategic plans but the Strategic documents of their parent bodies, Episcopal Church of Malawi (ECM) and Anglican Church of Malawi (ACM) affirm them as Christian entities and working within Christian values. It can be concluded that these facilities' work is aligned with EMMS's strategic statements.

A rights-based approach is propagated by all these facilities. All are working with their respective district councils and DHOs and one fundamental contribution they are making in their catchment areas is ensure that people access palliative care services as a right. That is why all facilities in this project are lobbying and advocating with District Councils to include alliative care in SLAs so that all those in need should access these health services. There is ample evidence from PCST on meetings held championing signing of SLAs.

A key aspect of inclusion for EMMS is protection from harassment and absence of discrimination. This is mainly appreciated when partners have policies to safeguard rights of clients and protect staff. All 5 members acknowledge that they are guided by their respective policies and professional ethics. The 5 facilities do not all have standalone policies on child protection and vulnerable adults but their professional ethics and organisation policies guide them in how to relate to vulnerable groups. With regard to participation, the facilities design their work based on needs of communities. However, one key piece that was missing is that these facilities could not demonstrate that they conduct *regular* client exit interviews.

The 3 partners visited say that they take environmental issues into consideration, but practice on the ground demonstrated that they should do more. All 3 facilities have demonstration gardens and have erected fences around them. Materials used are wood and glass. The facilities should plant trees next to demonstration gardens to demonstrate commitment towards good environmental management and shade. EMMS may need to share its *Environmental and Social Responsibility Policy* with these facilities.

On sustainability, EMMS's operational framework states that respecting the government's healthcare policy and contributing to strengthening its healthcare system are key. Malawi has a mix of government and private provision. Chifundo develops both, and helps facilities develop palliative care according to the national palliative care policy.

Conclusion

The objectives of Chifundo are on track in the 21 months the project has been implemented. The project has registered new palliative care patients and the demand for palliative care services is increasing in communities. This project was well thought of with different partners playing various roles while all work towards serving palliative care patients in hard-to-reach areas. The project is relevant since it is taking services closer to patients who face challenges of finances, nutrition and spiritual and emotional support. Through training health workers and a pool of social workers, the project has managed to create an environment where patients can be attended to by trained health and social workers. Chifundo has trained 67 providers and each facility has the required number of trained providers, although PCST must arrange 30 clinical attachments. Mtendere and Atupere have lost some trained providers, but the project has planned for all facilities to have more trained staff than needed, to mitigate later attrition of trained staff. While the project is relevant and has potential to bring impact to palliative care families, some problems are:

- DGMH is far behind in its enrolment of patients.
- Coordination by DGMH of its mentees is low. Some mentees are yet to be supported financially to refurbish rooms and some are not informed on the project. Visits by DGMH are irregular. One DHO querying how a partner was chosen to participate in the project signals that consultation with this DHO was not done.
- Chifundo has ensured that nutrition needs of patients and their families should be met by training in agriculture. However, hubs need to speed up work by mentees in this.
- Participation by clients is inadequate. Client exit interviews are not done regularly.
- PCST and PACAM maintain data, but others are doing little to manage project data.

Recommendations

1. Strengthen the project management for DGMH's area: There is huge potential for this project up north but there are slippages in how the project is being implemented. Mentees need additional technical support and somebody who is strong in project management to coordinate the project. Mentees should be supported to coordinate internally and ensure that senior leadership and critical team members are aware of the project and that mentee health facilities speak as units.
2. Community mobilisation: This must be considered and maybe some resources put towards it. Health facilities should build on existing relationships with communities.
3. Strengthen data and information management in facilities. Data is critical in project monitoring and evaluation and for learning. Facilities have challenges to provide accurate data and have it at their fingertips. Mentors should train mentees to manage data and document how the project is performing
4. Training of more health workers: The project should complete its clinical attachmnents and thereby complete training, since government plans to recruit over 2,000 health workers bring the possibility that many health workers may opt to join government.
5. Inclusion of client participation tools in project design and implementation: Facilities need to embed this in their work, and use simple tools like client exit interviews. The 5 partners meet quarterly and during these sessions can remind each other of some key working principles.

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Annexes

Terms of Reference for Mid-Term Evaluation of Chifundo

Introduction/background

EMMS International is a charity based in Edinburgh, Scotland, working to improve healthcare through partners in Bihar, Edinburgh, Malawi, Nepal and Zambia. On 6th July 2018, EMMS International and 5 Malawian partners started project Chifundo. 5 Malawian partners are: Palliative Care Support Trust (PCST), Palliative Care Association of Malawi (PACAM), Mulanje Mission Hospital (MMH), Nkhoma Mission Hospital (NMH) and David Gordon Memorial Hospital (DGMH). Chifundo is Chichewa for "Compassion". Chifundo is increasing numbers of people trained in and delivering various aspects of palliative care in hard to reach facilities over all districts of Malawi. Chifundo's budget is £994,095, of which £846,248 is from the UK's Department for International Development (DFID, branded UK Aid), and the remainder is from UK trusts (True Colours and 4 others). DFID's donation matches these and other donations from the UK public.

The purpose of the mid-term evaluation is: 1) to establish the status of Chifundo's indicators halfway through the project, 2) to compare these with the baseline survey and 3-year targets, and 3) to recommend changes to achieve these targets. EMMS will commission a consultant to conduct the evaluation and write a report.

The report will be copyright of EMMS International, who may publish it on its website, send it to major donors to Chifundo, and put a link to it on IATI (International Aid Transparency Initiative). EMMS International and its 5 Malawian partners may send the baseline survey report to their staff and key stakeholders in Malawi, including College of Medicine, Ministry of Health, Medical Council of Malawi, and Nurse and Midwives Council of Malawi. EMMS International and its 5 Malawian partners may present findings in conferences and in academic research papers. The Malawian partners may use the report to debrief all Chifundo's stakeholders (including staff, volunteers, churches, clinics, health centres, District Health Offices, Ministry of Health and traditional authorities) about the changes which Chifundo is bringing about.

Scope of mid-term evaluation to be carried out by the consultant

The scope is to measure the mid-term indicators of Chifundo's intended Impact, Outcome and 4 Outputs, to compare these with Chifundo's baseline survey indicators and 3-year targets, and to write a report including recommendations of any changes needed to achieve these 3-year targets.

Tasks: *Before starting:* Review attached Chifundo documentation and discuss scope of the mid-term evaluation with Dr. Cathy Ratcliff of EMMS, Ms Mwandida Nkhoma of PCST and Ms Glenda Winga of PACAM. Determine with Mwandida Nkhoma and Glenda Winga which 5 of 30 facilities to visit.

1. Visit Chifundo's 5 Malawian partners, in Blantyre, Mulanje, Lilongwe, Nkhoma and Livingstonia, and interview PCST's management (Ms Deliwe Kacheche and Ms Mwandida Nkhoma) and training manager (Alex Chitani) and project leads in MMH (Dr. Arie Glas, Ms Annie Kaseka and Mr. Tikondwe Katumbi), NMH (Ms Ellen Chizimba and Ms Anna Slingerland), DGMH (Ms Anastasia Nyirenda, Peter Nyirenda and Ishmael Nyirenda) and PACAM (Mr. Lameck Thambo), and other relevant staff to be determined at the time by these Malawian partners and the consultant. (1 day each = **5 days + travel**)
2. Analyse from the above interviews and other documentation, the status of palliative care provision in these districts, including against Malawi's National Palliative Care Policy, APCA standards and the Global Atlas of Palliative Care.
3. Visit 5 health facilities selected as described above. (**5 days plus travel**)

On all visits, to the 5 partners and the 5 health facilities selected:

- View all premises relevant to palliative care,

- Interview and hold discussions with staff working in palliative care,
- Talk to patients, family members, home-based care volunteers and others relevant to palliative care, such as Traditional Authorities, spiritual leaders and social workers,
- Assess the facility's status against Chifundo baseline and target indicators,
- Gather data on facility's total number of staff segregated by cadre, services provided, number of staff trained in palliative care, essential drugs available at time of visit, palliative care services provided,
- Briefly assess the facility's status against APCA standards,
- Assess facility against its strategic plan (if available) or general plans for next 3 years.

4. Consolidate and analyse data, disaggregate all by sex and age (under-18 or 18 and over), consider recommendations to make, write draft report using the format attached and with clear comparisons with baseline data, send to EMMS International and the 5 Malawian partners for review, and incorporate feedback into the final report. (**3 days**)

Format Use the Mid-Term Evaluation Report format attached.

Timing and budget

January to March 2020, with report to be finalised by agreement with all partners, coordinated by EMMS, no later than the end of March 2020.

Travel from home to the 5 project sites and back home. (Days included in the above)

Total: 13 days @ £75/day = £975 + expenses, payable upon presentation of receipts.

Logistics: The consultant will arrange their own travel to all sites. Malawian partners will organise accommodation for the consultant, all travel to health facilities and patients, and all meals.

Confidentiality

The report is for publication, and anyone may reference it. It will comply with EMMS International's Child and Vulnerable Adult Protection Policy regarding who to name with their permission.

Profile of the Consultant

An independent consultant who has conducted 10 evaluations and knows of palliative care in Malawi.

Outputs and timing

- A draft report, using the format attached, to be submitted to EMMS International, PCST, MMH, NMH, DGMH and PACAM by 15th March 2020.
- A final draft of the report, to be submitted to EMMS by 31st March 2020. EMMS will finalise for language, consult with partners on queries, and distribute to the other partners.

Attachments

1. Application form,
2. Logframe updated to September 2019 (with updated activities and indicators logs),
3. Current budget (note that a revision is expected soon),
4. Risk matrix updated November 2019,
5. Theory of Change – Step-By-Step Process,
6. EMMS International's mid-term evaluation report template
7. EMMS International Child and Vulnerable Adult Protection Policy
8. EMMS International Operational Framework
9. APCA Standards (National Palliative Care Policy to be given by PACAM)
10. Global Atlas of Palliative Care
11. Year 1 report and latest quarterly report submitted to Mannion Daniel

Questionnaires

The evaluation will focus on the following:-

EVALUATION QUESTION	INDICATOR	DATA SOURCE
How many facilities have you mentored to Level? How many times have you visited this facility ? On average how many patients has the facilities recorded by sex and age (age those under 18)? Overall how many should have been mentored by now? Overall what are the lessons learnt in mentoring the health facilities?	Number	Reports
When did you set up demonstration for conservation agriculture services? How many palliative care families were referred for training there? What are some positive things coming out of that?	Dates Number Stories	Reports
When did MMH hold the two agriculture & family nutrition conferences for 3 hubs' staff and Ministry of Agriculture How many palliative care families were referred to the demonstration training ?	Dates Number	Reports
How many malnourished palliative care patients were provided with Likuni Phala at the time government had stock outs?		
How many palliative care patients did you attend to in 2018 and 2019 by gender? What were the factors behind these trends?		
One of the activities in the project was that you would improve links with food supplementary programmes, produce likuni phala/peanut butter, refer all malnourished palliative care patients to this and other services, what has bene your experiences in this area.	Stories	Reports
What are some gaps that you have found while implementing this project? What can be done to improve these gaps?		
Overall, what contribution is Chifundo		Reports

project making towards improving provision of palliative care in the country? What are some practices, examples that one can point out?		

SEMI-STRUCTURED QUESTIONS TO COORDINATORS

1. What tools do you use to solicit client satisfaction?
2. How regular do you use these tools
3. What information do the mentees
4. Overall what is your assessment of the mentees
5. What can be done differently and what would be the reasons for doing that?

Traditional Leaders

1. What do you know about Chifundo Project
2. How relevant is the work of Chifundo in your community?
3. What health community structures exist in your community and how active are they
4. How are these structure working with the health facility to raise awareness on Chifundo project?
5. What do you think need to be done to bring more awareness of this project in your community?

Religious leaders

1. What do you know about Chifundo Project
2. How involved have you been with Chifundo Project?
3. How significant is your contribution to the work of Chifundo Project/ palliative care?
4. What would you like see happening with this project?

Social workers

1. Briefly describe your position and what you do?
2. What do you know about Chifundo project
3. How does your work relate with Chifundo Project?
4. In what instances has the project involved you?
5. What are some areas you think the project is making progress?

Which areas do you think the project requires adjusted?

EMMS International
Health for Today, Hope for Tomorrow

The information in this publication is correct at the time of going to press.

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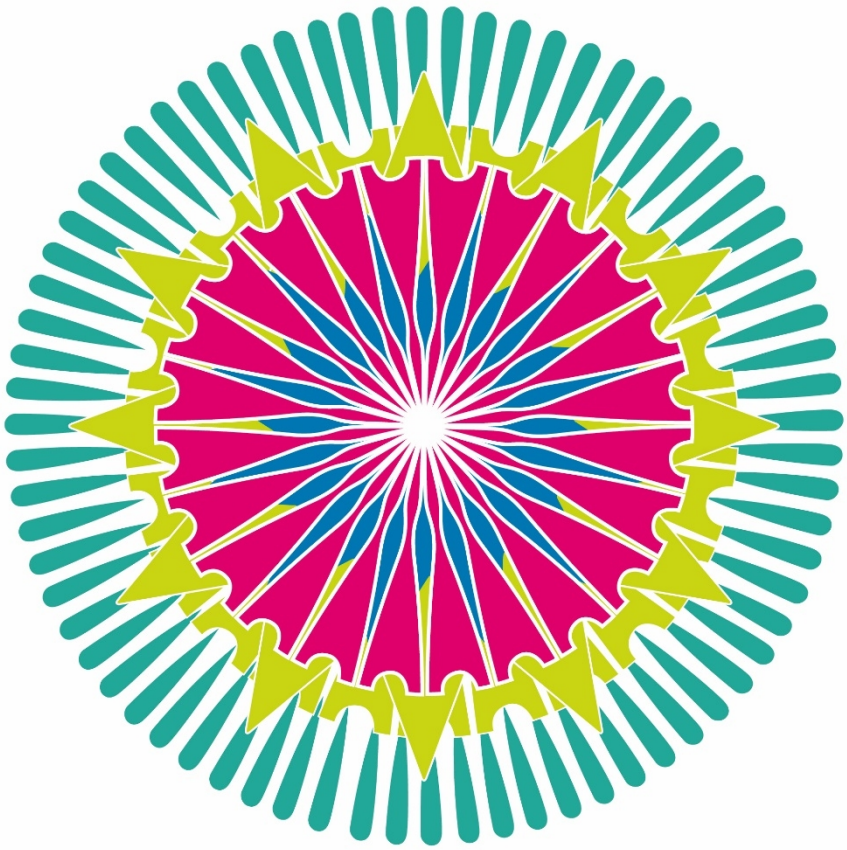

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