**External Evaluation**
**Thyolo Project, Malawi**
**Médecins Sans Frontières – Belgium**
**Operational Centre Brussels**

# A study of stakeholders' perception of Médecins Sans Frontières support to Thyolo district in Malawi

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FOREWORD

MSF Belgium has been working in Thyolo since 1997 supporting the Ministry of Health (MoH) in the provision of STI and HIV-TB care & treatment in the district. As in any context the project has evolved over time in order to remain responsive to medical demands, needs and developments. This evolution has seen the focus shifting from STI treatment and HIV prevention with home based palliative care in the early days of the project, to the provision of antiretroviral therapy (ART) since 2003 - a landmark being the attainment of universal access to ART in 2007 demonstrating that it is possible to scale up quality ART services in resource poor settings.

As such, the evolution of the project in Thyolo has also reflected the operational imperative within MSF to remain innovative and at the forefront of developments in HIV care. The piloting of new medical technologies and new models of service delivery has been a central and integral part of this. An important and concurrent operational objective in Thyolo has in turn been an ambitious operational research agenda that has allowed for the dissemination of findings at both national and international levels. Indeed, many of the best practices in HIV-TB treatment and care currently being advocated by MSF have reference to the experience gathered and described in Thyolo district.

At the same time the project has also evolved in response to changes in the national context relating to HIV – perhaps the most significant being the successful scaling up of the national treatment program. As the capacity of the national program has grown and strengthened, the nature of the support provided by MSF in the district has reduced and changed. Since 2008 HIV services have been increasingly integrated into general health care and thus MSF support into the MoH system, while an emphasis has at the same time been maintained on innovation and operational research to improve quality of care.

This scaling down and integration of MSF support continues today, with the aim being that the MoH increasingly assumes responsibility for HIV services in the district. A handover strategy is currently being planned together with the MoH to ensure that this transfer of responsibility occurs in a transparent, responsible and sustainable way. This evaluation was commissioned as part of this process - the aim being to gain a better understanding of partner and stakeholder perceptions of MSF support in Thyolo and elicit recommendations to guide the handover process.
MSF Belgium would like to extend our sincere appreciation to everyone who participated in this evaluation and for the invaluable feedback and recommendations we received.

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## About the author

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## Thanks

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## EXECUTIVE SUMMARY


In Malawi, one of the poorest countries in the world according to UNDP, Médecins Sans Frontières Belgium has been supporting MOH in the provision of HIV care since 1997 in Thyolo district, with provision of ART since 2003. MSF is looking to hand over program activities and phase out their presence. This external evaluation was commissioned with the overall objective of studying the perception of other stakeholders' perception of the MSF support to Thyolo district health services. The evaluation was conducted between March and May 2011, with a four week field visit in Malawi collecting qualitative data in Thyolo district, in Blantyre and in Lilongwe.

MSF support, in terms of financial, technical and material support, to Thyolo district was perceived as substantial and is appreciated by most stakeholders. The impact of MSF's intervention was perceived as undeniably positive, having contributed to a greatly improved access to care for PLWHA. MSF's intervention was also seen, particularly at district level, as having saved a lot of lives. MSF was also perceived as having pioneered ART and piloting innovating activities. Several stakeholders did however remark on the lack of sustainability of the MSF implementation with the creation of parallel and unique MSF systems where the overall health system is not strengthened. The majority of stakeholders was satisfied with how MSF communicates and collaborates with them. Some on district level did however remark on certain difficulties in collaborating with MSF, as MSF is seen as sometimes rigid and arrogant. Negative consequences of MSF's regional advocacy communication were also mentioned. On national level, stakeholders wanted more information on MSF's day-to-day operations.

In the district, most stakeholders, particularly beneficiaries, perceived MSF's decision to hand over the project as negative, fearing loss of acces to care and ARV's. In the community there was also a strong sense of doubt over the MOH's ability to take over the activities. Some stakeholders, particularly on national level, saw potential long-term gains for Thyolo and Malawi in MSF handing over the project. Challenges with ownership and aid dependency issues were seen as potential obstacles in the handover process, as well as gaps in HR, drug provision and transports being created as MSF pull out. MSF potentially staying in a mentorship position after 2013 was seen as positive by most. Regarding recommendations for the handover process most stakeholders focused on a multi-partner approach, MOH on district level being mentioned as a particularly important partner as well as the community, and a gradual transition including partners in planning was recommended. Stakeholders also mentioned changes in mentality being needed to obtain ownership.

Bearing in mind the scope of this evaluation, conclusions and recommendations could be drawn accordingly: informing the community on changes to come is important to appease worries and concerns over MSF's departure; creating conditions for dialogue and partnership is essential for a successful handover; and finally, a more efficient information sharing system could be put in place for lessons learned to be disseminated on national level.

## LIST OF ABBREVIATIONS

| | |
|---|---|
| 3M | Mai ndi Mai ndi Mwana |
| ADC | Area Development Committee |
| ART | Anti-retroviral Therapy |
| ARV | Anti-retroviral |
| CHAI | Clinton Health Access Initiative |
| CHAM | Christian Health Association Malawi |
| CBO | Community Based Organization |
| CO | Clinical Officer |
| CMT | Community Media Trust |
| DC | District Commissioner |
| DHO | District Health Officer |
| DHMT | District Health Management Team |
| DMO | District Medical Officer |
| FBO | Faith Based Organization |
| FLAEM | Family Life and Education Malawi |
| FOCHTA | Friends of Claude Ho in Thyolo Association |
| HSA | Health Surveillance Assistant |
| HRH | Human Resources for Health |
| HW | Health Worker |
| IEC | Information Education Communication |
| IHP | Improved Health Post |
| MANET+ | Malawi Network of People Living with HIV and AIDS |
| MOH | Ministry of Health |
| MP | Member of Parliament |
| MSH | Management Sciences for Health |
| MSF | Médecins Sans Frontières |
| NAPHAM | National Association of People Living with HIV/AIDS in Malawi |
| NAC | National Aids Commission |
| NONM | National Organization of Nurses and Midwives |
| OCB | Operational Center Brussels |
| OPC | Office of the President and Cabinet |
| PLWHA | People Living with HIV/AIDS |
| PMTCT | Preventing Mother to Child Transmission |
| PSA | Patient Support Assistance |
| TA | Traditional Authority |
| TDH | Thyolo District Hospital |
| TWG | Technical Working Group |
| UNDP | United Nations Development Program |

## 1. INTRODUCTION

The republic of Malawi is a small landlocked country located in Southeast Africa, with a population of approximately 14.85 million and a population density of 358 people per sq km of arable land, making the country one of the most densely populated countries in Africa. The country is one of the poorest countries in sub-Saharan Africa – ranking 160 out of 182 countries in the 2009 Human Development Index. According to UNDP, it is the 11th poorest country in the world, having a very narrow economic base with no significant mineral resources and high costs of external trade. Agriculture accounts for more than one-third of GDP and 90% of export revenues. Malawian economy is heavily dependent on aid from the IMF, World Bank and individual donor nations.[1]

In the health sector, the main problems are infectious diseases, especially HIV/AIDS, TB, Malaria and STIs, and maternal and infant health. With a prevalence in 2007 of 12.3%, Malawi ranks within the top 10 countries hardest hit by the HIV pandemic. According to most recent estimations, there are about 920,000 people living with HIV/AIDS in the country of whom 387,000 are in need of life-saving ARV treatment (according to <250 CD4 count).[2]

### MSF Project in Thyolo

MSF Belgium has been supporting MOH in the provision of HIV care since 1997 in Thyolo district in the southern region of the country. With a population of around 587,000 and an estimated HIV prevalence (adult) in 2004 of around 21% there are around 25,000 people in need of ART in the district, with HIV/TB co-infection rates also standing at around 75%. As in other parts of the country Thyolo also has around 70% vacancy rates for human resources in health placing severe constraints on the provision of HIV services and health related activities more generally.[3]

The primary objective of the project has been to reduce HIV/TB related mortality and morbidity in the district. Through a combination of decentralizing HIV care to health centre and community sites to increase access, task shifting to spread the workload and simplification of protocols for testing and treatment, it has been shown to be possible to achieve universal access to ART with reasonable/good clinical outcomes for large patient numbers in a high HIV prevalence, high TB caseload context. Critical also has been the engagement of the community and patient support groups to increase capacity, support program sustainability and strengthen the district's health system. Besides routine support to and capacity building of the district MOH, MSF is also using its project in Thyolo as a base for performing multiple operational research questions.[4]

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1 MSF, Country Policy Paper, 2011.
2 MSF, Country Policy Paper, 2011.
3 MSF, Terms of Reference External Evaluation, 2011.
4 MSF, Terms of Reference External Evaluation, 2011.

**Project Summary**

- Mission started in 1997. High prevalence, resource poor context with very high mortality rates due to HIV/AIDS and TB. Between 1997 and 2000, MSF project was directed mainly towards preventive activities, palliative care and the treatment of TB & STI.
- Introduction of antiretroviral therapy (ART) in April 2003.
- Decision to scale up to universal access taken in November 2005.
- Universal Access (defined as 80% coverage) achieved in August 2007.
- Re-orientation of the program towards integration and reduced involvement since 2008.
- Direct beneficiaries:
    1. 25,296 patients ever started on ART of which 2,249 (8.9%) children end Dec 2010.
    2. 18,753 active alive on treatment end Dec 2010.
- Ten ARV initiation sites (2 hospitals, 8 HCs), 24 follow up facilities (2 hospitals, 14 HCs, 8 IHPs).
- PMTCT (with < 350 CD4 protocol) available in 26 sites.
- Decentralised TB initiation at 1 site (Thekerani), but to be scaled up to 3 sites total in 2011

As mentioned above, MSF has been re-orientating project activities since 2008 with a view to reducing involvement and support to MOH by the end of 2013. As a first step in this process, HIV activities are increasingly being integrated into general health care provision with the concurrent aim being that MOH has the space to assume more responsibility. Planning for a more clearly defined exit strategy is currently underway with stakeholder meetings to discuss the process and agree on key indicators for handover planned for mid-2011. A critical element of the exit strategy will also be to more clearly define the gaps that MSF is currently filling and advocate for required resources at the zonal/national level.

## Rational for evaluation

The MSF Thyolo project is partially funded by DGCD who request periodic external evaluations as part of the funding agreement - the last external evaluation was conducted in 2007. MSF felt that as they were entering a crucial time in relation to their exit strategy, an external evaluation linked to this could potentially provide MSF with invaluable information and feedback to guide the handover process. As the active involvement and engagement of key stakeholders in the district will be imperative for the success of the exit strategy, it is felt that conducting an evaluation of the Thyolo project from the stakeholder perspective would be an important first step towards this. The approach to this project evaluation is thus very specific and

this report will only present key stakeholders’ views and perception of MSF support to Thyolo and is not an overall project evaluation.

Before presenting the main findings, an overview of the objectives of the evaluation and a short methodology section will follow below. The evaluator’s conclusions and recommendations will follow the main findings.

## 2. OBJECTIVES OF THE EVALUATION

### Overall Objective

To study the perception of other stakeholders in Thyolo District (community - MOH - other (I)-NGO) on the MSF support to Thyolo Health services in order to provide MSF with clear recommendations to guide the exit phase planning.

### Specific objectives

Objective 1: To gain a better understanding of how MSF support in Thyolo is perceived by stakeholders in the district.

Objective 2: To gain a better understanding of stakeholder perceptions of MSF's proposed exit strategy.

Objective 3: Receive clear recommendations from other stakeholders to MSF.

### Expected results

External analysis that will provide insight into stakeholder perspectives of MSF support in Thyolo and planned exit and in turn provide clear recommendations to guide the exit strategy process.

## 3. METHODOLOGY

The evaluation took place over a duration of eight weeks, between March and May 2011:

- One week for preparations, reading and briefings at MSF Sweden's office in Stockholm and at MSF-Belgium/OCB HQ in Brussels
- Four weeks in the field in Malawi for data collection : briefings, planning, visit of the project and first interviews (week 1), interviews in Thyolo district (week 2), interviews in Thyolo district and in Blantyre (week 3), interviews in Lilongwe (week 4).
- Three weeks writing up the report and for a presentation at MSF HQ in Brussels.

Qualitative methodology was used to collect primary data, mostly through semi-structured interviews with key informants representing a wide range of MSF stakeholders[5]:

- Ministry of health (district, zonal and national levels)
- Government (district and national levels)
- Local NGO's and networks (district and national levels)
- Community including traditional leaders and beneficiaries (district level)
- INGO's, UN-agencies, etc (regional and national level)
- Private (district level)

Sampling of the key informants was typical, as representatives of each group were selected on the basis of their representativeness of a particular group. The selection was made with the help of the MSF coordination team in Malawi. Selecting patients/beneficiaries and community leaders/CBO's to interview required more reflection as the population within those groups is much larger. The selection of these informants was made with the help of MSF staff familiar with the community. We selected one area with easy access to the Thyolo District Hospital (TDH) and Blantyre (Bvumbwe) and one area that was more remote and difficult to access (Thekerani). As the scope of this study is limited we did not use a large sample of the above population but rather collected data revealing some key issues, attitudes and perceptions. Another source of data was informal talks and discussions with MSF staff, community members and partners, as well as direct observation. The primary data was analyzed using domain analysis, a common method for qualitative data analysis[6]. Some secondary data sources were used consisting of key documents such as project documents, donor proposals, contextual documents, and evaluation reports.

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[5] For a detailed list of informants see annex 2

[6] For more information on domain analysis see for example Sarah Atkinson and Monica Abu El Haj, *Domain analysis for qualitative public health data*, 1996.

There are, as for all surveys, certain limitations to the results of this evaluation. The most obvious one is the evaluator's difficulty to disassociate completely from MSF. Although the evaluator was presented as an external consultant to the informants, had never worked for MSF in Malawi and used a translator who had never worked for MSF; the appointments were made by MSF staff, the evaluator arrived in a MSF car, and was introduced by MSF staff. This might have influenced answers given to a certain extent even if informants were asked to be as open and honest as possible.

## 4.1 HOW IS THE MSF SUPPORT IN THYOLO PERCEIVED BY STAKEHOLDERS?

### 4.1.1 Financial, material and technical support

At all levels, district, regional[7] and national, MSF´s financial, material and technical support to Thyolo district was seen as substantial and was by most, very appreciated. Types of support that were mentioned by informants were transport (district level), construction (district and regional levels), provision of drugs (district, regional and national levels), computerized data management (district and regional levels), laboratory support (district and national levels), and operational research (national level). Support in terms of staff, training and capacity-building was particularly emphasized (at all levels):

- Capacity building of stakeholders and community members, for example capacity building of NAPHAM[8] members.
- Capacity building and training of care givers through MSF expertise
- Capacity building of civil society
- Improvement of working conditions for health workers in rural areas
- Employment of local staff in the health sector

At national level, MSF's contribution to advocacy relating to the HRH crisis in Malawi was seen as important, particularly support in terms of technical support, information/evidence and financial support to local networks and organizations. Informants on national level and regional level dubbed this advocacy support to be actual mentorship and capacity building of civil society.

In the following sections, we will look at how the impact and appropriateness of this support is perceived by stakeholders at national, regional and district level.

### 4.1.2 Impact: MSF has improved access to health care

Stakeholders on district and regional level had an overwhelmingly positive response when asked what they thought of the impact MSF support has had in Thyolo district so far. The support was seen as having particularly benefited PLWHA in Thyolo district through the provision of better health care access with access to free ARV's, PMTCT and general medical treatment. As a manager of a support organization for PLWHA explained:

[7] In the findings, *regional level* refer to the informants interviewed in Malawi's southern region, but outside of Thyolo district, they include a representative of the MOH at zonal level.
[8] National Association of People Living with HIV/AIDS in Malawi

> "Provision of ART to members was good because their members' health was poor as they were suffering from AIDS. [Now] they were able to work and to do anything like a normal person"

Access to VCT and HCT, health education and psycho social support were also mentioned as beneficial to the population. The MSF IEC program was put forward as having given people much needed knowledge on HIV/Aids. Community leaders and PLWHA support group members also brought up access to nutritional support as valuable.

On both district, regional and national level, access to care through decentralizing health care, constructing and supporting rural health facilities (including the construction of IHP's), were also mentioned and underlined as having been especially beneficial to the health care needs of the PLWHA in Thyolo district. And, the IHP initiative was also seen as in line with national policy by a high ranking official of the MOH at national level. As explained by a PLWHA support organization representative:

> "It has brought pride to the members to know that someone is looking after their welfare and get the services at their own doorstep and they don't have to travel long distances."

MSF was seen, by a lot of the stakeholders, as having actively reached out to the community through the provision of health care in the most remote areas of the district. This is perceived by some, in this case by a village leader, as different from the way MOH provides health care services:

> "In the ministry of health services, […] people go to ask for the medication, they are offered reluctantly to the people. MSF comes to the villages and talks to the community, persuading the people to receive their services. So there is a difference between the services of the government and the services of MSF"

MSF was perceived, mostly by community stakeholders in remote areas, as having improved access to health through referral and transport of patients to health care facilities. MSF was perceived by community members and an MOH representative at district level as having improved not only access but also the quality of health care service in Thyolo district especially compared to other districts, through for example the reduction of congestion in health facilities.

#### 4.1.3 Appropriateness: MSF is perceived as having saved lives

The activities were seen by most stakeholders as appropriate to the needs of the Thyolo district population. Especially community members and leaders described the MSF intervention as having saved lives, there seemed to be a clear 'before and after' established in the community discourse, with people dying before MSF came, as illustrated by a community leader:

> "We have benefited from this organization. There used to be an issue of death, now there is no news of death. We have a lot of orphans, parents

> died before MSF came. The orphans' caretakers now survive thanks to the drugs offered by MSF."

In that respect ARV´s were perceived as MSF drugs in the community and MSF was perceived to be "looking after the people" and giving them their future back. Members of the community also perceived MSF as having encouraged openness and having induced less stigmatizing of PLWHA.

There were clear expressions of deep trust for MSF in the community. A couple of informants on district level mentioned MSF as having changed the mindset of the population, that more trust in western medicine has been created thanks to MSF. A community leader explained:

> "MSF has changed the mindset of people living in this area. People in the past would not trust the hospitals. Some went to the hospitals, some used traditional medicines. With the coming of MSF people have no fear of hospitals."

There were even expressions of emotional attachment to the organization; some spoke of a parent (i.e. MSF) to child (i.e. beneficiaries) relationship. Some in the district (support group members and representatives of local NGO´s) did however speak of MSF having "taught people to look after themselves" and not just MSF taking care of beneficiaries.

Emergency interventions, in particular response to outbreaks, conducted by MSF were also mentioned by a few stakeholders on district and regional level as having been appropriate to the needs of the population. These interventions also seem to have contributed to the good image of MSF in the community in Thyolo.

#### 4.1.4 MSF stands for pioneering and innovation on district and national level

At district level, MOH, the district government and some community leaders, perceived MSF as being pioneers, having put Thyolo district and Malawi on the map. The perception of MSF being at the forefront of HIV/Aids treatment was even stronger at regional and national level. A national stakeholder perceived MSF as a model and that lessons have been learned from MSF´s intervention.

MSF was seen as having piloted a number of different activities in Thyolo district: provision of ART and PMTCT and also proving that universal coverage is possible. Initiating and implementing task-shifting was seen as another innovation put in place by MSF, with its advantages and drawbacks. A high ranking official at MOH at national level saw, for example, both positives and negatives with using health surveillance assistants (HSA):

> "Using the HSA's is an inventive idea it's a cheap way of having a provider but it's also exploiting the health worker and it's also [not respecting] the regulations because you have someone who is not supposed to perform a service who is performing it. It's good because you can reach a lot of people but it's against regulation. Legally the HSA's are not registered as

> health workers but as a Ministry we are happy because they are providing a service."

A couple of stakeholders at national level perceived the "innovative" relationship between MSF and the district health management team (DHMT) as positive and "empowering", and as a partial explanation to Thyolo district success and performance. One of these stakeholders perceived this relationship as "a long term contribution crucial for Malawi".

Informants on national level all expressed that MSF has made important contributions on the national level in Malawi as well as in the district through the provision of strong support to the MOH and civil society, MSF being "key in the national response to HIV/Aids". MSF's work on national level was perceived as running mostly along two lines, (1) contributing to national policy on treatment of HIV/Aids; (2) contributing to solving the Malawian HRH crisis. MSF was seen as having contributed to policy development, to operational research and as having supported implementation in the national program. MSF support was perceived as especially important in pushing innovative approaches, as this informant explains:

> "Innovation is important because it helps to push the envelope in terms of where programming should be going, what kind of questions should be asking, which issues we should be considering. MSF can do that in a practical setting in Thyolo, they can try out new approaches. It's important because it helps prove that things can happen. MSF can then advocate for scaling up"

Another informant perceived MSF as having contributed to resource mobilization strategies and proposal writing for the Global Fund. Quite a few informants on all levels did think that MSF should scale up their support and thought it a "pity that they'd only concentrated their efforts in only one district".

#### 4.1.5 Lack of sustainability

Although MSF support to Thyolo district was perceived as having had a positive impact and as having been appropriate, some informants, particularly at national level but also at district level, pointed at issues of lack of sustainability in the way the MSF activities have been implemented. Representatives of different INGO´s, but also of national government, spoke of MSF having created a parallel system where the district is still very much dependent on outside input, in terms of for instance HRH, and where the overall health system has not been strengthened enough. On the district level, a local government representative spoke of MSF having set up their own structures. A member of the DHMT, underlines how HIV/Aids treatment programs are seen as MSF programs in the district and how this undermines sustainability of the activities:

> "Another example is PMTCT. All our nurses are trained on PMTCT so they should be given room to do PMTCT, MSF should just be there to mentor or to monitor. But if MSF has a nurse specifically to do PMTCT our nurses will not be doing PMTCT and they will think PMTCT is for MSF"

Another area where a number of informants pointed out issues of sustainability were the incentives and allowances given by MSF. For a period of time, incentives were given to MOH staff, something a member of the DHMT saw as detrimental on the long term:

> "Incentives is an area that killed the moral. When MSF started those issues of integration, they came with monetary incentives. […] So they said let's integrate and they gave our staff monetary incentives with performance conditions. The disadvantage is that when those incentives went off, now people are feeling that MSF left us with a lot of work but we are not getting paid anymore. […] The monitoring of that sort of process should have been done by the DHO [District Health Officer] but it was monitored by MSF. If we now go to the staff and tell them that it is their work they will say that MSF were given them something."

Some of the representatives of the local NGO´s interviewed at local level also expressed dissatisfaction on MSF giving allowances to community volunteers, making it particularly difficult for other organizations to come in and ask for volunteers to work for free and thus undermining activities:

> "That took away the spirit of volunteerism and it became difficult for the government and other stakeholders and NGO's to work with these committees because they were saying "we're MSF HBC committees" or "MSF HBC volunteers". It's difficult for those coming without incentives."

#### 4.1.6 Communication and collaboration: mostly excellent but a few hitches

The large majority of the informants interviewed felt collaboration and communication with MSF was smooth and sometimes even excellent. MSF was by most seen as transparent and open to collaboration. A high ranking official at MOH at national level even thought that MSF-Belgium in Malawi worked in a way unusual for MSF:

> "MSF has a history of not trusting governments but MSF-Belgium in Malawi has been very open to collaboration with the Ministry of Health. The collaboration could not have been better."

Informants at district and regional level, and some at national level, expressed satisfaction on the level of information shared by MSF. MSF are seen by some as very efficient and proactive in terms of information sharing. On national level, several stakeholders reflected on how good MSF is at participating in TWG, meetings and forums. One stakeholder qualified MSF's work as having a "multi-partner dimension".

A few stakeholders on district level, within the local government and MOH, were, on the other hand, critical of the way MSF communicates and collaborates, depicting them as arrogant and rigid:

> "There is some rigidity in the way they handle their issues. They stick to their guns when they want to do something."

> "I think the big thing is this they are being pushy and rigid, and sometimes they say these are the guidelines from the MOH. They somehow want to have their way. And it's not that nice sometimes."

> "MSF was taking itself as superior, know it all. As those who pioneered HIV/Aids treatment they have kind of a superiority complex. The other NGO's were kind of inferior. They are confident, they know everything and they cannot share with other NGO's."

One member in the district health management team (DHMT) perceived the difficulties in communicating as a result of changes in management:

> "Initially it was excellent, really good, but because of management changes, on MOH and MSF sides, the usual linkage that was there tends to loosen up. Maybe there wasn't a proper handover. […] Sometimes there are misunderstandings, the interests tends to differ. All in all we have been working together as partners in health. The end result should be that patients feel like that they are taken care of. "

Although most stakeholders felt like MSF is sharing enough information some stakeholders, at district and national level, felt a lack of information sharing. At district level, MSF were portrayed by a member of the DHMT as not sharing enough information and "hiding reports". On national level, several stakeholders wanted more information on MSF´s day-to-day operations. This was especially important, according to one informant, because of the innovative nature of MSF support in Thyolo:

> "From a public health stand point, in terms of lessons and learning to move the national response forward, it's critical to have a more effective dissemination system on what is going on, especially now that [MSF] are in transition to closing down shop. We risk losing what is going on because there hasn't been enough broad buy in"

The same informant pointed out that the information sharing system in Malawi does not work well and "you have to make a real effort for everyone to get the information". The same person also thought that MSF should have joined the HIV/AIDS donor group earlier, as "it would have been a way to ensure that others are aware so that they can also bring it up".

Two informants, both outside MOH and NAC (National Aids Commission), independent from each other brought up the subject of the communication initiated by MSF´s regional office on ARV stock outs in Malawi in 2010 and how it had tarnished MSF image with the MOH and NAC. According to one of the informants MSF has since then been "criticized for being a crying wolf by the MOH and NAC" and "discarded by NAC as a troublemaker":

> "You can take advocacy too far, you can be too strident and you have to be careful because then people stop talking and listening rather than

> addressing the problem. On a couple of occasions, MSF has tended to be the international strident advocacy organization. It could have been done differently to engage people in a dialogue to discuss how to solve the problems."

The same informant felt the issues should have been discussed with the government before going public. The second informant perceived the MSF communication as having "exposed a weakness in the Malawian system and thus embarrassed the government". None of the representatives of NAC/MOH interviewed at national level raised this issue.

## 4.2 HOW IS MSF'S PROPOSED EXIT STRATEGY PERCEIVED BY STAKEHOLDERS?

Most informants had heard of MSF impeding exit from Thyolo strategy, some had heard about it through rumors, some through official communication. A couple of informants on district and regional levels requested more information on why MSF had decided to leave, with "a presentation of baseline data, benchmarks and impact assessment".

### 4.2.1 Possible negative impact from handing over

On the district level, an overwhelming majority of stakeholders thought MSF´s decision to leave would have a negative impact on the district. Quite a few informants on district level (and a couple on national level) expressed apprehension and distress about MSF leaving. Especially community leaders and members of support groups for PLWHA thought the consequence would be dire: "people will suffer and die", "if MSF goes, there will be no chief, there will be no people, a lot will suffer", "if the mother [i.e. MSF] goes, the children will suffer", "we are crying because MSF is leaving". In fact a lot of community leaders and members equaled MSF´s presence to ARV provision and were worried things were going to go back to how they were before ARV´s were provided in the district. But also on national level, a high ranking official at the MOH expressed worry:

> "We're apprehensive of what is going to happen as MSF is pulling out, if we can go as far as MSF did, because we have a lot of people on treatment and that requires a lot of input. And so hope that all of that will be covered."

On all levels, stakeholders expressed fear of the risk of achievements being lost. One stakeholder on national level expressed worry because there was not enough information given on which mechanisms were going to be put in place to sustain those achievements. In the district, some informants said they could already feel the negative consequences of MSF ceasing some activities, in particular nutritional and monetary support were mentioned, as well as less presence of MSF staff in some health centers.

On the district level especially, and in the community particularly, a great number of informants expressed doubt concerning MOH´s ability to take over MSF activities. Several factors were mentioned as contributing to this inability:

- Corruption (including misuse of drugs):

> "If you surrender the MSF services to the government today, government will not care for them. After all pilferage is rampant in the government hospitals, so how MSF will be assured that government is assisting its people."
>
> "If you move out today, the government will definitely be the ones benefiting and not these people."

- The MOH's inability to meet HR needs
- Drug provision
- Quality of services
- Lack of funds
- Lack of commitment of MOH staff to providing good quality care

Also at national level, a representative of a local NGO expressed doubt concerning MOH's capacity to provide services at MSF level, she did however predict that MOH staff, if mentored and provided with capacity building, might be able to provide "60-70% of MSF services - Maybe".

#### 4.3.2 Possible long term gains with handing over

More informants on the national then on the district level thought that MSF´s decision to leave was a positive one; the perception being that more long-term gains could be made by handing over activities to the MOH. As one informant put it "It´s better to teach someone to fish then fishing for them", the same informant saw MSF leaving as a graduation opportunity for the district as the "bird has to be pushed out of the nest" at some point, potentially paving the way and setting a very important precedent for other districts. However the informant admitted it might be an impossible task for MSF in the context of aid dependent Malawi. A representative of a local NGO at national level thought it obvious that MSF should take another role in supporting the MOH and other Malawian partners:

> "For me, and that should have been approached in the first place, MSF-Belgium is an international organization, I think they have a critical role to build capacity. So my personal view is that's the way they should go, they should not busy themselves with service delivery. They should be supporting the structure that does service delivery. They should play that role in terms of support to the health facilities, the civil society organizations, the community based organizations, the organizations of people living with HIV to deliver the services. That should be their approach. [...] These [structures] may have their own challenges and that's where MSF become handy, in supporting these structures."

A representative of a local NGO on district level also perceived MSF leaving as a positive development as it would help sustain the activities.

Several other stakeholders on national level were more mitigated, saying that MSF exiting could have a positive impact if MSF withdrew in the right way: (1) if MSF withdraws responsibly; (2) if lessons are learnt and spread; (3) if other partners come in and fill certain gaps (not just the health district).[9]

### 4.2.3 The challenges of handing over will be multiple

Informants could identify multiple challenges that MSF would face when preparing and implementing the exit strategy. On the regional and national level, informants thought exiting would be challenging because of the lack of sustainability of the MSF intervention. A few informants spoke of the general context of aid dependency in Malawi and how dependency has been sustained by MSF in Thyolo, as “the district has been receiving a lot from MSF”, the risk being that:

> “The district sees [the achievements] as MSF achievements and not their own. There should be pride in achieving instead of deferring to outside forces”

Another informant on national level, positive to the decision to leave, believed that people in Malawi are used to have things given to them and there is a sense of not being able to achieve without outside help, making the process of exiting difficult for MSF. Two informants on the national level specifically mention obtaining district ownership as a challenge for MSF. One informant pointed at the uniqueness of the systems put in place by MSF in Thyolo and how exiting will create gaps in terms of ownership and capacity. The other informant spoke of the need to create confidence:

> “The biggest challenge is how to help people over the individual and collective hurdles that they need to get over in order to feel confident in that ownership.”

The same informant saw MSF support to Thyolo as a “wasted experience” if ownership is not obtained:

> “If it’s seen as “a MSF project and not our project”. If it’s seen as “We’re here because you’re paying, as soon as you go we will stop”. If that happens then it’s been a wasted experience”

> “Demonstrating that people can stand firmly on their own two feet, that they have the capacity to respond to this epidemic irrespective of what else might come in. We can still do something. That is critical. Especially because of a context where all hell could break loose and the donors withdraw all their funds. Ensure that the local communities can survive that storm if and when it comes ”

[9] For more recommendations made by stakeholders see section 4.3 and annex 3

On district level, a community leader used an eloquent car metaphor to illustrate how important ownership is:

> "If you have a car and give it to someone who hasn't sweated for it, the car will not be cared for. The care will be different. The one who has sweated for it will be much more careful than the one was just given the car."

In fact, obtaining ownership was also put forward by a member of the DHMT as a prerequisite for a successful handover process: "We need to own the programs and not to act as supporters". However the same informant expressed some skepticism towards MSF and whether MSF would relinquish power: "Proposals for change will not be accepted by MSF. Power is not given to the ministry." And the relationship between MSF and the DHMT was indeed seen as crucial for a successful handover by a number of stakeholders, on national and district level:

> "Another challenge is resistance within the DHMT, it depends on the relationship between MSF and the DHMT. If it's good, there won't be a challenge. If it's not good, it will be challenge, because they might say that the activities are MSF activities and not for them to do."

Another challenge brought up by several stakeholders on national level was how difficult it will be for MSF to witness what is going to happen as they pull out, witnessing the "decrease of quality of service" and having to sacrifice activities that they originally implemented for a reason. One stakeholder also mentioned it will be difficult for MSF to lose importance as stakeholder when pulling out. Stakeholders on national level also mentioned the challenge of facing the pressure to stay and continue to deliver services because of the high demand created to deliver those services in Thyolo district. An informant pointed out the frustration that could arise in the community as they will be expecting good services and not be receiving it anymore, a frustration that could be taken out on health workers.

Three specific gaps that would be created as MSF pulls out where identified by most stakeholders, but particularly on district level:

- Human resources
- Overall mobility and transports, particularly for outreach activities in hard to reach areas (gaps in terms of cars, maintenance, fuel and drivers).
- Drug provision

Some informants on district level also spoke of gaps in terms of quality of care, as MSF staff is perceived as more caring than MOH staff, health facilities could become congested again and counseling and psycho-social support might not be sustained. On the national level, stakeholders spoke of gaps in terms of financial and material resources as the handed over activities would be on top of what the health district already does, and also because of the difficult situation for funding of ART.

#### 4.2.4 Continued presence after 2013?

When discussing the possibility of MSF staying for mentorship after 2013, all of the stakeholders were positive. Some, on the national level, saw it as a possible (post)-exit strategy guaranteeing a more sustainable exit:

> "That will be a very good exit strategy. Because now it's like: "Holding my hand, let's go to work." That's the approach that has been taking now. But that would be saying: "One, two three, can you go and implement and I'll monitor how you're doing, if you need this we can provide it, but it's actually you as a health worker doing it."
>
> "The transition of going into mentorship is a good initiative. It guarantees continuity and sustainability and the MSF program will not just be ad hoc"
>
> "When you mentor and do capacity building you reach more people that can provide services themselves. You also transfer skills so people can do it themselves."

Still on national level, one informant thought that MSF was in a good position to mentor and do capacity-building, because of their experience and their expertise. A word of caution was given by one stakeholder, saying that a continued presence should not mean continued dependence.[10]

### 4.3 RECOMMENDATIONS BY STAKEHOLDERS

When meeting informants, they were asked to give recommendations to MSF on the upcoming handover process. Most were more than willing to give ideas and thoughts on what MSF should pay attention to when pulling out of Thyolo. However, support group members and beneficiaries in the community had just one main recommendation for MSF, which was to stay. For a detailed list of all recommendations made by stakeholders please see annex 3.

Regarding which actors MSF should be involving in the handover process, MOH at district level was mentioned by most informants, MOH at zonal and national level were also mentioned. Involving community leaders, community organizations and village committees was also seen as vital to the process by quite some informants, because they could play a potentially crucial role in making the handover sustainable, transparent and in holding MOH accountable. On national level, informants mentioned the local government as important to include in the process, in order to "mainstream HIV/Aids" and integrate the activities that are handed over into the district planning. A few informants recommended MSF to hand over some of the activities to other local or international NGO's.

[10] For more recommendations on a continued presence after 2013 see the next section but also annex 3.

Concerning planning, most informants underlined the importance of involving partners in the planning process: MSF should listen to partners, planning should be made with them and MSF should actively communicate expected roles and responsibilities. One informant wanted MSF to make sure "unreasonable expectations" were avoided and encouragement provided by defining responsibilities. Another informant (at national level) spoke of establishing terms of reference. Establishing a communication strategy in the community was seen as vital by some informants, especially by representatives of local and international NGO's. One representative of a local NGO in the district wanted to see "good-bye meetings" organized by MSF in the community:

> "People are hearing rumors that MSF are leaving. MSF should organize good-bye meetings where they present achievements, changes in the community and were they can express appreciation for the support given. It would help to motivate the people to see how they can make their community better. Also emphasize that the people continue working on a voluntary basis. Also include CBO's and youth organizations. It would be a chance to show off the MSF volunteers and link them with to CBO's and youth organizations"

Communication with the local government and the DHMT was also seen as important. Several informants emphasized that MSF's relationship with the DHMT has to be improved in order for the handover to be a success. One suggestion made by a member of the DHMT was more regular meetings.

As discussed earlier, transferring ownership of the activities to the MOH was seen as crucial by informants. To obtain ownership several recommendations were made by stakeholders, some referring to a change in mentality and culture:

> "MSF has to change, instead of being in the driving seat they have to come to the supporting role"

> "A culture of self-sufficiency should be created"

> "MSF needs to demonstrate a break in the mentality so that people own the epidemic and the response to it"

Other informants mentioned capacity-building of partners in order to ensure ownership. Generally, training and capacity-building were mentioned by a lot of stakeholders for MSF to invest into before leaving. Training of MOH and civil society was suggested. Establishing a scholarship program for training of health workers was mentioned by one informant, as well as training of community volunteers to make up for the lack of MOH staff.

Documenting lessons learned was seen as important, particularly by stakeholders on national level who saw a chance to extend MSF achievements in Thyolo to other districts:

> "MSF should also document best practices and lessons learned. MSF should also do an impact study. They should inform the national response

> and this information can be used by other NGO's and stakeholders in other districts and on national level. It would be very useful MSF should document what processes have led to the achievements and what delivery model of HIV services is used."

If achievements in Thyolo are not documented, one informant saw the risk of loosing what has been achieved by MSF.

Continued advocacy by MSF to contribute to solving the HRH crisis was mentioned as important by one stakeholder. National and international advocacy for more resources (funds and HR) to be allocated to the district to enable the MOH to take over the activities was also mentioned by several informants. As mentioned previously, most informants were positive to MSF potentially staying on in the district in a mentoring role after 2013. Informants mentioned capacity-building and strengthening of the health system as important after 2013, as well as supervision of the MOH. Finally, donation of material resources was mentioned as a recommendation by quite a few informants in the district, particularly donation of cars.

## 5. Conclusions

Going out in the community, meeting care providers, speaking to members of PLWHA support groups in Thyolo, the impact of MSF's intervention in Thyolo is undeniable, even in the most remote areas. After fourteen years in Thyolo district MSF has left its mark by proving universal coverage is possible in a high HIV prevalence, high TB caseload context. But the way MSF has gone about doing it, by putting in place their own systems, has created dependency on several levels in Thyolo district. In the community, MSF is perceived, rightly, as a life-saving organization without which the population feel they will not survive. As described, a very strong relationship has been created between MSF and the community, where there are expressions of great worry and fear now that MSF have announced they will hand over the activities. Although MSF and the MOH have been working in partnership for some time, the MOH is not perceived by the community as capable of taking over the activities implemented by MSF.

By the DHMT, MSF is seen very much as an outside force that has not been working in real partnership with the MOH, instead MSF is seen as being in the driving seat enforcing their own decisions and point of views without enough input and buy-in from the DHMT. Even if most stakeholders speak of excellent collaboration with MSF, MSF is, especially on district level and particularly by local NGO's, largely seen as a provider – of technical, material and financial support – and not as an equal partner. Not being an equal partner, and 'just' a provider, entails a power dynamic between the involved actors that easily translates into a dependency syndrome where one partner is dependent on the other. In the general context of aid dependency in Malawi, this dynamic is easily reproduced making issues of sustainability and empowerment difficult. On national level, where stakeholders can be seen as having more of a global and 'outsider' view of the project, the lack of sustainability in MSF's intervention is indeed remarked upon, especially because the Malawian context is a development context where, in general, aid interventions are expected to strive for sustainability and empowerment of local actors.

In view of MSF's upcoming withdrawal from Thyolo, issues of sustainability and empowerment will become crucial for a successful handover with hopes of services being maintained at a reasonable level. But as sustainability is not MSF strongest suit, the next few years are going to be key in how MSF manages to balance its usual direct implementation approach and the challenges of empowering partners in Thyolo to take over activities, empowerment in this case, as in most others, entailing real and equal partnership. Indeed, for some stakeholders on national level, real success of MSF's intervention in Thyolo will only be achieved with a successful handover, and thus with real long-term gains for Thyolo health district.

Looking at the recommendations given by the MSF stakeholders, there is a heavy emphasis on having a multi-partner approach in the exit strategy. The DHMT is of course seen as crucial for the success of the handover but quite a few stakeholders also brought up the role that the community could play, not only as beneficiaries of the programs but also as 'watch-dogs' and contributors. In creating such a close

bond with the community there is a potential for MSF to build a dynamic over the next few years where dependency could be turned into empowerment. Involving the community in the handover process could lay the grounds for a transparent process where different partners called upon to take over activities could be held accountable to the beneficiaries.

Creating ownership is also mentioned by several stakeholders as crucial during the handover process. But in order to create ownership of activities that are handed over, MSF has to let go of some of its own ownership, in fact to create equal partnership, MSF has to let go of some of the power, some of the ownership and some of the say and allow partners to fully participate in the process.

Finally, on national level, there was a strong demand for documentation on lessons learned in Thyolo. On lessons learned up until now, on the implementation of current and past activities, but also on the lessons that will be learned over the next few years. Because of the Malawian development type context, stakeholders have a specific interest in processes where local partners are empowered to achieve on their own providing long term gains for the country impossible to achieve with a direct service delivery approach.

## 6. Recommendations

Since the scope of this evaluation was limited to stakeholders' perception of MSF's intervention in Thyolo district, the recommendations given below will be limited to issues closely related to MSF's collaboration and communication with stakeholders.

**Recommendations on communication in the community**

When meeting beneficiaries, community leaders and support group members, great worry and apprehension were expressed in face of MSF pulling out of the district. Most had heard of the changes to come through rumours and there were a lot of question asked to the evaluator on the consequences of MSF's departure from Thyolo. Because many in the community seem to equal ARV provision to MSF, it is essential to communicate the difference between MSF and access to ART, the second can prevail without the first, things do not have to go back to how they were before ART was made available in Thyolo.

1. Information meetings in the community should be organized by MSF as soon as possible to hinder spreading of false rumours and to appease fears and worry

2. MSF should dissociate itself from ART and clarify that ARV's are not MSF drugs

3. Information meetings in the community should, if possible, be organized through out the exit process to engage the community in the process and gather information on specific issues

4. Roles and responsibilities of all of the actors involved should be clarified to the community

5. Partners should be invited to participate in the community information meetings

**Recommendations on collaboration and communication with partners**

Developing a good relationship with partners will be crucial for a successful handover. As suggested by Lauren Pett in her paper on MSF exit strategies, dialogue is key when trying to establish a good relationship with partners; she emphasizes on the difference between giving instruction/information and having an actual policy of dialogue.[11] Also, the assessment made of MSF's exit from an HIV/Aids project in Lesotho, where a specific exit strategy tool was used, the same that will be used in Thyolo[12], stressed the importance of improving dialogue and communication with partners during the exit process.[13] Thus, in view of some of the negative comments made by the DHMT, MSF's principal partner in the hand over process, time and energy will need to be invested into creating conditions for true partnership. Indeed, ensuring a true dialogue with partners will enable ownership transference and partners participation in the process.

1. A systematic and formalized information-sharing system, where information is shared frequently, should be implemented

2. The information shared by MSF should be consistent and transparent

3. A systematic and formalized meeting schedule, with frequent and regular meetings, should be implemented. The meeting agenda should not be systematically set by MSF, but participants should take turn in setting the agenda

4. Participatory methods should be used during meetings to avoid partners perceiving MSF as giving instructions

5. Partners' creativity and sharing of ideas should be stimulated during the exit process

6. A culture of patience is needed, partnership takes time to build

7. Recruiting staff in key positions with experience from integrated programs should be considered, with experience of working within or with the Ministry of Health, and with thorough knowledge of the Malawian context

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[11] Pett, Lauren, *A Different Approach to Ensure Better Outcomes for Patients after MSF Exit*, July 2010.

[12] The tool was provided and implemented for the handover of activities by Guillaume Jouquet, consultant for MSF-OCB, The tool has been used in Lesotho and South Africa. The method originated from a technique developed by Henry Mintzberg and promotes the formulation of a strategic objective from which operational objectives and indicators are derived.

[13] Désilets, Annie, *Assessment of Handover Strategy of MSF-B HIV/TB Programme*, 2010

**Recommendations on advocacy and information sharing on national level**

When interviewing informants on national level, there was a strong interest in MSF activities in Thyolo but also an expressed lack of knowledge on day-to-day operations that could benefit other stakeholders. Several stakeholders also emphasized the potential long-term gains that could be made in Malawi if the lessons learned by MSF in Thyolo were spread and duplicated.

1. Stepping up information sharing and dissemination of lessons learned on national level should be considered

2. The most effective ways of communicating and sharing information should be mapped out

3. Potential key areas of innovating activities in Thyolo that could be of interest to stakeholders in Malawi should be identified

4. Opening an advocacy position in Lilongwe to increase availability and proximity to stakeholders on national level should be considered

## ANNEX 1: REFERENCES


- Atkinson, Sarah and Abu El Haj, Monica, *Domain analysis for qualitative public health data*, Oxford University Press, 1996.

- Désilets, Annie, *Assessment of Handover Strategy of MSF-B HIV/TB Programme*, AD Management, 2010.

- Médecins Sans Frontières (MSF) Belgium, Operational Center Brussels, Country Policy Paper, 2011.

- Médecins Sans Frontières (MSF) Belgium, Operational Center Brussels, Terms of Reference External Evaluation, March 2011.

- Pett, Lauren, *A Different Approach to Ensure Better Outcomes for Patients after MSF Exit*, MSF UK, July 2010.

## ANNEX 2: LIST OF INFORMANTS (INDIVIDUAL OR GROUP INTERVIEWS)

***Ministry of health***

- Thyolo DHO
- Thyolo DMO
- Thyolo Health District - Matron, Administrator and Accountant
- Thyolo Health District - ART Coordinator
- Thekarini Rural Hospital - Two medical assistants
- Thukuta Improved Health Post - Two PSAs and one HSA
- Zonal Supervisor HIV Coordinator South-West Zone
- MSH - Senior HIV Advisor (former HIV Unit / Senior Technical Advisor)
- HIV Unit - Director
- HRH Department - Principal Human Resource Planning Officer, Training Officer and HR planning officer

***Government***

- Thyolo District Aids Coordinator
- Thyolo District Commissioner
- NAC - Head of Policy Support and Development

***Local NGO's and networks***

- NAPHAM Thyolo - District Coordinator and Program Manager
- CMT - Project Coordinator Thyolo
- FOCHTA - Executive Director
- Thyolo Active Youth - Two field officers and one program officer
- FLAEM - Executive Director
- NAPHAM - Executive Director
- MANET+ - Executive Director
- NONM - Director and Information and Advocacy Officer
- Malawi Health Equity Network - Project Officer Good Governance

***Community***

- Traditional authority of Nsabwe
- Group Village Head Ndaona
- Group Village Head Kajoli
- One 3M mother
- Three beneficiaries of the ART-program Thekerani Rural Hospital
- CBO representative of Thukuta
- ADC representative of Thukuta
- Members of  the Mbawela Support Group
- TA Bvumbwe

- Four Village Heads Bvumbwe
- Three CBO representative Makungwa
- Members of  the Ngolongoliwa Support Group
- Sub Traditional Authority of Ngolongoliwa

***INGO's, UN-agencies, etc***

- World Vision - Capacity Building Officer
- Dignitas - Medical Coordinator
- CHAI - Country Director
- UNAIDS - Country Coordinator

***Private***

- Confozi Tea Estate Health Center - Clinical Officer

| | Key actors to involve in the handover process | Recommendation made by |
|---|---|---|
| **1** | MOH district level | INGO/UN-agency<br>MOH (national level)<br>Local NGO (national level) |
| **2** | MOH zone level | MOH (national level) |
| **3** | MOH national level | INGO/UN-agency<br>Local NGO (national level) |
| **4** | Local NGOs including NAPHAM and MANET:<br>- Allow them to give input | MOH (national level)<br>Local NGO (national level) |
| **5** | CHAM (Christian Health Association Malawi):<br>- For them to understand the changes | MOH (national level) |
| **6** | Training institutions like the Malumolo Teaching College | MOH (national level) |
| **7** | The nurses union | MOH (national level)<br>Local NGO (national level) |
| **8** | Politicians at national level (MP) | INGO/UN-agency<br>MOH (national level) |
| **9** | Government at district level | INGO/UN-agency<br>MOH (national level)<br>Local NGO (national level) |
| **10** | Village committees | Local NGO (national level) |
| **11** | Community leaders | MOH (community level) |
| **12** | The community:<br>- To hold MOH accountable<br>- To allow for transparency in the handover process<br>- To ensure sustainability | Community leader<br>Local NGO (district level)<br>Government (district level) |
| **13** | UN-agencies | Local NGO (national level) |
| **14** | OPC (Office of the President and Cabinet) | Local NGO (national level) |
| **15** | MSF should link with CBO's and youth organizations before leaving | Local NGO (district level) |
| **16** | Empower the community, MOH cannot cover everything | Local NGO (district level) |

| | | |
|---|---|---|
| **17** | MSF should mobilized and sensitize community leaders to the role they can play | Local NGO (district level) |
| **18** | Another NGO should come in and take over after MSF | Government (district level) |
| **19** | MSF should hand over some or all activities to other organizations | Government (district level)<br>Local NGO (district level)<br>INGO/UN-agency |

| | **Planning** | **Recommendation made by** |
|---|---|---|
| **1** | There should be a gradual transition | MOH (zonal and national level)<br>INGO/UN-agency<br>Local NGO (district and national level)<br>Government (national level) |
| **2** | MSF should establish a good transitional plan identifying key areas and partners | INGO/UN-agency |
| **3** | MSF´s planning should be integrated into district planning. The planning should be joint and part of the district planning | Government (national level) |
| **4** | MSF should plan with partners | INGO/UN-agency |
| **5** | MSF should clarify to partners which type of support will and will not be provided | INGO/UN-agency<br>Government (national level) |
| **6** | MSF should define what they will do after exit, might do, and never do to avoid unreasonable expectations and provide encouragement. | INGO/UN-agency |
| **7** | Identify MSF activities as opposed to DHO (District Health Officer) activities | INGO/UN-agency |
| **8** | MSF should listen to partners to understand what assistance they need to take over, and support them in those areas | Local NGO (national level) |
| **9** | MSF should look at the national guidelines to examine what extra services they've put in place | MOH (national level) |
| **10** | MSF should prepare staff, MOH and partners | Local NGO (national level) |
| **11** | MSF should not start with new programs | MOH (district level) |
| **12** | MSF should share the plan with stakeholders, local authorities and partners. Everyone should be made aware, they should know which functions are taken over by who | Government (national level) |

| 13 | It should be made clear what sort of support MSF will be giving, clear roles and responsibilities for both parties are necessary. Terms of reference should be established: who is expected to do what and when, in other words a transition plan | Government (national level) |
|---|---|---|

| Communication | | Recommendation made by |
|---|---|---|
| 1 | MSF should communicate which activities are important to the community to the DHO and the DC | INGO |
| 2 | MSF should establish a communication strategy to the DHO, the DC and the community | INGO |
| 3 | MSF´s communication message to the community should be that the activities will continue | INGO |
| 4 | Sensitization should be done in the community by MSF on the changes to come, it should start immediately | Local NGO (national level) |
| 5 | MSF should organize good-bye meetings in the community:<br>- To present achievements, changes in the community and were they can express appreciation for the support given.<br>- It would help to motivate the people to see how they can make their community better.<br>- Include CBO's and youth organizations. It would be a chance to show off the MSF volunteers and link them with to CBO's and youth organizations | Local NGO (district level |

| Documentation | | Recommendation made by |
|---|---|---|
| 1 | MSF needs to make sure people know what has been done so it doesn't get lost | INGO/UN-agency |
| 2 | MSF should document and trumpet lessons learned | INGO/UN-agency<br>MOH (national level) |
| 3 | Reader-friendly and user-friendly guidelines and manuals should be created by MSF to be used to teach others | MOH (national level) |
| 4 | MSF should also document best practices, lessons learned, and do an impact study. They should inform the national response and this information can be used by other NGO's and stakeholders in other districts and on national level. It | Government (national level) |

| | would be very useful if MSF could document what processes have led to the achievements and what delivery model of HIV services is used | |
|---|---|---|

| For MOH ownership | | Recommendation made by |
|---|---|---|
| **1** | MSF has to change, instead of being in the driving seat they have to come to the supporting role | MOH (district level) |
| **2** | MSF needs to demonstrate a break in the mentality so that people own the epidemic and the response to it | INGO/UN-agency |
| **3** | MSF should not stay physically in Thyolo after 2013 | INGO/UN-agency |
| **4** | MSF needs to establish and clearly define what the “Thyolo model” is to create capacity building programs to pass on to other stakeholders. Talk not only to MOH and NAC (National Aids Commission) and OPC (Office of the President and Cabinet), but also to the DC because it is an issue of building broader capacity, to mainstream HIV/AIDS into the broader district agenda to have just one plan in the district and not a separate HIV/AIDS | INGO/UN-agency |
| **5** | A culture of self-sufficiency in the community should be created | Local NGO (national level) |
| **6** | MOH should become a real partner to MSF | MOH (district level)<br>Government (district level) |
| **7** | MSF should do capacity building | Local NGO (national level) |
| **8** | More room should be given to suggest how MSF should support the district health management team (DHMT) | MOH (district level) |
| **9** | MSF needs to establish a better collaboration with the DHO | MOH (district level)<br>Government (district level) |
| **10** | MOH should take more responsibility | Local NGO (district level)<br>MOH (community level) |
| **11** | MOH should do their own supervision with MSF going along once in while | MOH (district level) |
| **12** | MSF needs to be more flexible with their policies | MOH (district level) |
| **13** | There should be better communication and collaboration between MSF and MOH, including more regular meetings | MOH (district level) |
| **14** | MSF should organize MOH visits to other sites | MOH (district level) |
| **15** | The data should be managed by the MOH | MOH (district level) |

| | Training and capacity-building | Recommendation made by |
|---|---|---|
| 1 | Medical assistants should receive specialized training and be upgraded | MOH (national level) |
| 2 | MSF should do capacity-building of civil society organizations | Local NGO (national level)<br>Government (national level)<br>INGO/UN-agencies |
| 3 | MSF should train in the provision of ART and in counseling of MOH staff | MOH (district level)<br>Community leaders<br>Local NGO (national level) |
| 4 | MSF should do trainings in data management | MOH (district level) |
| 5 | MSF should train more health workers | Local NGO (district level) |
| 6 | MSF should train clinical staff and nurses in the health centers | Private stakeholder |
| 7 | MSF should provide scholarships for training of HW, especially in management positions | Local NGO (national level) |
| 8 | MSF should train community volunteers to make up for the lack of MOH staff | Government (district level)<br>Local NGO (district level) |

| | Advocacy | Recommendation made by |
|---|---|---|
| 1 | MSF efforts in advocacy in HRH should continue | Local NGO (national level) |
| 2 | MSF should lobby for more resources for MOH at international and national level | Government (district level) |
| 3 | MSF should advocate for allocation of more staff to the district | Local NGO (district level)<br>INGO/UN-agency |
| 4 | MSF should continue with international advocacy (for example Global Fund) because MSF has the weight to bring it on the international agenda. | INGO/UN-agency |

| | Continued presence after 2013 | Recommendation made by |
|---|---|---|
| 1 | MSF should build capacity within the health system | INGO/UN-agency |

| | | |
|---|---|---|
| **2** | MSF should mentor proper implementation of ART and PTMCT guidelines | INGO/UN-agency |
| **3** | MSF should do capacity building in management and not just clinical skills | INGO/UN-agency |
| **4** | MSF should train in leadership | Local NGO (national level) |
| **5** | MSF should do supervision of MOH | Community leader |
| **6** | MSF should stay beyond the exit phase to witness the consequences of their exit | MOH (national level) |
| **7** | MSF should focus on Thyolo District Hospital, Thekarini rural hospital, certain health centers, transport for supervision | MOH (zonal level) |

| **Other** | | **Recommendation made by** |
|---|---|---|
| **1** | MSF should have a post-exit strategy | INGO/UN-agency |
| **2** | MSF should stay and not pull out | Community<br>Private stakeholder<br>MOH (national and zonal level) |
| **3** | MSF should stay longer | Community<br>MOH (national and zonal level) |
| **4** | MSF should put in place an exit strategy for retaining staff in rural areas | MOH (national level) |
| **5** | MSF should provide the funding but let the district implement | Government (national level) |
| **6** | MSF should donate vehicles, computers, food and bicycles | Community<br>MOH (district level)<br>Local NGO's (district level) |
| **7** | MSF should donate of vehicles so that MOH can do their own supervision | MOH (district level) |
| **8** | MSF should secure funding from other donors | Community leader |
| **9** | MSF should put in place a good system for drug provision | MOH (district level) |
| **10** | MSF should visit districts to see the level of minimum package | MOH (national level) |