Report of the Final External Evaluation of the MATCH Project

Maternal and Child Health. Local Authorities and Decentralization of Services in the SADC Area

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ACRONYMS AND ABBREVIATIONS

APLWHA	Associations of People Living with HIV and AIDS
ANC	Ante Natal Care
ART	Antiretroviral therapy
ARV	Antiretroviral or Antiretroviral prophylaxis
BSC	Balance Score Cards
CMSR	Centro Mondialità Sviluppo Reciproco
COSPE	Cooperazione per lo Sviluppo dei Paesi Emergenti
CTC	Care and Treatment Centre
FDSS	Health System Development Fund (Congo DR)
HCT	HIV Testing and Counseling
LA	Local Authority
M&E	Monitoring and Evaluation
MoU	Memorandum of Understanding
MTCT	Mother-to-Child Transmission
NGO	Non-Governmental Organization
OVI	Objectively Verifiable Indicator
OIT	Oxfam Italy
PHC	Primary Health Care
PLA	Participatory Learning and Action
PMTCT	Prevention of Mother-to-Child Transmission
RCH	Reproductive and Child Health
SADC	Southern Africa Development Community
SC	Steering Committee
SPF	Small Projects Foundation
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

EXECUTIVE SUMMARY

The project **Maternal and Child Health. Local Authorities and Decentralisation of Services in the SADC Area** (MATCH) aims at developing the provision of services on Anti-retroviral therapy (ART) and Prevention of Mother-to-Child Transmission (PMTCT) for infant and mother in rural areas of three Southern African Countries (namely South Africa, Tanzania, and the Democratic Republic of Congo), by supporting the local authorities in the implementation of their own competences and by empowering the local communities to play a more meaningful role.

The project is coordinated by the **Region of Tuscany** (Italy) and is implemented in collaboration with four **non-governmental organizations**, three of which are based in Italy (Oxfam Italia, CMSR, COSPE), and one in South Africa (Small Projects Foundations). Three **local authorities** from South Africa, Tanzania, and the Democratic Republic of Congo are partners of the project, representing the local counterparts for the three areas of intervention. These are the District of OR Tambo in South Africa (in the Eastern Cape Region), the Kondoa District Council, in Tanzania (in the Dodoma Region), and the Ville de Kananga in the Democratic Republic of Congo (in the Kasai Occidental Region). Following the split of Kondoa into two new districts (Kondoa and Chemba), the project is now collaborating with the new district of Chemba as well.

The project is based on a virtuous and articulated **intervention strategy** for the prevention of mother to child transmission of HIV, inspired by the most up to date international standards and the previous experience of the partners. This strategy is implemented in the local target areas through a series of "**in-country activities**", and reinforced at international level through a series of "**trans-national activities**".

The in-country activities of Match include **actions at three levels**: actions for strengthening local authorities in the implementation of their own competences on HIV and PMTCT, actions for strengthening the health systems and improving decentralized ART and PMTCT service delivery, and actions for increasing community participation and empowerment in the fight against HIV and mother-to-child transmission. The transnational component of the project aims at managing project monitoring and evaluation and promoting the exchange of experiences among the partner territories, in order to increase learning and foster the scaling up of the intervention model for PMTCT in SADC countries.

This report presents the results of the **external final evaluation** carried out at the end of the third year of the project by an independent consultant. The main objective of the evaluation was to assess the **project's relevance, efficiency, effectiveness, impact and sustainability**, taking into consideration the changes occurred in the target areas since the start of the project, and highlighting the main challenges and opportunities encountered by Match throughout its implementation. Another objective of the evaluation was that of analyzing and assessing the **performance of the health care model** proposed by the project in the three territories. This latter level of evaluation investigated the health outcomes in PMTCT, mother care, children care and partner involvement in the clinics and dispensaries interested by the project,

The evaluation was carried out by using a wide range of **primary and secondary data sources,** including project documents and monitoring materials, and through a **field visit** that lasted 20 days from the 18th January to the 6th of February 2015. The field visit targeted the areas of the project in Tanzania and South Africa, while it was not possible to arrange a visit to the Democratic Republic of Congo due to mainly logistical and security reasons (distant data collection from Congo DR was therefore organized in the month of November 2014). The members of the internal Monitoring and Evaluation Task Team, as well as the project coordinators and project assistants for the different components of the project were interviewed and involved throughout the evaluation exercise.

The evaluation brought the attention to the **changes happened in the three local contexts** in which the Match Project is implemented, with subsequent changes in some of the activities carried on by the project.

At the beginning of 2014, the option B+ was introduced in all **Tanzania**, with training of medical doctors and nurses for its implementation. With option B+, all pregnant women living with HIV are now offered ART therapy for life, regardless of their CD4 count. This had strong positive effects on PMTCT, because it enabled women to access ART even in settings with poor or distant access to CD4 testing. The introduction of option B+ integrates PMTCT and ART, enabling nurses to administer both through simplified procedures in primary health care facilities where RCH is provided.

In **South Africa** the introduction of option B+ in the PHC system took place in April 2013, with similar positive results. The OR Tambo district has been selected for the pilot implementation of the new National Health Insurance (NHI) system, which is bringing resources for the strengthening of local health facilities through systematic public investments in the upgrading of infrastructures, equipment, human resources, and operating capacities. Moreover, a process of "re-engineering" of PHC services, through the introduction of the so-called "work-based teams", have restructured and intensified outreach activities in the rural communities, bringing preventive and primary health care in all district wards. The process was characterized also by the introduction of data capturers at clinic level, who register information, in electronic format, on patients in the clinics, and create files to be used by nurses and CHWs for their follow-up and treatment, and by the Province for statistical purposes.

In **Congo DR**, the objectives and activities of the project were reframed to better adapt to the new context, and the logical framework was subsequently updated. In the new context no VCT, ART, and PMTCT services were in place, and local awareness on HIV/AIDS was very low, therefore the project had to focus mainly on basic training of political levels and civil society on HIV/AIDS, and on supporting advocacy actions to obtain the necessary resources to start the ART and PMTCT services in the area.

The evaluation describes the main **results** obtained by the project, in terms of **relevance, efficiency, effectiveness, impact and sustainability**. However, there are severe **limits to impact measurement** in the evaluation, because no counterfactual data have been collected for comparison purposes on control groups in other similar districts. Moreover, the **alignment of project intervention with national policies**, although might be considered as an important sustainability factor of the project approach, makes it difficult to identify with certainty the impact that the project had, intended as the positive (or negative) changes that the local systems would not have seen if the project had not been implemented.

Relevance: the intervention was surely more relevant in the Eastern Cape area than in Kondoa and Chemba, where HIV prevalence is very low[1]. Nonetheless, the strengthening of preventive services, and the structuring of appropriate services for the management of HIV cases as they arise, seem to be important elements of a strategy to avoid the growth of the epidemic in the future, and to prepare the local system to deal with this likely future challenge. Therefore, the project can be considered relevant in Tanzania as well, although its relevance is weaker if compared to other alternative interventions. In Congo DR, the activities that had been initially planned by the project for the Province of North Kivu encountered more challenges in the new project area in Kananga, and the partners had to make important efforts to adapt the project to the new context.

Efficiency: The first year delays appears to have been fully recovered at the end of the project, with most of the activities already implemented before the end of January 2015. Regarding the transnational component of the project, all the activities were implemented efficiently, and some improvements in terms of efficiency have been added during project running with the change of location for the exchange seminar from Italy to South Africa.

The project management demonstrated a very good level of response and adaptation to contextual changes, which led to modifications in some activities, and the programming and implementation of new ones. In some other cases, the content and approach of the activities changed. The good level of coordination between project partners, as well as at the alignment with policies and change processes that happened at district level, are two of the main reasons for the good balancing between results achieved and available resources. The project in many cases added-on nationally enforced changes, contributing to their effectiveness and to the capacity of absorption new knowledge and procedures of the local health system and of local human resources.

A great value added in terms of efficiency of the intervention has been brought by the presence of the partner SPF in **South Africa**, because their continuous presence on the field guaranteed significant locally

1. Tanzania has a national prevalence of 5,1% in 2011, while the Region of Dodoma has a slower rate of 2,9%. Kondoa and Chemba districts have some of the lowest rates in the Country, with a 0,3% prevalence rate.

grounded expertise in the areas of health and social development. in South Africa, the frequent change of political referents was a challenge to project effectiveness.

In **Tanzania**, the stability of partners created good conditions for the regular running of the activities and for their efficient adaptation to governmental and district level addresses. Moreover, the active collaboration of the District Medical Officers (DMO) and of the District Executive Directors (DED), as well as the interest and continuity of the nurses responsible for PMTCT, helped CMSR running the activities smoothly. Nonetheless, the order of implementation of some of the activities might have limited their effectiveness: the training with ALPHWAs was realized too late to enforce positively other project activities and the project outcomes. The **i**mplementation of the project in **DRC** saw a relevant degree of inefficiency, mainly caused by the overall situation of the local and by the difficulty to keep all the phases of the process fully under control. However, it should be noticed that the additional costs that the project had to face in the country were paid for by the project coordinator (Tuscany Region), and this, together with an efficient management of the last months of the project, ensured that at the end of the reporting period all the activities had successfully been implemented.

Effectiveness: The overall objective of the project has been reached both in Tanzania and in South Africa, if analyzing data collected in the local health facilities. The positive influence of the introduction of option B+ and the reengineering of PHC and outreach services strongly contributed to these good results in terms of PMTCT and mother and children ART coverage.

In **Tanzania**, the most significant contributions were: i) the installation of solar panels for the dispensaries; ii) the training on option B+ and on PMTCT for nurses and dispensaries personnel; iii) the transnational activities, followed by the scaling-up meetings, which contributed to the introduction of innovations; iv) the activities of awareness and sensitization in schools and villages with peer educators, as well as the training to CBOs and APLWHA. Regarding awareness results, the training of nurses, CHWs, CBO members, and peer educators, together with the implementation of structured campaigns in villages and educational activities in schools had probably a good result on awareness increase and service utilization. It should be noted that the government of Tanzania has recently introduced its own policies to improve service utilization (policy on provided initiated HCT, policy to encourage male participation in ANC, etc), and it is all very possible that the good results of those are acting synergistically with the work of Match.

In **South Africa**, the introduction of innovative services was a consequence of the application of national policies at district level. The project contributed importantly in accompanying the changes introduced, through: i) the provision of a mobile VCT clinic, used for the outreach activities of the clinics during the reengineering of these services; ii) "clinic health audits" conducted to clean and reorganize the patients' information system; iii) training of clinic committees and the introduction of the Balance Score Card. Regarding awareness results, a steep increase in the use of condoms can be partially attributed to project awareness activities, as other campaigns have also being realised by the MoH locally during project duration. However, the local population and in particular the male population is scarcely open to health education and sensitization messages concerning HIV. Behavioral change remains therefore a challenge**,** in particular for the involvement of men, which seems very difficult to without any specific activity dedicated to this target. However, the project showed good results on the awareness raising of the younger generations, through health education campaigns, and pregnant women.

In **Congo DR**, the objectives, expected results and indicators of the project in DRC were reframed and adapted to suit the local context and the possibilities that the project had to have an impact, , provided that no VCT, ART, and PMTCT services were in place in the Aires de Santé involved in the project[2], and the level of awareness on HIV/AIDS was very low among both the local institutions and the population. The project put significant effort in engaging local stakeholders, in particular the local institutions. The aim was to bring attention to the need to mobilize resources and expertise to fight HIV/AIDS in rural Kananga. FDSS welcomed the request to activate VCT and ART services in the uncovered areas, but did not guarantee the sustainability of drugs and other supplies after the first 6 months. Given these conditions, OIT decided that the proposal was neither fair nor affordable and sustainable, and subsequently decided to refuse. At the same time, some positive results were also achieved. The realization of a scale up workshop in October

[2] VCT, ARV and ARV services were in place only in some areas of the Ville de Kananga, mostly urban. The Aires de Santé involved in the project were rural ones, not covered by these services.

2014 reinforced the commitment of the local stakeholders to the fight against HIV/AIDS, and identified the key areas for future action. The awareness raising activities in the DRC were carried out in the summer of 2014. In general terms, the project reported a positive response by the community considering that it was the first time that this type of issues were discussed in the rural communities of Kananga, and we cannot expect a significant impact from a campaign of this kind if it remains an isolated case.

Performance of the healthcare model and project impact: regarding **mother care**, the health outcomes in the 18 selected dispensaries of **Tanzania** were found being very positive: ANC attendance of mothers increased from 83% in 2011 to 88,2% in 2014. However, the ANC attendance before 16 weeks has decreased from 26,9% in 2011 to 17,7% in 2014. VCT coverage of mothers increased from 71,4% of 2011 to 82,8% of 2103. The HIV incidence of mothers was very low compared to national data, with a 0,8% in 2011. In the following years it decreased furtherly, reaching 0,4% in 2014. Mothers' CD4 testing grew from 25,7% in 2011 to 62,5% in 2013. ART coverage passed from being the 25% in 2011 to 100% in 2013 and 2014. With regards to **children care**, the health outcomes were found positive, but their significance may be criticized, being the total number of positive children very low. Lastly, **partner involvement** has been a success in Kondoa and Chemba districts: partner attendance at ANC went from 34,7% in 2011 to 53,4% in 2014, and partners of HIV+ pregnant women who have been tested grew from 47,6% in 2011 to 71% in 2014.

In **South Africa**, regarding **mother care**, the health outcomes were found being very positive: ANC attendance increased from 90,7% in 2011 to 100% in 2014. ANC attendance before the 20th week is however unsatisfactory, showing that more work has to be done to encourage early contact of pregnant women with health facilities. The clinics improved very much on VCT coverage, with an intensive testing campaign carried on in the first two years of the project. HIV prevalence decreased from 21% in 2011 to 15,9% in 2014. This positive data is also attributable, partially, to awareness raising campaigns run by the project in 30 secondary schools, and by the growth in condom utilization. CD4 test increased from 74,7% in 2011 to 82,7% in 2012. In 2013 and 2014 the rate decreased to 56,1% and 68,7% because the introduction of option B+ in April 2013 made this test not compulsory for decisions on ART treatment. ART coverage of positive pregnant increased considerably during the project timespan, going from the weak coverage of 34,2% in 2011 to 90% in 2013 and 90,4% in 2014. . With regards to **children care**, the health outcomes were found positive: ARV treatment coverage with nevirapine improved from 2011 (15,2%) to 2013 (73,1%). ARV prophylaxis coverage with AZT has improved, progressively, passing from 54,6% in 2011 to 91,7% in 2014. This proves that the capacity of follow-up of patients in the clinics grew considerably during project timespan, if we consider that AZT treatment lasts for 6 months after the delivery, equivalent to the lactation period. Diagnosis improved, passing from 55,3% in 2011 to 87% in 2014. ART treatment on children also improved, passing from 26,1% in 2011 to full coverage (100% of positive children treated) in 2014. Regarding **partner involvement**, the project had no results in ANC attendance of the partner and in VCT.

Potential sustainability of project results: in **Tanzania,** project results seems to be sustainable, also thanks to the strong local ownership of the innovations introduced through the project. The role of CHWs seems to be the weakness point of the project in terms of sustainability. These workers in fact enjoy little recognition and their work is still on a volunteer basis, and thus discontinuous and not monitored by the local government. The project conveyed some resources to remunerate their work for 9 months, but this does not appear sustainable because there is still no assurance that authorities will guarantee continuity after the end of the project. Nonetheless, some decisions were taken, at district level, to reduce this weakness, and policies at the national level hopefully seem to look toward a stabilization and recognition of CHWs as public officers. The exit strategy of CMSR in Tanzania foresees a continuity of presence and participation in the development of health and community services in both districts, even if not many operational solutions are foreseen in it. The presence of CMSR in Dodoma Region after Match project, together with the stability of local authorities in the districts, may constitute a positive factor for the institutional sustainability of project results.

In **South Africa,** the project strengthened existing innovation processes introduced by the MoH, and assisted in the development of key services such as the outreach activities, recently reengineered, data collection and follow up of patients. The embedding of project results in the local (and national) process of innovation in PHC services constitutes the main base for their sustainability. The sustainability of the results obtained with clinic committees on the introduction of BSC can only be reached with an active presence of

project partners in next years. Differently from Tanzania, CHWs sustainability does not constitute a criticality in South Africa. In fact, the 26 CHWs who were trained and worked in the project have been employed with the Community Work Programme of the district, allowing continuity to their daily work in communities. As regards awareness raising and community mobilization actions, the project results seems to be sustainable because they were obtained through the work of trained peer educators who worked in previous projects of SPF, and will work in the future education programme of SPF in the area, known as “Bright Futures Programme”. The potential sustainability of results, both at community awareness and at health care model levels, is relatively high, thanks to the presence of SPF with other projects in the area, that is already planned and will continue in the next 30 months. The continuity of SPF in the area is even more important, considering the planned exit of OIT from OR Tambo at the end of the project.

In **Congo DR** the local institutions did not commit to the necessary level of funding for the medium and long term to start VCT, ART, and PMTCT services in the project area service. In this situation, we may assume that all the other actions of the project (training, awareness raising campaign) will hardly be sustainable, unless the local authorities unblock the resources and decide to activate the services in the short term. The most important and sustainable actions taken by the project seem therefore to be the advocacy actions aimed at unblocking the relevant budget line for HIV, and the active mobilization of the local stakeholders (including the partners of the awareness raising campaigns, PNMLS, UCOP+). A positive result of this process was the activation of a dialogue between the local governor and the PNMLS, which was a necessary pre-condition for the implementation of concrete government actions to fight HIV/AIDS in the future. Moreover, through the scale up workshop, the project fostered the collaboration between all the local stakeholders, setting a shared agenda for coordinated action to tackle HIV in the area.

The sustainability of **transnational activities** can be observed mainly in Tanzania: in fact, Kondoa and Chemba districts experimented many practices already in place in South Africa. The Tanzanian districts adopted also strategies inspired by the South African model, especially regarding the motivation and recognition of CHWs role. The exchange between National, Regional and Local levels has been another important and unexpected outcome of the transnational activities in terms of sustainability. Participants from the district had the possibility of a direct confrontation with Regional and National level during the seminars, and the central authorities identified good practices to be replicated in other areas of their countries. The only weakness point in terms of sustainability of the transnational component results is constituted by the online platform, which was underdeveloped to become a virtual place of exchange between participants. This weakness has been partially mitigated by the creation of an internet site of Tuscany Region’s Global Health Center, which contains an online platform where the project outputs will be integrated, and the project participants will be invited.

Finally, the evaluation presents some important **lessons learnt** and some **recommendations** for the phasing out and follow up of the project, as well as for future similar projects to be designed by the project partners.

1. INTRODUCTION

1.1 Background of the evaluation

Maternal and Child Health. Local Authorities and Decentralisation of Services in the SADC Area (acronym: MATCH) is an international cooperation project coordinated by the Region of Tuscany and supported by the European Commission under the EuropeAid funding line for Non State Actors and Local Authorities in Development.

The project is implemented in four districts in Southern African countries (OR Tambo District in South Africa, Kondoa and Chemba Districts in Tanzania, Ville de Kananga in the Democratic Republic of Congo) in partnership with the respective local authorities, and with four NGOs: Oxfam Italia (IT), Centro Mondialità Sviluppo Reciproco-CMSR (IT), Cooperazione per lo Sviluppo Paesi Emergenti – COSPE (IT), Small Projects Foundation-SPF (SA).

The project duration, initially established in 36 months, (starting from 1st October 2011 and scheduled to end on 30th September 2014), has been extended, with a new ending date on 31st of March 2015.

The project aims at developing the provision of services on Anti-retroviral therapy (ART) and Prevention of Mother-to-Child Transmission (PMTCT) for infant and mother in rural areas, by supporting the local authorities in the implementation of their own competences and by empowering the communities to play a more meaningful role.

In order to pursue this goal, the project implemented a set of in-country activities in South Africa, Tanzania, and Congo DR, accompanied by a set of transnational activities that aimed at the promotion of international exchange and at the capitalization of experiences and lessons learnt.

The MATCH project established a Steering Committee (SC), made up of representatives from all the partner countries, responsible for the overall governance and policy direction of the project. The SC designated an internal "Monitoring and Evaluation Task Team", in charge of project Monitoring and Evaluation (M&E), with the aim of capitalizing the lessons learnt through the analysis of models for the scaling up of the intervention. The M&E task team has adopted a Monitoring and Evaluation Plan, which contains the specific procedures and tools for M&E of the project. Among these, the Plan foresees the realization of one mid-term and one final evaluation to be carried out by an external expert.

This report presents the results of the independent final evaluation that has been carried out by the external consultant Mr. Dario Marmo, in January and February 2015.

The report summarize the results of such evaluation, and provides some useful inputs for the follow – up of the project and its exit strategy, as well as for the planning of similar projects in the future. Additionally, the report presents an analysis of the sustainability of its achieved results, and some recommendations for their strengthening.

The main audience of the present report is represented by the project partners, in particular: the project coordinator Tuscany Region, the implementing partners Oxfam Italia, CMSR, SPF, and COSPE, the four District Authorities of OR Tambo (South Africa), Kondoa, Chemba (Tanzania), and Kananga (Democratic Republic of Congo, DRC). More specifically, the Steering Committee and the Monitoring and Evaluation Task Team are key targets of this report, with the aim of providing a useful knowledge tool for consolidating the lessons learnt from the project. Furthermore, this report addresses to the European Commission, to complement its Result Oriented Monitoring (ROM) work with a renewed analysis, which takes under consideration also the last year of project implementation.

1.2 Document structure

This document is organized as follows.

After this short introduction, **Section 2** presents the main objectives of the evaluation, and clarifies the role of the final evaluation as requested by the terms of reference issued by the M&E Task Team. The chapter illustrates the limits for impact measurement and the learning opportunities that are characteristics of this evaluation.

Section 3 briefly presents the evaluation methodology, starting from an illustration of the approach used and listing the different sources used to gather the data. A general list of primary and secondary data is provided, and more details are included in the Annexes to the document. The limitations of the methodology are also discussed in this chapter.

Section 4 presents a brief description of the logic of intervention of the project, as well as the main changes that took place in the operational context during its implementation. This section has to be considered as an update to the more exhaustive project description provided in the mid – term evaluation, where the state of art of PMTCT and ART services in the districts is described with detail.

Section 5 illustrates the results of the evaluation. It is organized into five subsections discussing respectively:

- project relevance
- project efficiency
- project effectiveness measured against the logical framework indicators
- performance of the health care model and project impact
- potential sustainability of project results

Each of these levels of analysis is discussed in relation to the three countries and, where relevant, the transnational component.

Section 6 presents a list of *lessons learnt* that emerge from the project. These lessons examine areas of weakness and strength of the project, and aim to place the emphasis on all the relevant aspects both for the planning of similar future interventions and for the strengthening of the sustainability of the results reached by the project.

Lastly, **Section 7** presents the conclusions of the evaluation and the key recommendations that the evaluator would like to take to the attention of the partners in the phase out of the project, and for the follow – up of project results at the end of it.

2. OBJECTIVES OF THE EVALUATION

2.1 Role and objectives of the external evaluation

According to the terms of reference of the project, the external evaluation has to provide an assessment that goes beyond the simple verification of planned activities and outputs, and looks at the broader dimensions of project relevance, efficiency, effectiveness, impact, and potential sustainability. These dimensions should be reflected on the health care services developed by the project. In this sense, the external evaluation serves as an opportunity to reflect on the data produced by the health outcomes monitoring grid, and to understand the underlying dynamics leading to the observed health outcomes and performance of the health care system.

For the final evaluation, additional specific questions regard:

- the institutional sustainability of the results obtained by the project;
- the quality and set in motion of a phase out and hand over strategy;
- the impact of the introduction of the monitoring system on the improvement of services;
- the main challenges and opportunities, as well as the lesson learnt during through the project.

Finally, the evaluation findings will be used for the Final Seminar and for project follow – up activities.

2.2 Composition of the evaluation team

The planning phase of the evaluation was managed in connection with COSPE, that within the project is the partner in charge of the implementation of transnational and M&E activities. The role of team members is presented hereunder.

Mr. Dario Marmo	External evaluator	Visited Tanzania and South Africa, and conducted distance and direct interviews in Italy.
Mr. Giorgio Menchini - COSPE	Evaluation team leader	Organized the final evaluation agenda, briefed the evaluator and participated to the visit in South Africa. Revised the final evaluation report draft.
Ms. Martina Luisi - CMSR	Team Leader on the field in Tanzania	Coordinated and participated to the final evaluation in Tanzania. Revised the final evaluation report draft.
Dr. Richard Ntahonsigaye - CMSR	Evaluation coordinator on the field in Tanzania	Participated and coordinated on the field the final evaluation in Tanzania. Facilitated interviews in Swahili.
Mr. Riccardo Riccardi – OIT	Team Leader on the field in South Africa	Coordinated and participated to the final evaluation in South Africa.
Mr. Paul Chromhout – SPF	Evaluation coordinator on the field in South Africa	Participated and coordinated on the field the final evaluation in Tanzania. Facilitated interviews in Xhosa.
Dr. Daniela Ambrosi - COSPE	Internal health monitoring expert	Provided data and analysis on the health outcomes, collected by project internal monitoring system. Revised the final evaluation report draft.
Mrs. Sara Albiani - OIT	Project coordinator	Provided a framework for the evaluation of the project in South Africa and Congo DR, and revised the final evaluation report draft.
Ms. Adele Amato - OIT	Assistant Project Manager for South Africa	Provided a framework for the evaluation of the project in South Africa and Congo DR, and revised the final evaluation report draft.

2.3 Peculiarity of the evaluation: learning opportunities, limits for impact measurement

This evaluation highlights several learning opportunities. Firstly, it gives the possibility of comparing the results of a similar intervention approach on two different contexts (Kondoa and Chemba districts in Tanzania and O.R. Tambo district in South Africa). Secondly, the final evaluation identify organizational, social and cultural factors that challenged the attainment of project health outcomes and the improvement of the primary health care services at district level, and suggest some strategies to overcome these factors in the future. Thirdly, the evaluation tries to understand the contribution of project inputs to the improvement of the health care service in the covered areas. In other words, it attempts to extract some impact evidences.

Regarding this last dimension, it is important to note that there are severe limits to impact measurement in the evaluation. I fact, even though baseline data have been collected in all the eighteen facilities in Kondoa and O.R. Tambo districts at the beginning of the project, no counterfactual data have been collected for comparison purposes on control groups in other similar districts, challenging the attribution of impact to project intervention.

Moreover, the alignment of project intervention with national policies, although might be considered as an important sustainability factor of the project approach, makes it difficult to identify with certainty the impact

that the project had, intended as the positive (or negative) changes that the local systems would not have seen if the project had not been implemented.

3. METHODOLOGY

3.1 Approach used and rationale for the choice of methodology

The project evaluation used a common framework for the analysis of the three countries, in order to compare lessons learnt and compare results from the implementation of a common model in different contexts. Nonetheless, there are some differences in the logical framework and work plan for the Congolese component of the project, and consequently the evaluation has been conducted on different basis in this country, where the activities ended earlier, in November 2014.

Due to these facts and to difficulties of logistical nature, the project partners decided that the final evaluation should not include a field visit to Congo DR even if distant data collection was carried out in October and November 2014.

The evaluation is integrated with the internal M&E, as indicated in the M&E plan produced by the SC. The external evaluation used the information contained in the Quarterly Monitoring Reports and in the datasets produced by the health service monitoring system, and analyzed this with additional participatory data collection and iterative exchanges with the internal monitoring expert and other project staff. The exchange between the external evaluator, the evaluation team leader, and the internal health monitoring expert further reinforced the integration between technical and non-technical evaluation aspects.

The evaluation approach was as much participatory as possible, in order to give voice to all the parties involved and to collect more reliable and shared information; many participants where stimulated to be reflective about what is being done and what could be done better, and many recommendations are a synthesis of selected suggestions emerging from the interviews. A broad range of stakeholders was involved at all levels and from many different perspectives. The interviews focused not only on the project itself, but also on relevant contextual features of the target areas and on the broad challenges, dynamics, and trends in relation to the health and social issues tackled by the intervention.

Stakeholders involved included project partners, staff, local authorities, health managers, health service providers, community-based organizations, community volunteers and peer educator, while it was not possible to interview final beneficiaries during field visits. These where interviewed during the mid – term evaluation, which is taken under consideration in the evidences presented in this report.

3.2 Data sources and methods for data collection and analysis

The evaluator reviewed all the relevant documentation provided by the project and some additional written materials collected on site and/or through the web. The full list of documents is showed in a specific annex to this report.

Primary data sources collected consisted of interviews with project partners and stakeholders as well as direct observation through visits to project sites. Interviews targeted project partners and staff based in Italy and in the partner countries.

People consulted in the countries included:

- Project Coordinator;
- Project managers;
- Assistant Project managers for the three countries;
- Administration and Financial Officers;
- Other project officers and staff (including campaign coordinators, trainers, etc);
- Representatives of project partners;
- Direct and indirect beneficiaries and other project stakeholders, including: health managers and health service providers, Community Health Workers, lay counselors, community volunteers and peer educators, clinic committees, members of associations of PLWHA, Community-Based Organizations.

In relation to the Congo DR component of the project, due to the impossibility to carry out a visit on the field, the evaluation included the following:

- Interview to the expatriate project manager (performed after his return to Italy) ;
- Questionnaire to the project manager (exchanged via email);
- Questionnaire to the Executive Director of PNMLS in Kananga (exchanged via email).

The evaluator conducted other interviews in Italy with health and monitoring expert, and with the Region of Tuscany. A full list of the conducted interviews and of the project site visited is presented in the report section dedicated to the annexes.

Consultation of partners and local stakeholders was done individually and in groups, using semi-structured interviews. Project partners provided local translation where necessary.

The evaluation started the second week of January 2015 and the field mission took place between 18th January 2015 and the 5th February 2015. Some final interviews in Italy were conducted during the following two weeks. The interviews in distance with Congo DR were done in October and November 2014.

4. PROJECT DESCRIPTION AND ANALYSIS OF THE OPERATIONAL CONTEXT

4.1 Project information and logic of intervention

The European Commission, under the Local Authorities line, funded the Match Project. The main applicant is the **Region of Tuscany**, which coordinates and implements the project in **partnership** with:

- three local authorities in SADC countries:
  - OR Tambo District Municipality in South Africa;
  - Kondoa District Council in Tanzania;[3]
  - Ville de Kananga in the Democratic Republic of Congo.
- three Italian NGOs:
  - Oxfam Italia (OIT);
  - Centro Mondialità Sviluppo Reciproco (CMSR);
  - Cooperazione per lo Sviluppo dei Paesi Emergenti (COSPE).
- one South African NGO:
  - Small Projects Foundation (SPF).[4]

The **project objective** is to *develop the provision of services on Anti-retroviral therapy (ART) and Prevention of Mother-to-Child Transmission (PMTCT) services for infant and mothers in rural areas, by supporting the local authorities in the implementation of their own competences and by empowering the communities to play a more active role.*

In each country involved (South Africa, Tanzania, DRC) the project implemented specific *in-country activities* aimed at pursuing this goal; moreover, the project organized some *transnational activities*, with the aim of involving the partners in international exchange and capitalization of experiences.

For each country, the responsibility over implementation is attributed to one NGO: in South Africa and the DRC the responsibility of implementation is given to Oxfam Italia, in Tanzania it is given to CMSR. Transnational activities and overall project monitoring and evaluation are the responsibility of COSPE.

The project's **expected results** are:

1. Improved capacities of decentralized local authorities – also through the creation of a network of local authorities at both national and international level - in health service planning, service delivery and adopting a multisectoral approach;
2. Level of health services improved with active involvement of communities;

3 The Kondoa district was divided in two districts in 2012, namely Kondoa district and Chemba district. This latter became a project beneficiary, being now a separate entity from the Kondoa.

4 SPF started as associated partner and became full partner after the start of the project.

3. Increased awareness and involvement of communities in HIV prevention.

Targets groups and **final beneficiaries** of the project are the elected and executive representatives of local authorities, and in particular executive representatives at health district level; health district technical staff; community health workers and members of CBOs, Support Groups and Associations of PLWHA active in the project's areas; pregnant women attending ANC, their children and partners, with special focus on the either HIV positive or exposed to infection among them; members of the local communities and traditional leaders.

The project **started** officially on 1 **October 2011** and it is expected to end on 31 March 2015. The logical framework can be found in annex to this report, while a brief description of the intervention strategy is illustrated in the next paragraph.

The **available budget** for the action is € 1.300.000, of which € 975.000 has been funded by the European Commission and € 325.000 are contributions from the partners.

The project strategy of Match draws from the experience of Tuscany Region and its non-governmental partners in HIV/AIDS work in developing countries, which is reflected in the Strategic document on PMTCT adopted by COSPE and the Regional Working Group on HIV/AIDS of Tuscany Region.

The approach targets in particular women of reproductive age (between 15 – 49 years old) who are more affected by HIV/AIDS than men of the same age; women are also easier to reach through Ante-Natal Care (ANC) services, and they are more receptive to health education messages and willing to take care of their health and that of their families.

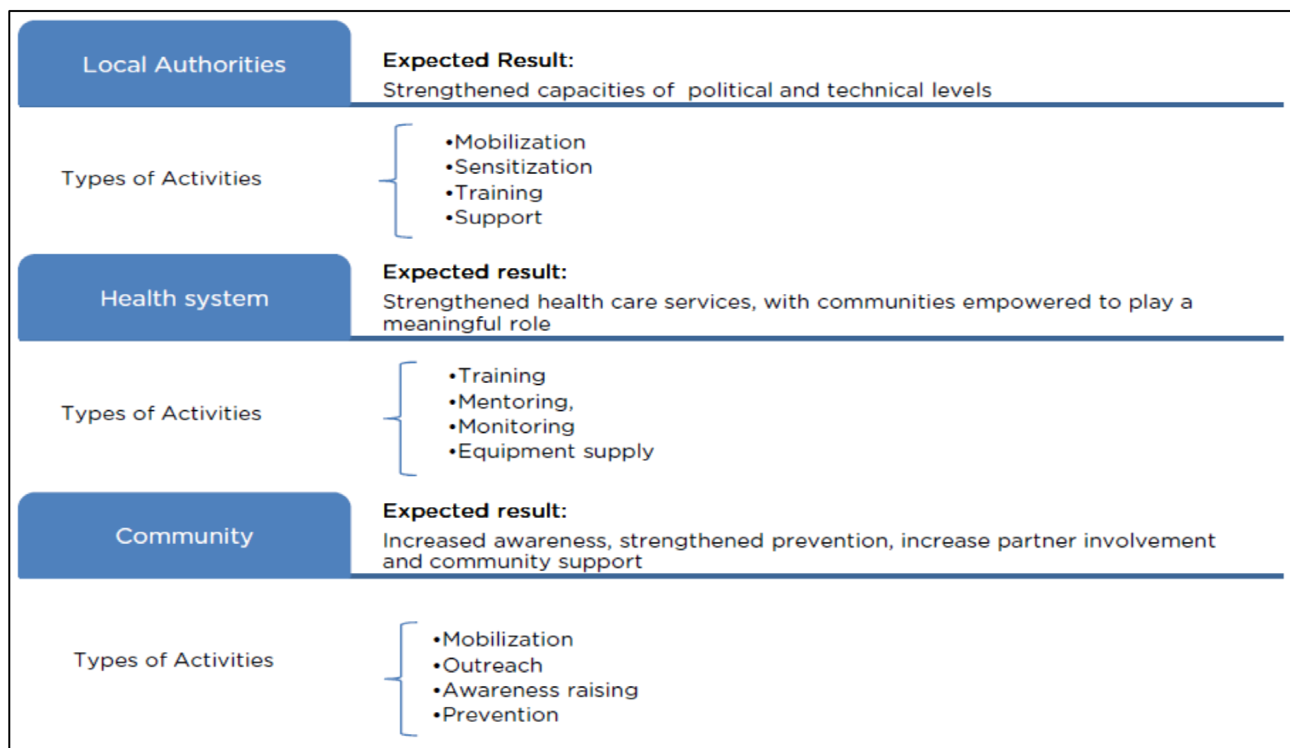
PMTCT services are considered as an entry point for this and therefore it constitutes the basis of a broader strategy to fight HIV/AIDS globally, as has been suggested both by the WHO and UNAIDS. In order to implement this approach, and to provide women with better health care, appropriate health information, and comprehensive social support, it is necessary to strengthen both the health system and the organizations existing in the communities, mobilizing and making best use of all the available resources (social in addition to financial or material).

At the district level, the Match project targets the strengthening of the following processes:

- Decentralization of ART, VCT, PMTCT services
- Integration of PMTCT in Reproductive and Maternal Care
- Adoption of WHO Guidelines
- Improvement of a comprehensive and family-centered approach for prevention, treatment care and support
- Collaboration with CBOs and APLWHA.
- Improvement of the role of Community Health Workers

In order to achieve this, the project supports the strengthening of three different but **interconnected levels**: local authorities, health system and community. At each of these levels, the projects states its expected results and develops a set of activities that aims to achieve them. This comprehensive approach is illustrated in Figure 1.

Figure 1– Levels of intervention of Match strategy



Transnational activities complete the strategy, allowing the partners in different countries to meet and exchange about their experience and views. The transnational component of the project embraces the communication and visibility aspects of the project and the final dissemination of results and lessons learnt.

The different levels at which the transnational strategy of the project operates are summarized in the Figure 2, that shows also a broad indication of the groups of activities related.

4.2 Changes of the operational context

For a detailed analysis of the socio-cultural backgrounds and different states of implementation of PMTCT services in the three Countries interested by this project, we refer to the mid – term evaluation issued in November 2013.

In this section we present the main changes that happened in the operational context of every Country in 2014.

Tanzania

Concerning Tanzania, with the adoption of the WHO guidelines, at the end of 2013, the option B+ was introduced gradually in all the Country, with training of medical doctors and nurses for its implementation. In Kondoa and Chemba Districts the guidelines were adopted during 2014. With option B+, all pregnant women living with HIV are now offered ART therapy for life, regardless of their CD4 count. This had strong positive effects on PMTCT, because it enabled women to access ART even in settings with poor or distant access to CD4 testing. The introduction of option B+ integrates PMTCT and ART, enabling nurses to administer both through simplified procedures in primary health care facilities where MCH are provided.

In September 2013 the government has issued new PMTCT guidelines, that stress the importance of improving decentralization and referral systems, improving integration of services, taking a comprehensive and family-centered approach to HIV and PMTCT, strengthening the role of CHWs and NGOs.

The original partner of the project, Kondoa District, was split into two different administrative units (Kondoa and Chemba) and the new authorities of Chemba were involved in the project. With the split of the district, exactly half (9) of the 18 dispensaries initially selected for the project fell under the new Kondoa district, and the other half (9) fell under the new Chemba district[5]. The institutions in Chemba were already established

5 Haubi, Itaswi, Baura, Kiteo, Masawi, Kingale, Atta, Kisaki, Kikilo dispensaries in Kondoa district, and Kinamshindo, Jogolo, Lalta, Lahoda, Chambalo, Kidoka, Tumbakose, Mwaikisabe and Farkwa dispesaries in Chemba district.

and operational in 2014, but they are still based in Kondoa, due to lack of electricity and facilities in the village of Chemba. Furthermore, Chemba district still relies on Kondoa district hospital, and the construction of a district hospital in Chemba is foreseen for 2015.

A five-year (2011-2016) USAID-funded project led by the NGO Africare, the Mwanzo Bora Nutrition Program, is under implementation in the area. Mwanzo Bora integrates agriculture and nutrition to address a host of malnutrition issues in women and children. The project employed CHWs in villages, and has thus to be considered an important integration to the Match project, especially for nutrition improvement and for sustaining the work of CHWs.

CHWs are still not formally employed by the district nor by the Government, but guidelines for their regulation will be issued in 2015 at a governmental level. The MoH wants to introduce a one-year training for CHWs, who will be selected at the grassroots level among the existing ones, and re-trained. The national accredited centre has still not approved the training curricula.

More in general, Tanzania efforts in HIV prevention is reflected in the good result obtained between 2009 and 2013, when HIV prevalence among adults aged 15 to 49 decreased from 5,7% to 5%.[6]

South Africa

The introduction of option B+ in the PHC system took place in **South Africa** in the same year of Tanzania (2013), with similar positive effects.

OR Tambo district has been selected for the pilot implementation of the new National Health Insurance (NHI) system, which is bringing resources for the strengthening of local health facilities through systematic public investments in the upgrading of infrastructures, equipment, human resources, and operating capacities. Even though the NHI implementation started very slowly in the district and is far from being fully implemented, certain interventions already took place in some of the district clinics, including the thirteen covered by the project[7].

These interventions pursued the structural renovation of the clinics, under the Government project known with the name of “Ideal Clinics”. The project aims at improving the quality of public health offer in order to increase its competitiveness with private health care services.

Moreover, a process of “re-engineering” of PHC services, through the introduction of the so-called “work-based teams”, have restructured and intensified outreach activities in the rural communities, bringing preventive and primary health care in all district wards. The re-engineering of PHC services introduced a distinction between CHWs employed in outreach activities and CHWs assisting nurses in clinics.

Another important innovation launched at the end of 2013 in the re-engineering process is the introduction of data capturers at clinic level, in every clinic. Data capturers register information, in electronic format, on patients in the clinics, and create files to be used by nurses and CHWs for their follow-up and treatment. At the same time, they produce data for health statistics at district level, improving the public health system of data collection and analysis.

Finally, the MoH selected the Aurum Institute,[8] a Southern African public benefit organization, to recruit and train pharmacists and pharmaceutical assistants in Eastern Cape Province. As will be presented in the evaluation findings section, this influenced some of the activities planned by the project in OR Tambo.

Congo DR

No specific changes in the operational context took place in the Democratic Republic of Congo DR during the third year of the project. We may recall that in this country, both the geographical area and local institutional partner had been changed in the first year of the project, due to the intensification of the armed conflict in the district of North Kivu, which was initially meant to be the project area of MATCH. The new project area was identified in the Ville de Kananga, where 6 Zones de Santé were selected in collaboration

6 WHO Global Health Observatory, 2014.
7 Bhala, Flagstaff, Khanyayo, KTC, Holly Cross, Nkozo, Xopozo clinics in Flagstaff sub-district, Bodweni, Magwa, Malangeni, Mpoza, Quakeni and Xhurana clinics in Lusikisiki sub-district.
8 www.auruminstitute.org

with the local authorities, and an extensive work of stakeholder engagement had to be made in order to ensure the local ownership and success of the project.

The objectives and activities of the project were reframed to better adapt to the new context, and the logical framework was subsequently updated. It is worth reminding that in the new context no VCT, ART, and PMTCT services were in place, and local awareness on HIV/AIDS was very low, therefore the project had to focus mainly on basic training of political levels and civil society on HIV/AIDS, and on supporting advocacy actions to obtain the necessary resources to start the ART and PMTCT services in the area.

5. EVALUATION FINDINGS

5.1 Project relevance

Tanzania and South Africa

The project objective of strengthening PMTCT services in the rural areas of **Tanzania** and **South Africa,** through the support to local authorities and clinics at community level, is strongly relevant for both Kondoa and Chemba districts and for the district of OR Tambo. Both contexts, in fact, were characterized, at the beginning of the project, by the presence of different factors that hindered the full coverage of all the pregnant mothers for testing, and the referral and follow up of mothers and their children.

These factors were mostly organizational limits and lack of adequate capacities and recognition of human resources employed at clinic and community level, such as nurses and CHWs. A third main factor, the lack of resources to improve the public MCH services in the areas, was not directly tackled by the project activities, but nonetheless the project contributed to its reduction, sustaining some of the less empowered actors at the local level, CHWs.

The relevance of the project is obviously different in the two countries. The Eastern Cape Province has a very high prevalence rate of 29%, according to 2010 official data. In OR Tambo, HIV prevalence was estimated at 31,5% in 2010. [9] In the target areas, the data reported by 4 clinics (Flagstaff, Malangeni, Bodweni, Bhala) shows a lower rate of HIV prevalence (14,9% among pregnant women in 2011) which raised some doubts about the reliability of the data. As regards HIV incidence, the Eastern Cape province shows a slightly higher rate (1,5%) compared with the national rate (1,2%).

Tanzania has a national prevalence of 5,1% in 2011,[10] while the Region of Dodoma has a lower rate of 2,9%. Kondoa and Chemba districts have some of the lowest rates in the Country, with a 0,3% prevalence rate.

The intervention is thus surely more relevant in the Eastern Cape area than in Kondoa and Chemba. Nonetheless, the strengthening of prevention interventions, and the structuring of appropriate services for the management of HIV cases as they arise, seem to be important elements of a strategy to avoid the growth of the epidemic in the future, and to prepare the local system to deal with this likely future challenge. Therefore, the project can be considered relevant in this context as well, although its relevance is weaker if compared to other alternative interventions (improving the geographical coverage of wards, reducing transport problems to reach the clinic, for example).

The health care model implemented by the project, focusing on decentralization, service integration, WHO guidelines, family-centered approach, and role of the communities, is strongly aligned with national policies and processes. In fact, in recent years, the Governments of South Africa and Tanzania have formally adopted an approach to HIV in line with international standards and with the project strategy, recognizing also the importance of the key elements recalled above.

All the stakeholders perceive the health care model as being correct and appropriate and that the project has not introduced new elements, but rather it has strengthened existing processes, supporting the local systems in the implementation of their own goals and strategies.

The decentralization of responsibilities implies a strengthening at district and most importantly at clinic level on planning, data collection and management, service utilization monitoring, referral systems and follow-up

9 Eastern Cape AIDS Council - Provincial Strategic Plan for HIV/AIDS, STIs and TB 2012-2016.
10 Tanzania HIV/AIDS and Malaria Indicator survey, 2011-2012

of patients, and the improvement and systematization of outreach services in the villages. At the same time, the role of local communities, including CBOs and APLWHA, seems to be too discontinuous in both countries, and relies on a relatively weak support.

The project, focusing on local authorities, CHWs, nurses and clinic personnel, clinic committees, CBOs and APLWHA, strengthened processes of improvement of the above mentioned needs, and its community-centered approach seems to be its most important dimension of relevance. The introduction of Balance Score Cards (BSC) in the clinics of OR Tambo district thorough the training of Clinic Committees, as well as the awareness-raising campaigns in schools and in villages implemented in Tanzania, can be shown as practical examples of how the project focused on the community level in these two countries.

The project demonstrated also a good capacity of adaptation to the changes and innovations that the local health systems introduced, like the use of data capturers and the re-engineering of clinic services in South Africa, as well as with the introduction of Option B+ in both South Africa and Tanzania. The introduction of activities not initially planned, but considered relevant for accompany local processes, as well as the adaptation of activities to emerging needs and lesson learnt, is an important feature of the project. These adaptations will be explained in the analysis of activities conducted in the “effectiveness” section of this report.

Congo DR

As was shown in the mid-term evaluation, the specific features of the local context in DRC require to assess the project relevance in this country looking at different elements compared to the other two countries of MATCH. Indeed, the overall picture of HIV/AIDS prevalence and MTCT rates is unclear due to a lack of specific data in rural Kananga, and decentralized ART and PMTCT services are not yet in place. Similarly, local knowledge on HIV/AIDS is very low and political attention and commitment to these issues was very limited before the start of the MATCH project.

In order to develop an action that was clearly relevant for this context, the project decided to change part of its activities and reframe the specific objectives for the DRC component. Activities aimed at strengthening local PMTCT services and at monitoring the effectiveness of decentralized and integrated models of care were removed and the project focused its attention on:

- Transferring basic knowledge and concepts of HIV/AIDS to local authorities and health managers and staff, who were largely lacking such knowledge and had not been exposed to previous trainings on these issues;
- Carrying out awareness raising campaigns targeting the local population, in order to spread some initial knowledge on HIV/AIDS and encourage the adoption of safe behaviors and non-stigmatizing behaviors;
- Carrying out advocacy actions aimed at attracting the resources and political commitment necessary to introduce VCT, ART, and PMTCT services in rural Kananga.

We can therefore observe that, while the activities that had been initially planned by the project for the District of North Kivu were not relevant for the new project area in Kananga, the partners made important efforts to adapt the project to the new context and eventually implemented actions that were relevant for the new area.

5.2 Efficiency of the implementation

The official start date of the project was the 1st October 2011, and its end date was moved from the 30th September 2014 to the 31st of March 2015. This happened because the first year of the project has seen many delays and most of the activities have actually seen their start in the second year of the project.

The initial delays in the startup of Match have been caused by postponements in the transmission of funds from the Delegation of the European Union to South Africa to the Region of Tuscany and from the Region of Tuscany to the partners, due to long administrative procedures for the registration of funds in the regional budget. The delays were also caused by the long time for the signature of a Memorandum of Understanding between the Region of Tuscany and the partners. The first transmission of funds from the Region of Tuscany to partners happened in June 2012, 9 months after the official launch of the project.

Some additional unexpected changes occurred in the local contexts, which required adaptations and revision of the partnership and delayed further the startup of the activities. In particular:

- Tanzania: split of Kondoa District into the new Kondoa and Chemba districts, which leaded to a new partnership agreement between project partners with the new Chemba district officials; the establishment of functioning district offices for Chemba, as already mentioned, slowed initially some of the processes set up by the project.
- South Africa: the OR Tambo district changed its boundaries and some facilities were assigned to a different district. In South Africa there are also some reported weaknesses in the relationship with local health authorities: i) several changes of referents in OR Tambo District municipality, due to political instability; ii) coordination problems in relation to some specific aspects, like the change of needs for the support in relation to the training of pharmaceutical assistants.
- Democratic Republic of Congo: intensification of the conflict in North Kivu and impossibility to implement the project here as initially planned. The project was therefore forced to seek a solution that was found in the change of local partner in favor of the Ville de Kananga. This implied that many months were lost for: 1) attempts to reactivate the partners in North Kivu, 2) decision to change partner, involvement of the new area of Kananga, and presentation of the official request to the EU delegation to South Africa.

The first year delays appears to have been fully recovered at the end of the project, with most of the activities already implemented before the end of January 2015, as indicated in the table 2, presented hereunder.

Regarding the transnational component of the project, all the activities were implemented efficiently, and some improvements in terms of efficiency have been added during project running with the change of location for the exchange seminar from Italy to South Africa. Transnational activities, as explained further in the section 5.4 of the report, influenced positively the adoption and replication of best practices and lessons learnt, particularly in Tanzania.

Table 2: Implemented activities from November 2013 to January 2015

Activity	Tanzania	South Africa
Transnational activities		
1.3 Creation of a web portal	A web portal was created in October 2012 and updated during the project, after transnational and scaling-up activities[11].	
1.4 Exchange seminar	The exchange seminar "Integrating PMTCT into Maternal Health – key challenges and good practices towards 2015" was held in Pretoria from 11th to 13th May 2014. About 50 people representing various bodies, organizations and institution were invited and attended the event from Italy and the three African countries involved in the project.	
1.5 Study tour	The study tour was held in the sub-district of Quakeni, in South Africa, 14th- 16th of May 2014. It was decided to organize said event in South Africa, rather than in Italy as initially foreseen, because of the wider impact such experience can produce on foreign delegates.	
1.6 Final Conference	The final conference is foreseen to take place in Florence, Italy, between the 24th and the 26th of March 2015.	
1.7 Final publication	The final publication is under preparation, and will be released before the final conference.	
In-country activities		
2.3 Capacity building[12]	2.3.1 – 2.3.2 – 2.3.3: A combined training on PMTCT was already held from 14th to 16th of November 2012 for 20 Health Managers representing Council Health Management Team (CHMT) for Kondoa District and 18	2.3.1: On the 19. 20, 24 of March 2014, capacity building sessions were organized for clinic committees to train them on their role, responsibilities and on balanced scorecard utilization. In Flagstaff, 20 clinic committees'

11 http://www.match-africa.org/
12 Ongoing activities to be completed by end of February 2015 in Tanzania: i) 2.2.2 Participatory Learning and Action workshop; ii) 2.3.1 Refresher training to hospital workers on Option B+; iii) Video documentation

	Nurses, Clinicians and Medical Attendants from the 18 dispensaries interested by the project. 2.3.1 – 2.3.2 – 2.3.3: A refresher training on PMTCT and Option B+ with service providers was held from 15th to 20th of December 2014, with 18 participants among nurses, clinicians and medical attendants of the dispensaries interested by the project. 2.3.7.1: Capacity building training workshop from 3rd to 5th September 2013 for 36 representative of CBO's and SGs from Kondoa and Chemba districts, on organization concept, governance and management skills. The participants were selected together with the Kondoa and Chemba Districts Community Development Officers. 2.3.7.1: The CBO Kiwajako from the 19th to the 24th of February 2015 conducted a training for 15 APLWHA of Kondoa and Chemba, with 36 participants. 2.3.7.2: A training of 50 peer educators was held from 10th to 14th September 2013, to strengthen their capabilities and implement particular activities in the framework of the project as awareness campaign and young people sensitization	members attended the training, in Lusikisiki it was attended by 17 members. Another training session was held on the 25th of March 2014 as a combined training for clinic committees and nurses on balanced scorecard development and utilization, for a total of 25 participants The two training session were contemporarily held in Lusikikisiki and in Flagstaff. 2.3.3: Two workshop sessions were organized on the 26th of June 2014 for clinic committees and nurses on balanced scorecard finalization. The workshop was attended by a total of 15 people (7 clinic nurses and 8 clinic committee members) in Flagstaff, and 17 people (14 clinic committees members and 3 nurses) in Lusikisiki. 2.3.4: Mentorship of pharmaceutical assistants was not implemented, as communicated during project running by OIT to the EC, due to contextual changes[13]. 2.3.6: Training of 26 CHWs was held in March 2013, as reported in the mid-term evaluation. 2.3.7: two training sessions were held for 9 CBOs working in Lusikisiki and Flagstaff areas on the 23, 24,25 April and 28, 29, 30 April. 8 representatives for 3 CBOs attended the first training round, 18 people representing 6 CBOs the attended the second. All of the present CBOS profiles had been previously surveyed during a CBOs capacity analysis conducted by SPF.
2.4 Outreach programmes and awareness campaigns	2.4.1: Several outreach support activities were implemented with 420 visits conducted in 18 dispensaries from November 2013 to November 2014. 2.4.2.: Implementation of a community based HIV/RH literacy programme for youths with special attention for young girls. The activities were conducted in 4 selected Secondary Schools of Dilai, Farkwa, Gwandi and Kiteo from 8th -10th October, 2014. The programme was planned with the District Management Officer at the beginning of October 2014. Other two secondary schools of Mwailanje and Intela were added up in November 2014. 2.4.3: Implementation of Community Based HIV/AIDS Prevention and Awareness Campaign at District level. From 29/9/2014 to 3/10/2014 awareness activities with peer educators were conducted in Haubi, Kiteo, Mwaikisabe, Chambalo, Kadoka, Kingale, Itaswi and Farkwa villages. Other villages include Baura,Kisaki,Kikilo, Masawi, Tumbakose,Lalta,Lahoda, Jogolo and Kinyamshindo. The peer education	2.4.1: Several ward based outreach support activities were implemented with the 13 clinics from November 2013 to November 2014. 2.4.2: awareness and education campaign on sexual and reproductive health. Since March 2013 to date, a total of 28 schools located in Flagstaff and Lusikisiki areas have been involved in the Bright Futures Programme, an initiative launched and put in place by the implementing partner Small projects foundation, engaging over 1000 students from grade 7 to grade 9.

13 The AURUM Institute, in partnership with the South African Government, through the PEPFAR Programme has been able to release funds to cover this activities and the enrolment of 4 pharmaceutical assistants.

	programme from November 2013 to November 2014 reached a total of 6733 community members with couple clinic attendances, STI/HIV prevention, proper condom use and sexual and reproductive health in school youths as their important sessions.	
2.5 Voluntary Counselling and Testing	2.5.1 – 2.5.2: These activities were implemented during outreach activities already mentioned above.	2.5.1 – 2.5.2: These activities were implemented during outreach activities already mentioned above.
2.6 Developing a routine PMTCT programme	2.6.1: Activity modified by the introduction of Opt. B+ in Kondoa. 2.6.2: Adherence support – this activity was implemented by CHWs of the project in every clinic, during the last 18 months, also through the introduction of mobile phone follow – up. 2.6.4: Activity overcomed by the introduction of Opt. B+.	2.6.1: Activity modified by the introduction of Opt. B+. 2.6.2: Adherence support - "Health audits" have been conducted during 2014 quarterly in all the 13 clinics supported through the MATCH project, as a way to review the patients' filing system and re-organize it on the basis of weekly schedules and control lists[14]. Training session on the new system's procedures have been held with the data capturers working in the beneficiary facilities. 2.6.3: Activity modified by contextual changes. Tutoring and training was provided to clinics nurses for drug management improvements during "health audits". 2.6.4: Activity overcomed by the introduction of Opt. B+.
2.7 Scaling up workshops	A feedback meeting after the exchange seminar held in South Africa was conducted on 21 July 2014 at Kondoa District Council. Participants attending were Council Health Management Teams from both Kondoa and Chemba districts, representatives from CMSR – Tanzania and Regional Health Management Team.	Qaukeni sub-district scaling up workshop was held in Lusikisiki, May 5th, 2014. It was sponsored by OTD. It was an occasion for clinic health staff, community health workers, data capturers and sub-district officials involved in HIV and PMTCT from Qaukeni Sub district to meet up and share their experiences. 25 people participated to the meeting facilitated by SPF staff.
2.8 VCT Equipment and supply	All the 18 clinics were provided with solar panels for delivery rooms services. Community Health Management Team of Chemba District was provided with a pc to sustain its work.	The VCT mobile unit was provided to the clinics for VCT activities.

The project management demonstrated a very good level of response and adaptation to contextual changes, which led to modifications in some activities, and the programming and implementation of new ones. As an example, the resources not employed for pharmaceutical assistants in South Africa were used efficiently for the other project activities, including new ones such as the training on BSC of clinic committees.

In some other cases, the content and approach of the activities changed: this happened, for example, in the case of the training for nurses on HCT, PMTCT and ANC, which was already provided by the MoH in South Africa. In this case, the project partners decided to focus on paediatric ART, which was traditionally done at

14 These are to be managed and followed by CHWs involved in community-based outreach teams, in order to guarantee an effective monitoring of follow-up and to ensure immediate tracing of defaulters and lost-to follow-up patients.

hospitals because there was insufficient knowledge and skill among clinic nurses. The project provided this training, with the use of the Paediatric ART Toolkit.

Another interesting adaptation and efficiency example coming from Tanzania is the decision to use also radio announcement as an awareness tool, and to distribute handbooks already developed by the Ministry of Health on sexual and reproductive health, specifically targeted for adolescents, rather than producing and printing new ones.

A great value added in terms of efficiency of the intervention is brought by the presence of the partner SPF in South Africa, operating in the OR Tambo district in the health sector during many years. Their continuous presence on the field guaranteed high operational capacity, excellent knowledge of local context, good reputation and relationships with local stakeholders, as well as significant locally grounded expertise in the areas of health and social development.

As already mentioned, in South Africa, the frequent change of political referents was a challenge to project effectiveness; its negative effects were reduced by the presence of SPF and by the clinic – centered approach of the project, considering the fact that the technical referents were stable in their role during the project duration.

In Tanzania, the good stability of partners created good conditions for the regular running of the activities and for their efficient adaptation to governmental and district level addresses. Moreover, the active collaboration of the District Medical Officers (DMO) and of the District Executive Directors (DED), as well as the interest and continuity of the nurses responsible for PMTCT, helped CMSR running the activities smoothly.

Nonetheless, the order of some of the activities might have limited their effectiveness: some of the activities, like the training with CBOs and APLWHA, implemented in February 2015, as well as the refreshment course on PMTCT, held in December 2014, were realized too late to enforce positively other project activities and the project outcomes.

Finally, it is important to note that the good results obtained in the clinics covered by the project in both countries, as shown in the section 5.4 presenting health outcomes, has been reached with a relatively small amount of resources, as acknowledged by many of the interviewed stakeholders of the project. The same can be supposed to have happened for the awareness activities in communities, even if their impact is hardly measurable with the data collected during the project monitoring and evaluation.

This evaluation points at the good level of coordination between project partners, as well as at the alignment with policies and change processes that happened at district level, as two of the main reasons for the good balance between results achieved and available resources. The project in many cases added-on nationally enforced changes, contributing to their effectiveness and to the capacity of absorption new knowledge and procedures of the local health system and of local human resources.

Congo DR

As was extensively described in the interim reports and in the mid-term evaluation, the first year of activities in DRC encountered many challenges and saw significant delays, due to the change of partner and project area, and the related adjustments that became necessary. The project also consumed a large part of its budget in this first year, due to the high participation to the training sessions for local institutions and health personnel, which was above the partners' expectations and reflected the strong need for this kind of intervention in the area.

Moreover, at the end of the first reporting period, Oxfam Italia country coordinator for DRC returned to Italy and left the project, posing the challenge of finding an appropriate replacement.

The second half of the project therefore had to face a number of challenges, which affected the overall efficiency of the project:

- Difficulty to find and retain a new country coordinator for Oxfam Italia. After a short attempt with a new coordinator that left early for personal health reasons, in May 2014 Oxfam Italia found a new coordinator who successfully guided the project until its end in November 2014. The long gap (around 6 months) between before the hiring of this new coordinator caused a delay in most planned

activities (especially training and awareness raising). However, during these months the project carried out advocacy activities directed at the local and national stakeholders. Advocacy meetings were carried out by the local project manager and aimed to negotiate the future introduction of ART and PMTCT services in the project area.

- Decision of the two local assistants (in charge of data collection and awareness raising) to leave the project before the end of their contract, in July 2014. Since the activities that involved them had not been implemented yet, and the resources available were very scarce, Oxfam Italia decided to involve two local partners (PNMLS and UCOP+) and to organize the activities in collaboration with them. This allowed to save money and to strengthen the collaboration with relevant local actors.
- Lack of resources available for trainings and awareness raising campaigns, since the entire available budget had been spent on year 1 due to the high number of participants to the training sessions. In order to ensure the implementation of the remaining activities, more resources were made available by Tuscany Region to fund training and awareness raising campaigns in Kananga.
- Other difficulties led to changes in the project schedule, for example, the scale up workshop was moved from April to October due to the absence of the local Medicin Chef.

Overall, the implementation of the project in DRC saw a relevant degree of inefficiency, mainly caused by the overall situation of the local context (particularly challenging, and different from the area for which the project had been initially planned) and by the difficulty to keep all the phases of the process fully under control. However, it should be noticed that the additional costs that the project had to face in the country were paid for by the project coordinator (Tuscany Region), and this, together with an efficient management of the last months of the project, ensured that at the end of the reporting period all the activities had successfully been implemented.

5.3 Project effectiveness - analysis against logical framework's results

In this section we present the results indicated in the logical framework of the project in its latest update, and their level of realization at the end of the project. The results are explained, critically analyzed under the light of contextual conditions, and connected to the activities carried forward by the Match project.

The Logical framework is included in the annexes section of this report. The objectives and results are presented following the sequence of the logical framework, with an analysis of the indicators collected during the monitoring phase of the project and with the final evaluation of it. Where considered necessary and possible, the sources of verification were expanded by the evaluator, adding new relevant data for the explanation of results. In those cases where data was missing or unfindable, other information collected during the final evaluation process will support the explanation of the results reached by the project.

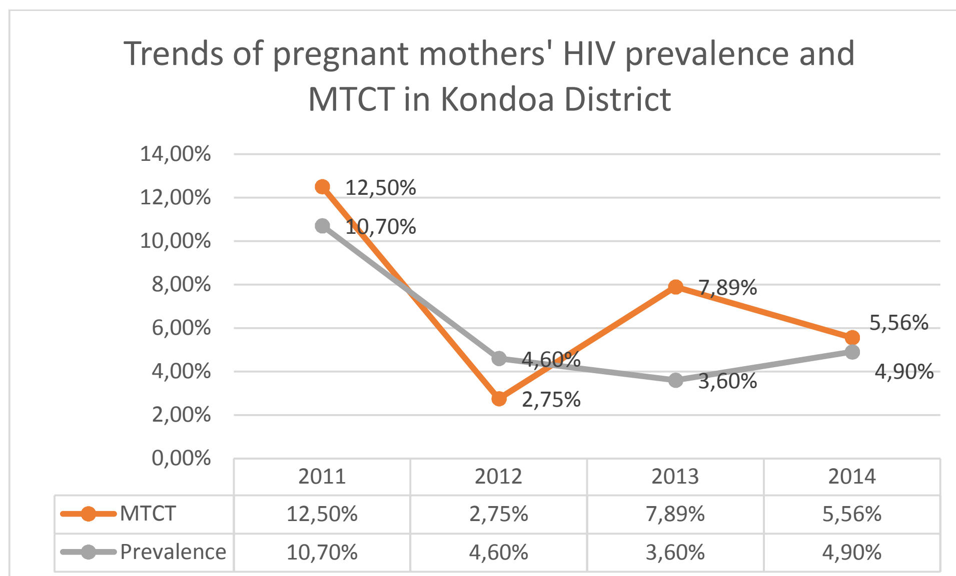
Overall objective	**To reduce the morbidity and mortality due to HIV infection in rural areas, enhancing the role carried out by the local authorities in the reduction of poverty and in the quality management of the primary health care services.**	**Objectively verifiable indicator (OVI):** **1- Decrease of MTCT rate = o > 10% in the target areas between the beginning and the end of the project**	**Sources of Verification:** **Annual reports at district and provincial/regional level**

The overall objective of the project has been reached both in Tanzania and in South Africa, if we analyze data collected in the clinics. However, data for the area covered by the project in Kondoa district show different results, with an increase of MTCT during last two years caused by the existing low prevalence, which makes this data very sensitive to any change in absolute numbers.

The reduction of MTCT in Tanzania has been substantial. In 2011, the 12,50% of the children born from HIV positive mothers in the Whole Kondoa District resulted positive[15]; this figure has decreased during the years of implementation of the project, reaching the 5,56% in 2014[16].

15 It corresponds to 8 HIV+ children on 64 mothers who were diagnosed being HIV positive during labour and deliveries.
16 It corresponds to 4 HIV+ children on 72 mothers who were diagnosed being HIV positive during labour and deliveries.

Graph 1: MTCT and Prevalence in Kondoa District



	2011	2012	2013	2014
MTCT	12,50%	2,75%	7,89%	5,56%
Prevalence	10,70%	4,60%	3,60%	4,90%

Source: Kondoa District annual PMTCT reports, 2011 - 2014

The decrease of MTCT rate was of 7%, instead of the 10% proposed by the logical framework indicator. Nonetheless, it is possible to observe a good trend of the district health system, coherently with the data collected in the 18 dispensaries of the project. The data presented in the graphs covers all 36 dispensaries of Kondoa. It is thus possible to attribute partially the impact in MTCT decrease to the project intervention.

It should however be noted that the MTCT in the 18 clinics covered by Match was 0 in the first three years of the project, while in 2014 there was one children out of 11 born from positive mothers, because the mother was not in the area during ARV treatment. Howsoever, the numbers of positive mothers is very low in the area, and is almost not reflected in district – level data.

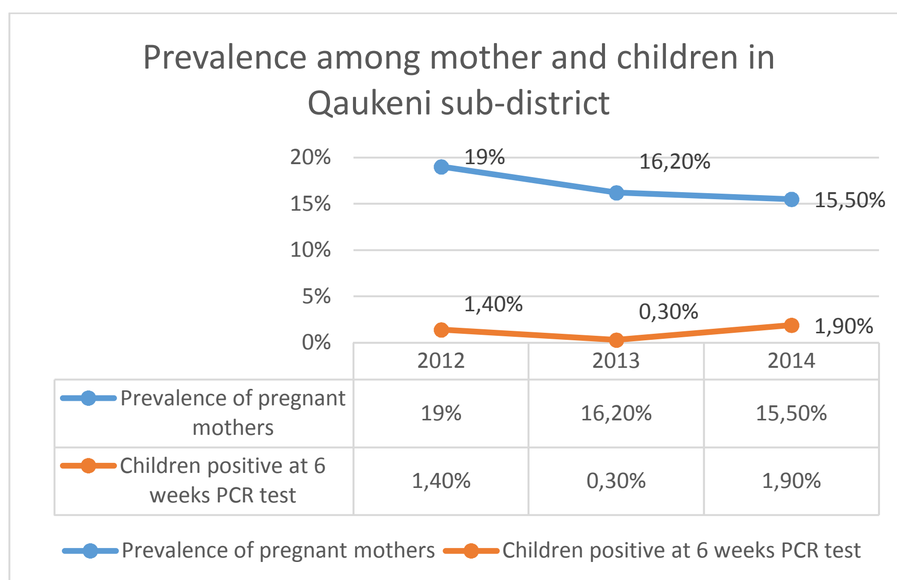
It should equally be noted that the improvement obtained between 2013 and 2014 is surely caused by the adoption of the option B+ that permitted to have almost the full ART coverage of the positive pregnant mothers who were registered in the district.

The oscillation of MTCT data, and the increase in 2013, has also to be explained through the presence of a low number of positive mothers and children, and consequently through the small dimensions of the samples, making the indicator very sensitive to small and casual changes.

This data has been extracted from the District annual PMTCT reports. It should be noted that the data for Chemba district are under elaboration for 2014, and that for the period 2011 – 2013 data for Kondoa refers to present-day Chemba and Kondoa districts.

Regarding South Africa, it has not been possible to calculate MTCT at district or sub-district level, because only percentage values were found. Nonetheless, it is interesting to note, in the Qaukeni sub-district, the progressive decrease of prevalence among pregnant mothers (from 19% in 2012 to 15,5% in 2014), and the very low percentage of children being found positive at 6 weeks PCR tests, varying from 0,3% to 1,9% and showing no clear trend.

Graph 2: Children and mother prevalence in Qaukeni sub-district



Source: Qaukeni sub-district annual PMTCT reports, 2012 - 2014

In the clinics covered by the project, the result was positive and in line with the rest of the district, with MTCT being 1.19% in 2011, 0.58% in 2012, 1.04% in 2013 and 0.79% in 2014. The project consolidated thus the good performances on MTCT already shown by the local health system. The positive influence of the introduction of option B+ and the reengineering of PHC and outreach services strongly contributed to these good results.

Specific objective	**To facilitate the provision of innovative services on Anti-retroviral therapy (ART) and Preventing Mother-to-Child Transmission (PMTCT) for infant and mother on rural areas supporting the local authorities in the implementation of their own competences and empowering the communities to play a more meaningful role.**	**Objectively verifiable indicator (OVI):** **1- At least 1 policy document on delivery of Primary Health Care services - issued by local authorities at regional/provincial or district level in the 3 target areas by the second year of the project, - endorses the approach and the targets of UN Global Plan 2011 with regard to PMTCT and ART** **2- By the end of the project 80% of the selected health facilities in the Districts of OR Tambo (South Africa) and Kondoa (Tanzania) provide innovative PMTCT and ART services according to 2010 WHO guidelines and UN Global Plan 2011**	**Sources of Verification:** **Policy documents on delivery of PHC services issued by LA in the target areas.** **Annual Reports of Health Districts of OR Tambo and Kondoa.**

The specific objective was reached by the project both in Tanzania and South Africa, but the indicators chosen cannot be considered as being appropriate for describing the positive effect of in-country and of transnational activities on the provision of ART and PMTCT services in the covered areas, and in supporting local authorities.

Concerning OVI number 1), policy documents on delivery of PHC services were collected for every one of the three covered districts[17]. The plans refer to the WHO guidelines, and contain a detailed analysis on the coverage and quality of the services at District Level and an identification of critical issues and priorities. These documents clearly define objectives and targets, as well as the resources needed to implement the plan, including a budget and the indication of the sources to cover the cost of the services. The documents apply national policies at district level; they are thus both local policy documents and operational plans to be applied by local authorities. It should be noted that the policy documents and plans were already produced

17 The “Annual technical and financial report for implementation of comprehensive council health plan for year 2013/2014” for Chemba and Kondoa, and the “HIV/AIDS strategic plan 2009/2014” for OR Tambo District.

before the intervention, and that their creation cannot be attributed directly or indirectly to project activities. Their use as OVI constitutes a limit of the logical framework as initially conceived by partners and approved by the EC.

With regards to OVI number 2), by the end of the project all the selected health facilities in the Districts of OR Tambo, Chemba and Kondoa (Tanzania) provided innovative PMTCT and ART services with the adoption of the option B+, whose application is coherent with 2010 WHO guidelines and UN Global Plan 2011. These innovations were not introduced through the project, but were rather the result of the evolution of national policies in this field. Nonetheless, the project accompanied the introduction of these processes with its training activities for health personnel at clinic level on option B+ (in Tanzania), and its awareness raising activities (both in Tanzania and South Africa).

Many of the interviewed actors at community, clinic, and local policy level have witnessed the contribution of the on the introduction of innovative services. In Tanzania, the most significant contributions were:

- the installation of solar panels for the clinic, that improved access and increased the number of deliveries in the dispensaries, as well as the identification of the dispensary as a public space where CHWs can provide assistance and counselling.
- the training on option B+ and on PMTCT for nurses and clinics personnel, which consolidated knowledge in an area where HIV and PMTCT treatments are not common, due to low prevalence.
- the transnational activities, followed by the scaling-up meetings, contributed to the introduction of innovations such as sustain actions and recognition measures for CHWs (provision of ID card, mobile phone credit for follow-up of patients, experimentation of the Community Health Fund as a resource for CHWs activities, just to mention the most important).
- the activities of awareness and sensitization in schools and villages with peer educators, as well as the training to CBOs and APLWHA bring new resources and tools for improving the quality of implementation of counselling and awareness services in rural areas.

In South Africa, the introduction of innovative services was equally consequence of the application of national policies at district level. The project contributed significatively in accompaining the changes introduced, most significantly thorugh:

- the provision of a mobile VCT clinic, used for the outreach activities of the clinics during the reengineering of these services.
- within each supported clinic a “clinic health audit” was conducted to clean and reorganize the patients’ information system, restructuring it on the basis of weekly control lists. This assistance with the filing system of clinics facilitated also the introduction of the new functions of the data collectors.
- the training of clinic committees and the introduction of the BSC, that constituted an interesting experimentation to be consolidated.
- the educational activities in secondary schools, which covered an important number of students, affecting positively the increase of safe reproductive behaviours in communities where cultural factors still strongly influence sexual and reproductive practices.

Expected result (1)		OVI:	Sources of Verification:
	1. Improved capacities of decentralized local authorities – also through the creation of a network of local authorities at both national and international level - in health service planning, service delivery and adopting a multisectoral approach.	1.1. 1 operational plan to secure the provision of PMTCT and ART services at community level, according to the approach and the targets of UN Global Plan 2011, is drafted and adopted by the district authorities in the 3 target areas by the end of the project. 1.2. At least 1 Annual report on the progress towards the targets of UN Global Plan 2011 on PMTCT and ART services is issued by Health Districts in the 3 target areas, by the end of the project. 1.3 By the end of the project, 50% of local staff responsible for providing PMTCT, VCT, ART	Health service plans at district level Annual monitoring reports at district level Project’s monitoring reports Reports on training courses (including questionnaires on the quality perceived by

		services in the selected health facilities, has completed and passed with a positive note a training cycle in the target areas of Tanzania and South Africa.	the participants to the courses).

Regarding the OVI 1.1) the operational plans of OR Tambo District and of Chemba and Kondoa Districts were collected during the final evaluation in the offices of local authorities, and all of them have been found being in line with the national policy indications, targeting objectives of PHC and PMTCT as indicated by the Global Plan 2011.

For OVI 1.2), the district managers responsible for PMTCT in the two countries provided reports and data useful for the assessment of progresses of the health care model on PMTCT and ART services. The focus of the project on the improvement of data collection and data analysis, and the introduction of a "health monitoring grid" in the clinics surely contributed to the improvement and reliability of the data collected at clinic level. Moreover, it should be noted that the introduction of data capturers in South Africa not only improved the follow-up of patients at clinic level, but standardized more data collection at District level, increasing the reliability of data produced in the annual reports.

The evaluation acknowledges also the achievement of OVI 1.3), with at least one nurse and two CHWs responsible for providing PMTCT, VCT, ART service trained by the project in every clinic. The unclear definition of "local staff" and the uncertainty about the role of CHWs (not employed but voluntarily working in dispensaries of Tanzania) challenges the possibility of defining the exact percentage of local staff trained. If only the 13 covered clinics of South Africa and 18 dispensaries of Tanzania are taken under consideration, then it is possible to affirm that surely more than half of the staff in these facilities has been trained by the project. It was not possible to find all the trainings evaluations during the evaluation visit. Some of the trainings did not include an evaluation, but all the participants interviewed by the evaluator considered the trainings useful and narrowed to local capacity needs and priorities.

Expected result (2)	2. Level of health services improved with active involvement of communities	OVI: 2.1. 50% decrease of the gap to the target for Universal Access to PMTCT and ART services for HIV positive pregnant women between the beginning and the end of the project, in the selected health facilities of Kondoa (Tanzania) and OR Tambo (South Africa) 2.2 50% decrease of the gap to the target for Universal Access to PMTCT and ART services for exposed children between the beginning and the end of the project, in the selected health facilities of Kondoa (Tanzania) and OR Tambo (South Africa)	Sources of Verification: Monitoring reports from health facilities selected as a sample in each target area

The level of health services improved during the project, also through an active role of the communities not only for the promotion of outreach VCT services, but also for the supervision of the clinic management, especially with the introduction of BSC to clinic committees in South Africa.

The OVI 2.1) has been fully reached by the project, both in Tanzania and South Africa. In Tanzania, ART coverage of positive pregnant women passed from being 25% in 2011 to 100% in 2013 and 2014. It was an important result not so much for the number of positive pregnant mothers, which was very limited, oscillating from 5 to 12 in the 4 years, but rather for the reduction of the difficulties of follow – up that the dispensaries had at the beginning of the project. The training and the introduction of new procedures for the follow – up of patients are the real improvement to be considered to explain the success of the project in Tanzania regarding this dimension. In South Africa, ART coverage for pregnant mothers increased from 34,2% in 2011 to 90,4% in 2014, an exceptional result, considering the high number of pregnant mothers in the selected facilities. For both countries, these good results should be considered under the light of the introduction of

option B+ and (for South Africa) the reengineering of outreach activities. Thus, the result obtained in the clinics and dispensaries can be only partially attributed to the project.

The OVI 2.2) The achievement of this result is difficult to be measured for Tanzania, because almost no children was found positive during the four year of the project (only one baby registered in 2014, she had access to ART treatment). For South Africa, the ART coverage for positive children grew from 36% in 2011 to 100% in 2014, showing the strong improvements in ART enrolment reached by the clinics of OR Tambo district.

Expected result (3)	3- Increased awareness and involvement of communities in HIV prevention.	OVI: 3.1. 1 operational agreement and 1 specific programme on active collaboration with CBOs and Support Group of PLVHI in place in at least 50% of the selected health facilities, in the target areas of Tanzania and South Africa by the end of the project. 3.2. Number of competent Community Health Workers in the target area of Tanzania and South Africa increased by 20% by the end of the project 3.3. Increment of number of partners sharing VCT services with pregnant women = o > 15% in the selected Health Facilities in Tanzania and South Africa by the end of the project	Sources of Verification: Project's monitoring reports Reports on training courses (including questionnaires on the quality perceived by the participants to the courses). Monitoring reports from health facilities selected as a sample in each target area.

The effect of the project on awareness is difficult to measure, and it was not possible to collect specific data during project monitoring to measure its impact on the health behaviour of the covered population. The awareness campaigns results are even less easy to be detected in Tanzania, where the awareness campaigns took place in the last semester of the project, and are thus supposed to have effects in the following year.

However, the interviewed actors and beneficiaries showed enthusiasm about the introduction of awareness campaigns, especially in Tanzania, where some of the activities, like school education, were not implemented before the project by local authorities and partners. The project, in this sense, created a best practice that will be replicated locally in the near coming future.

Interviewed actors reported an improvement in the levels of awareness and a change of behaviors especially among men, as a result of the community mobilization workshops (PLA) and the trainings carried out by the project. The training of nurses, CHWs, CBO members, and peer educators, together with the implementation of structured campaigns had probably a good result on awareness increase.

It should be noted that the government of Tanzania has recently introduced its own policies to improve service utilization (policy on provided initiated HCT, policy to encourage male participation in ANC, etc), and it is all very possible that the good results of those are acting synergistically with the work of Match.

In South Africa, the interviewer nurses and CHWs noticed a steep increase in the use of condoms, and this can be partially attributed to project awareness activities, as other campaigns have also being realised by the MoH locally during project duration. However, the local population and in particular the male population is scarcely open to health education and sensitization messages concerning HIV. Behavioral change remains therefore a challenge**,** in particular for the involvement of men, which seems very difficult to without any specific activity dedicated to this target. However, the project showed good results on the awareness raising of the younger generations, through health education campaigns, and pregnant women.

Regarding the OVI 3.1), no operational agreement has been formally signed between the dispensaries and clinics and the CBOs and APLWHA. These actors tend to be informal, and in fact, their activities are regularly run in villages in continuous coordination with clinic nurses and CHWs. This holds true, with local differences, both for South Africa and Tanzania.

The OVI 3.2) has been fully reached, with 50 new CHWs trained in each country, 26 CHWs employed for one year by the project in South Africa and 36 CHWs employed for nine months in Tanzania, representing more than 20% of the district CHWs. However, there has been no official recognition or insertion of district registers of these human resources in Tanzania, because this role is still not fully recognized as clinic personnel of dispensaries for the moment. More detail on this issue will be provided in the section 5.6, dedicated to sustainability of project results. On the other hand, the 26 CHWs were employed, from April 2014, by the Community Works Programme of the district, and consequently recognized in their role.

The result described by the OVI 3.3) was more than achieved in Tanzania, with a partner VCT testing that grew from 34,7% 2011 to 53,4% in 2014. Both the introduction of incentives in the dispensaries for male testing and partner ANC attendance, and the awareness-raising activities of the project share the merits of this achievement. On the other hand, the cultural reasons behind the lack of male attendance to VCT in South Africa were not easy to be tackled through the activities programmed in South Africa, and more effort should be dedicated, with narrowed interventions, to improve this dimension in OR Tambo District. Unfortunately, partner attendance remained almost inexistent at the beginning and at the end of the project. More indications on this matter can be found in the recommendation and lessons learnt section of this report.

Congo DR

As was already said, the objectives, expected results and indicators of the project in DRC were reframed and adapted to suit the local context and the possibilities that the project had to have an impact, provided that no VCT, ART, and PMTCT services were in place in Kananga, and the level of awareness on HIV/AIDS was very low among both the local institutions and the population.

Below we report the indicators adopted and comment on the extent to which the objectives were met by the project.

Specific objective	Facilitate the provision of services in ART and PMTCT, for mothers and children in rural areas, with the active collaboration of local authorities and the communities.	OVIs: 3.1. At least three facilitation sessions are implemented for the promotion of collaborations between many actors, including Government, LA, civil society, technicians of the health sector. The workshops will focus on the strategies to improve quality in the delivery of effective services if ART and PMTCT, in the rural areas of the project. 3.2. At least one session of advocacy is organized at Provincial level, to push the provincial government to finnce the delivery of effective services if ART and PMTCT, in the rural areas of the project.	Sources of Verification: Reports and presence lists of the sessions and of related activities. Report and presence lists of the session.

Considered the efforts made by the project especially in the last months of activity, these objectives can be considered achieved by the project.

As was already said, during the last year, the project put significant effort in engaging local stakeholders, in particular the local institutions. The aim was to bring attention to the need to mobilize resources and expertise to fight HIV/AIDS in rural Kananga. These advocacy actions were carried out in Kananga and Kinshasa, and involved a number of actors, including:

- Major of Kananga,
- Medicin Chef of Kananga,

- Exective Director of PNMLS (National Plan to Fight HIV/AIDS),
- Provincial Secretary of PNMLS for Kananga,
- Representatives of FDSS (Health System Development Fund),
- Provincial coordinator of PNLS for Kananga,
- Coordinator of the project FDSS/SANRU_FM on malaria and HIV, covering different health zones from those covered by Match.

The results of these advocacy efforts were that the FDSS welcomed the request to activate VCT and ART services in the uncovered areas, but unfortunately it also required that Oxfam Italia or the project partners contributed with substantial resources to pay for training, logistics, and other support. Moreover, FDSS did not guarantee the sustainability of drugs and other supplies after the first 6 months. Given these conditions, Oxfam Italia decided that the proposal was neither fair nor affordable and sustainable, and subsequently decided to refuse.

At the same time, some positive results were also achieved. The realization of a scale up workshop in October 2014 reinforced the commitment of the local stakeholders to the fight against HIV/AIDS, and identified the key areas for future action. Moreover, as the provincial executive secretary of PNMLS in Kananga highlighted in the course of the evaluation, the advocacy work and the support given by the project contributed to the creation of a Provincial Multisectoral Council for the Fight Against HIV in Kananga, which marks an additional step towards the activation of appropriate policies and services in this field.

Expected result (1)	1. Improved capacities of decentralized local authorities in planning and delivery of health services, through the adoption of a multisectoral approach.	OVI: 1.1By the end of the project, in RDC at least 50% of the officials of provincial government, of the members of provincial assembly and of the health staff who have been selected have benefitted of a training cycle, passing it with a positive note.	Sources of Verification: List of participants and results of the examinations.

This result has also been achieved by the project. The project delivered most training in the first year, with some refreshers courses in the second year. The participation to the trainings of the first year was much higher than expected, showing a high interest of the local actors in acquiring new knowledge and tools to face the HIV/AIDS challenge. A high number of members of the local authorities, health managers, and service providers were reached, and were trained on the basic concepts of HIV and its transmission and prevention. The test carried out after the training showed that their level of knowledge had significantly improved. However, due to the low levels of previous knowledge and the absence of local services for HIV in the project area, after 1 year a new test showed that the level of knowledge had decreased and a refreshers' course was made necessary. After this, the results were again positive, but we can observe that the possibility to retain the acquired knowledge and to achieve an actual impact from these capacity building actions (beyond a short term improvement of theoretical knowledge on HIV) will depend on the actual establishment of comprehensive VCT, ART, and PMTCT services in the area.

Expected result (2)	1. Improved awareness in the communities in the field of HIV prevention.	OVI: 1.1By the end of the project, in RDC at least 50% of the girls who participated to the awareness campaign in schools benefitted of a sensitization cycle, passing it with a positive note.	Sources of Verification: List of presences of the 300 young girls, and results of the tests.

The awareness raising activities in the DRC were carried out in the summer of 2014. These consisted of two different campaigns: one in collaboration with PNMLS, and one with the local NGO UCOP+. The initiatives used mixed methodologies including street theatre, songs, radio broadcasting, and video forums. Around 11.578 people were reached with messages on HIV/AIDS and maternal and child health, encouraging prevention, voluntary testing, and positive (non-stigmatizing) attitudes towards the disease. It is still too early to observe any changes in the population's behaviours and attitudes, and the available information does not

allow to estimate the extent to which these activities actually had an impact on the population. In general terms, the project reported a positive response by the community, and as a result of the campaign run by PNMLS, 161 people (10 women and 151 men) asked to be referred to a facility to be tested for HIV. However, it should also be noted that it was the first time that this type of issues were discussed in the rural communities of Kananga, and we cannot expect a significant impact from a campaign of this kind if it remains an isolated case.

5.4 Performance of the health care model and project impact

As already presented in the previous sections, the project demonstrated a high alignment with national policies. This made quite difficult to identify with certainty the impact that the project had, intended as the positive (or negative) changes that the local systems would not have seen if the project had not been implemented. The absence of a baseline study on the entire district, does not give the possibility to keep the non-intervention areas as a control group for the final assessment of project impacts in the intervention areas. The performance can thus be measured only with the data collected in the covered clinics, adopting a "before – after" approach.

Impact correlations proposed in this section have to be considered as likely assumptions, based on the triangulation of data collected at clinic levels with information gathered during interviews and through documentary analysis.

Pregnant mother care in Tanzania

Regarding mother care, the health outcomes in the 18 selected dispensaries[18] of Tanzania were found being very positive:

- ANC attendance of mothers increased from 83% in 2011 to 88,2% in 2014. Nonetheless, the ANC attendance before 16 weeks has decreased from 26,9% in 2011 to 17,7% in 2014. It should be noted that in 2013 this indicator showed a good improvement, reaching 47,1%. The ANC attendance before 16 weeks was introduced recently as a criteria (before 2011 ANC before 20 weeks was accounted), and is still not diffused enough as a practice. Issues with the reliability of these data have been raised because ANC appears in some areas >100%. This can be attributed to the mobility of the population among different facilities.
- VCT coverage of mothers increased from 71,4% of 2011 to 82,8% of 2103. In the first semester of 2014 a stock of test expired, and for more than one month the 18 dispensaries could not perform VCT tests. This is reflected in the decrease of the percentage of yearly tested mothers, which reached only the 67,1% in 2014.
- The HIV incidence of mothers was very low compared to national data, with a 0,8% in 2011. In the following years it decreased furtherly, reaching 0,4% in 2014.
- Dispensaries regularly manage ANC and integrated VCT services for pregnant women, but could not collect blood samples for CD4 tests, and HIV+ people were therefore referred to the District Hospital CTC, where often they were lost to follow up. ART therapy for eligible women was then managed directly at the CTC, while only non-eligible women were referred back to the dispensary where ARV prophylaxis can be initiated and continued. The introduction of option B+ overcame this problem, because all HIV+ mothers are now immediately eligible for ART therapy, which is now provided at dispensary level. The project activities aimed at improving the follow-up of patients produced very good results on this dimension, increasing mothers' CD4 testing from 25,7% in 2011 to 62,5% in 2013. The value decreased in 2014 to 45,5%, due to the introduction of option B+[19].
- ARV for mothers had already a coverage of 100% in 2012. It is not provided anymore in 2014, with the introduction of option B+.
- ART coverage passed from being the 25% in 2011 to 100% in 2013 and 2014. It is important to note that because of the improvements in patients follow – up this value was 100% even before the introduction of option B+.

Children care in Tanzania

18 The presence of very few documented cases of HIV in the project area is the reason for the decision to monitor all the 18 dispensaries, in order to observe the performance on a more significant number of cases.
19 The mothers were tested with CD4 count at the beginning of 2014, this is why "CD4 test" indicator is not 0 in 2014.

Regarding children care, the health outcomes in the 18 selected dispensaries of Tanzania were found positive, but their significance may be criticized, being the total number of positive children very low.

- Regarding ARV treatment with nevirapine, the 50% of children were treated in 2011 and in 2014. It is difficult to make consideration on this figure, being the number of children being very low.
- ARV treatment at 6 weeks with AZT improved, passing from 0% in 2011 to 62,5% in 2013 and to 50% in 2014. Even in this case, the low number of children makes this figure not significant.
- Diagnosis improved, passing from 30% in 2011 to 60% in 2014. Nonetheless, it should be noted that the only center for DBS test is in Dar er Salam, and that geographical distance still constitutes the major weakness of the health care model. In fact, the 40% of the test results did not came back to Kondoa District Hospital timely.
- ART treatment for children was necessary (and regularly provided) only for one case in 2014. It is thus impossible to reach to any interpretation or conclusion on this dimension.

Partner involvement in Tanzania

Partner involvement has been a success in Kondoa and Chemba districts: partner attendance at ANC went from 34,7% in 2011 to 53,4% in 2014, and partners of HIV+ pregnant women who have been tested grew from 47,6% in 2011 to 71% in 2014.

This result has been explained by the local partners and health staff as a consequence of some innovative and smart strategies that the government of Tanzania in implementing nationally. Among these, the rule that allows couples showing together at ANC to skip the queue of the facility and be attended first. Another strategy that is proving successful implies that ANC cards are not handing in to pregnant women until they bring their husbands. Of course, this rule can be adapted to each individual case, and cannot be imposed to the users. However, health staff are being successful in persuading women to bring their husbands for joint counseling- - and apparently, many men are accepting the invitation.

Finally, it should be noted that cultural stigma of partner participation in ANC and VCT in dispensaries is existing, but it appears to be less embedded in local culture, compared to the context of OR Tambo district in South Africa.

Pregnant mother care in South Africa

Regarding mother care, the health outcomes in the 4 selected sample clinics of South Africa were found being very positive:

- ANC attendance increased from 90,7% in 2011 to 100% in 2014[20]. The result is very positive, although partially attributable to a social welfare policy supporting mothers with a "*child support grant*". According to this national policy, mothers who attended ANC visits receive the documents to deliver in district hospitals. Hence, this kind of incentive strongly influenced pregnant women participation to ANC services.
- ANC attendance before the 20th week is however unsatisfactory, showing that more work has to be done to encourage early contact of pregnant women with health facilities. The ANC before 20 weeks increase during the project period, but only from 26,4% of the year 2011 to 39,9% in 2014.
- The clinics improved very much on VCT coverage: the data for 2011 were 97,1%, increased to 92,5% in 2012, then decreased to 88,4% in 2013 and 88,4% in 2014. The decrease is mostly attributable to the high coverage of the first two years that made unnecessary to repeat testing on mothers already tested in the first two years.
- HIV prevalence decreased from 21% in 2011 to 15,9% in 2014. This positive result can be explained with the intense testing campaign done in 2011 and 2012, which left over a smaller pool of mothers, who were not positive the previous years. This positive data is also attributable, partially, to awareness raising campaigns run by the project in 30 secondary schools, and by the growth in condom utilization witnessed by the interviewed nurses and CHWs.

20 This data is not fully reliable, being the exact figure of 101,3%. There is a problem with birth rate, that has been recalculated on data coming from the 2010 census, and appears to be very high (36,6%) if compared to national figures. Moreover, it should be noted that the levels of ANC are higher than 100% in some clinics of the sample, because many mothers not from the catchment area come to the clinics for ANC visits.

- Local facilities reported that blood for CD4 test is regularly collected from all positive pregnant women and sent to the relevant diagnostic laboratory, but the results often fail to come back to the clinic and therefore the CD4 test coverage rate was low. Nonetheless, it increased from 74,7% in 2011 to 82,7% in 2012. In 2013 and 2014 the rate decreased to 56,1% and 68,7% because the introduction of option B+ in April 2013 made this test not compulsory for decisions on ART treatment.
- ARV treatment on pregnant mothers decreased from 66% in 2011 to 48% in 2014, because this measure was overcome by the introduction of option B+.
- ART coverage of positive pregnant mothers is one of the best results obtained in the clinics covered by the project. It increased considerably during the project timespan, going from the weak coverage of 34,2% in 2011 to 90% in 2013 and 90,4% in 2014. The attribution of this result is basically on the introduction of option B+, considering that in 2012 the ART coverage increased, but only to 60,7%.

Children care in South Africa

The health outcomes on children care are coherent with the good results reached by the Qaukeni subdistrict in mother care:

- ARV treatment coverage with nevirapine improved from 2011 (15,2%) to 2013 (73,1%), but the low value of 2014 (19,7%) is challenging to be interpreted: it is possibly connected with the increase of mothers who delivers in the District Hospital rather than in clinics, due to the introduction of the "child support grant" welfare policy[21].
- ARV prophylaxis coverage with AZT has improved, progressively, passing from 54,6% in 2011 to 91,7% in 2014. This proves that the capacity of follow-up of patients in the clinics grew considerably during project timespan, if we consider that AZT treatment lasts for 6 months after the delivery, equivalent to the lactation period.
- Diagnosis improved, passing from 55,3% in 2011 to 87% in 2014. This is an important result, considering that diagnosis of HIV in children is not performed at clinic level. In fact, the blood samples collected have to be sent to a higher level facility. Hence, the positive result is surely linked with the reorganization of the patients' information system, which brought to an improvement in patients follow-up and to a more efficient the filing system at clinic level.
- ART treatment on children also improved, passing from 26,1% in 2011 to full coverage (100% of positive children treated) in 2014. The result is fully attributable to the passage from option A to option B+, considering that in 2012 the coverage was of 36,4%, and in 2013 (year of introduction of option B+) has been of 93,3%.

Partner involvement in South Africa

As already mentioned, the project had no result in South Africa, both in ANC attendance of the partner and in VCT. An important indication for future intervention to improve this weakness comes from the outreach activities implemented by the project: in fact, male partners do agree to be tested during outreach activities, because of the higher privacy guaranteed during this kind of visits, and of course because of the proximity of the service. Outreach activities can thus reduce significantly the lack of male HIV testing in the district. Simultaneously, it will be important to develop awareness tools and community-level engagement strategies to increase male participation to ANC services provided by the clinics, as shown with more detail in the recommendation section of this report.

5.5 Potential sustainability of project's results

Tanzania

In Kondoa and Chemba Districts, the local ownership of the project results seems to be particularly high. In fact, the project worked in close collaboration with the authorities and in particular the District Medical Officers, Community Development Officers, and RCH coordinators. The local staff, with the support and supervision of CMSR staff, have directly implemented all the activities, coherently with the project approach, that was intended as a support to local decentralization of functions related to PMTCT services, in line with national policies.

21 Children born in District Hospital are in fact automatically registered in the civil registry, activating the right for the woman to have access to the child support grant.

The innovations introduced in the health care model by the project seem to be sustainable for several factors, listed synthetically hereunder:

- The introduction of option B+ consolidates the results obtained through the training activities aimed at empowering local human resources, especially the RCH coordinators and the nurses in the district clinic and in dispensaries.
- The MTCT monitoring system introduced by the project is very similar to the one currently used for official data collection in clinics, producing data that are aggregated at district and regional level. Even if dispensaries and clinics will not continue the specific data collection process put in place by the project after the project, the data collection exercise and the assistance provided by the project on data management will surely contribute to the consolidation of the dispensaries monitoring practices officially in place.
- The district of Kondoa in recent fiscal years increased the budget allocated for health human resources, most particularly for nurses, and this expansive policy in the health sector will surely contribute to the improvement of the health care model put in place in recent years. This seems to be one of the most important sustainability factor, being staff shortage the main threat to the sustainability of the decentralized health care model introduced by governmental policies in the last 5 years. The district of Chemba is still in a stabilization phase, but the continuity of this process is assured by the presence of the former DMO of Kondoa, who has been appointed in July 2013 as DMO of Chemba,
- The installation of photovoltaic systems providing electricity to the 18 dispensaries covered by the project is in itself a measure contributing to the sustainability of health services at village level. It should be added that the districts appointed a district technician responsible for quarterly maintenance of these infrastructures, and that a budget dedicated for maintenance and change of spare parts is collected through the Community Health Fund (CHF).

As regards awareness raising and community mobilization actions, the project results seems to be sustainable because they were obtained through the work of existing CHWs and peer educators. Their work seems to be promising although partly threatened by a lack of material resources, which keeps them working near Kondoa town and in the main villages, and does not allow them to reach the most isolated communities of the districts.

However, it should be noted that the resources of the project stimulated the implementation of activities also in most isolated communities. At the same time, the educational activities carried out in schools created a best practice that will probably be replicated and expanded in terms of coverage in next years by the district, using booklets distributed by the government and the coordination and facilitation of the Community development Officer. Moreover, the screening of announcement through a local radio, implemented in the very last month of the project, may enforce the positive results obtained by the other sensitization activities.

It is important to note that the project worked with peer educators who already collaborated with previous interventions of CMSR in Tanzania. This allows engaging them furtherly, if CMSR intend to continue its sensitization activities in the districts in the near coming future. On the other hand, CBOs tend to be under structured, under supported and highly informal, and their activity in villages, although very important, cannot be considered stable and systematically implemented.

The role of CHWs seems to be the weakness point of the project in terms of sustainability in Tanzania. These workers in fact enjoy little recognition and their work is still on a volunteer basis, and thus discontinuous and not monitored by the local government. The project conveyed some resources to remunerate their work for nine months, but this does not appear sustainable because there is still no assurance that authorities will guarantee continuity after the end of the project. Nonetheless, some decisions were taken, at district level, to reduce this weakness, and policies at the national level hopefully seem to look toward a stabilization and recognition of CHWs as public officers. These factors of potential sustainability are indicated in bullet points hereunder:

- The districts decided, during the scale-up workshop organized by the project, to make some changes to the Community Health Fund (CHF): teachers at village level collect this fund, which guarantees the family coverage for PHC expenses, and its subscription is on voluntary basis. The

districts decided that from 2015 CHWs will collect the fund, and 1/13 of it[22] will be destined to cover expenses of CHWs operating in villages.
- District authorities identified alternative strategies to motivate the CHWs, giving them benefits that can last over time (ID cards, top-up for mobile phones, bicycles, to be used for their work in communities).
- The Government is going to release new guidelines regulating the work of CHWs at a national level in 2015, and will establish a one-year curricula and a selection process that will help creating a register that will be used to recognize (and sustain) their work in communities.

The exit strategy of CMSR in Tanzania foresees a continuity of presence and participation in the development of health and community services in both districts, even if not many operational solutions are foreseen in it. The presence of CMSR in Dodoma after Match project, together with the stability of local authorities in the districts, may constitute a positive factor for the institutional sustainability of project results.

South Africa

In OR Tambo district, the project strengthened existing innovation processes introduced by the MoH, and assisted in the development of key services such as the outreach activities, recently reengineered, data collection and follow up of patients. The interviewed staff acknowledge the usefulness of the training and the direct application of the knowledge acquired in their daily work. Moreover, the inclusion of OR Tambo district in the pilot experimentation of the NHI system promoted by the government is expected to act synergistically and to reinforce impact and sustainability of the interventions made by Match.

The sustainability of the innovations introduced in the health care model by the project is reinforced by the following factors:

- The introduction of option B+, which reduced the criticalities on patients ART treatment follow up.
- The reengineering of outreach services, that systematized the activity carried on by clinics in their catchment areas, which improved also thanks to the logistical support provided by the project. In this sense, the donation of the mobile clinic to the district constitutes an important value added in terms of sustainability.
- The reorganization of the data collection system, whose introduction was facilitated by the local partner, SPF, through a “clinic health audit” aimed at cleaning and reorganizing the patients’ information system, restructuring it based on weekly control lists. The MTCT monitoring system introduced by the project is very similar to the one currently used for official data collection in the clinics. Probably the specific data collection process put in place by the project will not continue after project ending, but the assistance provided by the project on data management has strongly contributed to the consolidation of the monitoring practices officially in place.
- The introduction of data capturers in every clinic of the district has strengthened the capacity of patients tracking and follow-up.

The work done with clinic committees on the introduction of BSC has been surely an important innovation for improving the management and tracking the health outcomes of every clinic, but its sustainability can only be obtained with an active presence of project partners in next years. In fact, clinic committees receive no resources for running their activities, and covers their role in clinics with strong limits (distances, costs of communication and displacement, lack of capacitation). The timespan of the project was not enough to stabilize the positive results reached with the introduction of BSC methodology in the clinics.

Differently from Tanzania, CHWs sustainability does not constitute a criticality in South Africa. In fact, the 26 CHWs (2 per clinic) who were trained and worked in the project have been employed with the Community Work Programme (CWP) of the district, allowing continuity to their daily work in communities. This was possible thanks to the active collaboration between LA and SPF. More in general, CHWs are officially recognized as workers in South Africa, usually paid by the Province as regular staff in the local health system. Some of them, as happened in this project, may be integrated as additional health workers through the support offered by the CWP (whose budget is provided by the District Municipality).

22 The CHF costs 13000 shillings per year. 1000 shillings from every enrolled family will be used to sustain the work of CHWs. The mechanism creates a strong incentive for CHWs to enrol as much families as possible, increasing the coverage at village level.

As regards awareness raising and community mobilization actions, the project results seems to be sustainable because they were obtained through the work of trained peer educators who worked in previous projects of SPF, and will work in the future education programme of SPF in the area, known as “Bright Futures Programme”.

The potential sustainability of results, both at community awareness and at health care model levels, is relatively high, thanks to the presence of SPF with other projects in the area, that is already planned and will continue in the next 30 months. The continuity of SPF in the area is even more important, considering the planned exit of OIT from OR Tambo at the end of the project.

One weakness issue, in terms of institutional sustainability, is given by the distribution of responsibilities and priorities among the different political levels within the area, which seem to attribute higher control over the issues concerned by the Match to the Province rather than the District - which has been the formal partner of the project. In fact, the mandate of the district authorities requires them to focus on other priorities (eg. water and sanitation), and their budget on HIV/AIDS prevention and treatment is mainly destined to M&E, address and supervision functions, through the coordination of the local AIDS council. To overcome this limit, the project intensified its collaboration with the Province with positive results.

Lastly, the overall political instability at both provincial and local level is an inevitable limit to the sustainability of the actions targeting the local authorities, which has been obviously out of control of the project. Nonetheless, as already mentioned, the continuity of SPF’s presence in the area can reduce this weakness.

Democratic Republic of Congo

If we look at sustainability as the endurance of the implemented actions, we may assess the activities in DRC first of all in relation to their capacity to build a solid basis for the future introduction of the HIV/AIDS services that are currently lacking in rural Kananga.
Indeed, in the present situation, without such services, the positive results achieved by the project in terms of training and awareness raising may be quickly neutralized, unless the local authorities unblock the resources and decide to activate the services in the short term.

For this reason, the project did all that was in its possibilities, given the context, to convince the local authorities and the Congolese Health system development fund (FDSS) to implement the national AIDS strategy and provide the necessary resources to start VCT, ART, and PMTCT in the project area. However, it was not possible to find, within the project timeframe, an agreement that was sustainable, because the local institutions did not commit to the necessary level of funding for the medium and long term.

On the other hand, the project obtained the creation of a Provincial Multisectoral Council to fight HIV/AIDS, which is expected to foster stronger political commitment to fight AIDS in the area, and to improve the chances to implement full coverage of the services in the near future.
Moreover, the project obtained the mobilization of the local stakeholders, including the partners of the awareness raising campaigns (PNMLS, UCOP+), and the other actors involved in the scale up workshop held in October 2014. The workshop led to the definition of a shared agenda for advocacy and action in the area of HIV/AIDS, which should foster collaboration and coordination among all the stakeholders interested by this challenge, and increase the overall level of sustainability of the actions implemented by Match.

Potential sustainability of transnational activities

As already presented, the transnational activities realized by the project obtained good results in terms of exchange, experimentation, replication and scaling up of best practices and strategies.

The sustainability of these results can be observed mainly in Tanzania: in fact, Kondoa and Chemba districts experimented many practices already in place in South Africa, such as the development of mobile phone services and the experimentation of sexual and reproductive education in secondary schools. The Tanzanian districts adopted also strategies inspired by the South African model, especially regarding the motivation and recognition of CHWs role.

This was possible not only through the implementation of transnational activities, but also with the organization of inclusive scaling up workshops, who were used to capitalize and scale up the lesson learnt in the exchange seminar held in Pretoria and in the study tour held in Qaukeni.

The exchange from between Tanzania and South Africa did not bring to the same effect in terms of replication in both countries. The adoption of practices in South Africa was weaker, because of the differences of contexts and because of the fact that the seminars were in South Africa, and thus participants perceived a stronger focus on the South African model rather than on the Tanzanian one. Lastly, Congo DR has a very different context, and the results of the transnational activities were probably more difficult to be experimented in Kananga.

The exchange between National, Regional and Local levels has been another important and unexpected outcome of the transnational activities in terms of sustainability. Participants from the district entered in contact with Regional and National level during the seminars, and the central authorities identified good practices to be replicated in other areas of their countries.

The only weakness point in terms of sustainability of the transnational component results is constituted by the online platform, which was underdeveloped to become a virtual place of exchange between participants. Moreover, the facilitation of the participation to the platform by project partners was not very developed in the activities, and consequently the platform became a repository of documents produced by the project, with very low results in terms of participation.

6. LESSON LEARNT AND RECOMMENDATIONS FOR THE FOLLOW – UP OF THE PROJECT

6.1 Lesson learnt

The experience developed by partners during the running of Match is consolidated in the final publication produced by the project. Some of these lessons learnt were identified during the final external evaluation, are briefly listed hereunder, and may be added to the ones indicated in the final publication.

1. The project was developed **in line with national policies and integrated with the local health systems**, and had the capacity to flexibly adapt to local changes, through a continuous dialogue with local authorities. This approach constituted a strength point of the project, and may be seen as an example to follow for similar interventions in this field.

2. The project demonstrated the **importance of developing strong partnerships with local actors** operating in health and social areas: this is a major factor of success of the project in South Africa, where the partnership with SPF has brought value added to the project, increasing the potential sustainability of its results.

3. The project demonstrated having severe limits in terms of impact measurement, due to **lack of comparison group baseline data**, which would have been useful for counterfactual comparison purposes. In fact, even though baseline data have been collected at the beginning of the project, no counterfactual data have been collected for comparison purposes on control groups in other similar districts, challenging the attribution of impact to project intervention.

4. The project trained **community volunteers and CBOs**, who played a meaningful role in terms of assistance and supervision to pregnant mothers (especially those with HIV), in order to encourage and support their participation and adherence to PMTCT services. APLWHAs supported their members as well, through small loans and help for transportation to reach distant health facilities. Unfortunately, **community organizations and networks are mostly informal and under structured**, and need to be adequately equipped and supported to improve their capabilities. Therefore, **investing in CBOs and ALPHWAs capacitation, with a focus on mutuality** as a key factor to reduce problems of access to services, may be a key success factor of future interventions.

5. The **MTCT monitoring system introduced by the project was very similar to the one currently used for official data collection** in clinics. This contributed to the consolidation of the monitoring practices officially in place. The assistance of the project on data management in clinics and dispensaries was very practical and oriented to problem solving, aiming to solve the needs arising after local context analysis; this happened, in example, with the introduction of new referral forms in Tanzania and with the implementation of “clinic health audits” in South Africa.

6. The **role of CHWs was central** in this project for their positive influence on VCT and follow up of chronic patients. Moreover, CHWs are a strategic resource in contexts characterized by a scarcity of health staff and where health facilities are scattered on vast areas and not easy to be reached from remote villages. Nonetheless, their role is not fully recognized at national level in **both Tanzania and South Africa**, as **no official training curricula exist for CHWs**. Moreover, **CHWs still work on a voluntarily base in Tanzania**, thus the continuity of their presence in the local health system is not guaranteed nor sustainable.

7. **Mobile phone services have been a significant innovation introduced by the project** in Tanzania for the follow up of patients, compensating the weaknesses due to distances, uncertainty of catchment areas (and difficulties to cover some areas showed by some clinics), data management and filing. Mobile phone services can be a smart solution for future development of services, but their sustainability, if applied for other health services, on larger number of chronic patients, can become a future challenge.

8. **Outreach services** proved to be not only very important for bringing PHC services in remote villages, improving general coverage of the population, but also stimulating a stronger participation of patients to the services offered by the clinics. The phase out of the project should consider the necessity to monitor the continuity and regularity of outreach activities running. The reengineering of outreach introduced in South Africa seems to be a very good result in this sense.

9. **Peer education and reproductive health education in schools** demonstrated to be a key factor to reduce incidence, overcoming taboos related to religious and traditional beliefs, as well as to family. The introduction of this best practice in the areas of Tanzania covered by the project should be seen as a good practice to be scaled up, while in South Africa the activity is already consolidated in the "Bright Futures Programme" of SPF.

10. **Male partners' involvement** constitutes the biggest challenge in South Africa, to be tackled through a three-folded approach, through the deployment of: i) specific HIV counselling and testing services offered during village **outreach sessions**, which seems to be successful in engaging men, due to the higher confidentiality and privacy the programme offers on these delicate matters; ii) **communication campaigns specifically addressed to a male audience**; iii) a **higher involvement of traditional and village-level authorities** in the promotion of male participation to ANC attendance and VCT.

11. **Transnational activities** produced the unexpected outcome of strengthening connections between LA and national level actors, influencing replication and scaling up of best practices nationwide. This good result may be considered in the design of transnational activities of similar future projects.

6.2 Recommendations

Following the "lessons learnt" section, we conclude this report with the addition of some recommendations for the phasing out and follow up of the project, as well as for future similar projects to be designed by the partners. These recommendations are listed concisely hereunder.

1. For future programming on HIV/AIDS prevention activities, (and more generally in the health sector in the area interested by the project in South Africa), it will be important to **involve, with a more central role, the Province of Eastern Cape**. In fact, as already mentioned, the Province seems to have higher control over these issues, and appears to be the key player for the evolution of health service in OR Tambo.

2. The **introduction of BSC in clinics**, with the active engagement of clinic committees and nurses, is surely an important benefit of the project in South Africa, being a contribution to the improvement of planning and management of results at clinic level. Nonetheless, its stabilization can only be obtained with an active presence of **SPF continuing this work with clinic committees in next years**.

3. In Tanzania, an improvement in **coordination and harmonization of CMSR activities with other projects** and interventions in Kondoa and Chemba districts is strongly recommended, not only for increasing the potential impact of future projects, but most importantly for cumulating and coordinating the resources used to activate CHWs in the area. To show an example, during the period 2011 - 2014, CHWs were sustained by Match and by the USAID-funded project "Mwanzo Bora". These interventions had also some components in common (i.e. the focus on nutritional integrations through familiar horticulture for positive lactating mothers), but never entered in contact.

4. As already mentioned in the previous section, a different strategy may be adopted in South Africa to **increase male involvement**: this strategy should consider **specific outreach sessions for male VCT, a tailored communication campaign, and a stronger involvement of traditional authorities**.

5. In South Africa, under the educational programme "Bright Futures programme", **students clubs** were created in each involved school, as **support and counselling spaces providing a safe and confidential environment for students** to have a chance to express their problems and be assisted. This best practice may be adopted also in Tanzania, with the expansion and consolidation of educational activities in Kondoa and Chemba districts.

6. In future interventions, a focus on the **official recognition of CHWs as a profession** at the national level is equally important in both South Africa and Tanzania. This includes the provision of consultancies from project partners to national authorities about the adoption of specific training curricula for CHWs, the identification of criteria for their selection, as well as the observation of local processes (especially in Tanzania) to start recognizing CHW as a profession.

7. In future interventions, it would be important to **collect baseline data for comparison purposes on control groups in other similar districts**, to have clearer information to explain the attribution, in terms of impact, of the project intervention.
8. In future projects, it will be important to **adopt OVIs that may fully reflect the logic of intervention** of the project, in particular the link between activities and outputs produced.
9. Even if the project was mostly successful, and the differences between the three countries allowed interesting comparative analysis, the rate of prevalence in Chemba and Kondoa districts appears to be too low, thus, the relevance of the intervention in the area might be criticized. In similar projects to be proposed in the future, the **existing rate of prevalence might be a stronger criteria for the selection of intervention areas,** even though the results in terms of prevention of incidence growth in the two Tanzanian Districts selected by the project has to be positively considered, highlighting the importance of these kind of projects in low prevalence areas.
10. The sustainability and evolution of project results is strictly connected to the **continuity of partners' presence** in the districts. This is assured by the SPF future programmes, and is clearly stated in the exit strategy produced by CMSR in Tanzania**.**

7. LIST OF ANNEXES

The following annexes are integrating this report:

1. Agenda of the evaluation and list of persons interviewed
2. List of documents and data sources
3. Logical Framework of the project