Mangochi Basic Services Programme 2012 – 2016

MID-TERM EVALUATION

Final Report

Submitted to ICEIDA by:

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Abbreviations/Acronyms

ARI	Acute Respiratory Infections
ADC	Area Development Committee
AEC	Area Executive Committee
CHAM	Christian Health Association of Malawi
CLTS	Community Led Total Sanitation
DEM	District Education Manager
DEMIS	District Education Management Information System
DHO	District Health Officer/Office
DDP	District Development Plan
DOA	Director of Administration
DOF	Director of Finance
DPD	Director of Planning & Development
DWDO	District Water Development Office/Officer
EMIS	Education Management Information System
EPI	Extended Programme for Immunization
GOM	Government of Malawi
HAC	Health Centre Advisory Committee
HC	Health Centre
HHs	Households
HMIS	Health Management Information System
HSA	Health Surveillance Assistant
HSSP	Health Services Strategic Plan
ICEIDA	Icelandic International Development Agency
IFMIS	Integrated Financial Management Information System
HIS	Integrated Household Survey
IPC	Internal Procurement Committee
MHDC	Mangochi District Council
M&E	Monitoring and Evaluation
MGDS	Malawi Growth and Development Strategy
MOH	Ministry of Health
MOLGRD	Ministry of Local Government and Rural Development
MOEST	Ministry of Education Science and Technology
MTE	Mid-Term Evaluation
NGO	Non-Governmental Organization
ODPP	Office of the Director of Public Procurement
SIP	School Improvement Programme
SPSS	Statistical Package for Social Scientists
TA	Traditional Authority
TAULAR	Teaching and Learning Using Locally Available Resources
TOR	Terms of Reference
VDC	Village Development Committee
VHC	Village Health Committee
VHR	Village Health Register
WASH	Water Sanitation and Hygiene
WMA	Water Monitoring Assistant
WPMC	Water Point Management Committee

1.0 Executive Summary

ICEIDA has been Malawi's development partner since 1989 and has a long history of project support in the country particularly in Mangochi District where it has been involved in fisheries, health, adult literacy, primary education, as well as water and sanitation. In 2010 ICEIDA approached Mangochi District Council for a partnership based on Program Approach as a new aid module and in 2012 a tripartite cooperation agreement was signed committing ICEIDA to provide program-based assistance to Mangochi District Council to support its development strategy in the areas of social services namely: Water and Sanitation, Education and Public Health. In addition the Program included capacity building at district level which was incorporated into relevant sectors of support.

1.1 Programme objectives

The overall objective of the Mangochi Basic Services Programme (MBSP) is to *assist the Malawian Government and the Mangochi District Council to improve living standards in rural communities in Mangochi District* and the immediate objectives (outcomes) are: a) Health Programme - *Increased availability, access and utilisation of high impact, quality maternal and child health services in Mangochi District*, b) Water and Sanitation Programme - *Increased and sustainable access to and use of improved safe water sources and improved sanitation practices in TA Chimwala,* and c) Education Programme - *improved quality of education in target schools to reduce dropout and repetition, and promote effective learning.*

1.2 Evaluation Purpose

The Mid-Term Evaluation (MTE) was commissioned to: a) take stock of the first implementation steps in the new partnership between ICEIDA and Mangochi District Council, b) inform the three implementing sectors on how to strengthen their implementation effort and /or use ICEIDA's support to broaden beneficiary impacts, c) feed MTE recommendations into the management cycle of the latter half of the program (2014 – 2016), and d) help to prepare interventions beyond 2016 if the program is successfully implemented.

1.3 Preview of the status of social sectors in Mangochi at the Programme Design Stage

Prior to programme implementation Mangochi District faced numerous challenges in social sectors and these included**:** Health care services: There were a number of weaknesses in the health delivery system including: shortage of human resource and inequitable distribution, weak referral systems and over-reliance on hospitals for primary health care delivery; Water and Sanitation: At the programme design stage the water situation in rural Mangochi was described as poor and sanitation conditions worse**;** Education**:** The primary education sector was characterized by high teacher : pupil ratio, high classroom : learner ratio, high dropout rate, low pass rate, low retention rate and poor learning environment; Delivery capacity of Mangochi District Council: The District Council Office faced various challenges in delivering its services including lack of human resources as well as poor infrastructure.

1.4 ICEIDA's investment in addressing developmental challenges

In order to address the challenges in the district's social sectors ICEIDA's investment has focussed on: a) Health Programme - improvement of infrastructure in health facilities, expansion of infrastructure for high impact, quality reproductive health services, strengthening of health support and community health service delivery systems, and building and strengthening human resource capacity, with particular focus on health services organisation and management; b) Water and Sanitation Programme - Improving access to and sustained use of safe water supply and improving access to and sustained use of adequate sanitation facilities, and c) Education Programme - infrastructure and capacity strengthening in target schools, enhanced equity and improved

retention of girls and OVCs in target schools, and improved management of target schools. ICEIDA has aligned its development efforts with international agreements and declarations and has incorporated their principles into its operational procedures in Malawi. This has been formalized through a tripartite agreement (2012-2016) between ICEIDA, the Ministry of Local Government (MoLGRD) and Mangochi District Council (MDC).

1.5 Evaluation methodology

The evaluation process involved desk review, developing evaluation tools, stakeholder consultations in Lilongwe and Mangochi respectively, community level interviews and focus group discussions. Consequently a number of tools were developed and utilized in gathering relevant information to assess programme performance and these included: Key informant Interview (KII) checklists, Focus Group Discussions (FGDs) guides, Household Questionnaires, and pre-designed data capture sheets for programme outputs, funds utilization, schools' and health facilities' data. Field data collection was done by Research Assistants in 10 days. Quantitative data mainly Household Questionnaires was analyzed using the SPSS Platform while information generated through KIIs and FGDs was processed in Excel Spreadsheet to determine common response domains.

Evaluation Questions

The tools were specifically designed to capture relevant data to address Mid-Term Evaluation questions as specified in the five standard evaluation criteria namely: programme relevance, efficiency, effectiveness, impact and sustainability. The actual evaluation questions are presented Table 1 and Annex 5.

1.6 Summary of Evaluation Findings

1.6.1 Programme Relevance

MTE findings indicate that overall, the MBSP is relevant and consistent with ICEIDA's programming priorities for Malawi and government policies as outlined in the MGDS II for the three target sectors. It is also particularly important to acknowledge that the vulnerabilities identified at the programme design stage in the target sectors (Health, Water and Sanitation, and Education) remain valid and are being addressed with MBSP implementation.

1.6.2 Programme Efficiency

The MTE findings confirm that there is good compliance on part of ICEIDA in the disbursement of funds to the District Council for the latter to implement the programme based on work plans and budgets. As a result there has been no disruption to the programme implementation process. There is also compliance on part of Mangochi District Council with financial and progress reporting to ICEIDA as specified in the Partnership Agreement.

MTE findings have also revealed that at community level utilization of existing community structures for project delivery instead of the programme creating its own new structures to facilitate programme implementation is an efficient way of achieving cost-effectiveness in programme delivery as there are no direct overheads related to the operations of community-based institutions apart from training costs, which is an investments in human capital.

However, the indicative average funds utilization rate for the three sector programmes during the first half of programme implementation (2012 – 2014) is 71.7% reflecting carry-over funds to the next implementation cycle (2014 – 2016). This means that during the next half of programme implementation (2014 – 2016) Mangochi District Council will have to utilize about 130% of programme funds in order to achieve all the planned outputs.

This will be a daunting task for the MBSP if strategic adjustments are not incorporated into the implementation plan/process particularly civil works which are behind schedule for the Health and Education Programmes.

1.6.3 Programme Effectiveness

Overall 67.2% of programme outputs have been achieved (Health 70.3%; Water and Sanitation 55.1%; Education 76.4%), which is an indication that the MBSP is making good progress towards the achievement of immediate objectives mid-way in the implementation cycle and there is also progress towards the programme goal. While there are slippages in the achievement of a number of programme outputs, civil works is the most visible component in Health and Education Programmes largely because some activities are dependent on the completion of civil works. Overall the Output to Outcome analysis shows that there is good progress towards achievement of programme outcomes by 2016 if the infrastructure and other remaining outputs are accomplished as planned.

1.6.4 Programme Impact

MTE findings indicate early impacts being generated by the programme based on change in outcome indicators between the baseline period (2011 – 2012) and 2013 – 2014 representing the programme implementation period . For example: Health – the proportion (%) of births attended by skilled health workers has increased (baseline 68%, MTE July 2014 results in target HCs 96.8%); Under one year immunization rate has increased (baseline 69%, MTE July 2014 results 83.5%); Water and Sanitation: access to safe water (baseline 62.8%, MTE results for areas where water facilities have been provided 99.1%); the number of villages verified as ODF is gradually rising (baseline 0 village, 2013/2014 programme results 16 villages); Education – there is improvement in all outcome indicators: primary school retention rate (baseline for Mangochi district 80%, MTE July 2014 results for programme schools 85.8%); selection rate to secondary schools (baseline for Mangochi district 41%, July 2014 rate in programme schools 60%).

MTE results also show high community satisfaction with programme delivery in all the three sectors as compared with the situation before programme implementation: for example 83.9% of the 249 women interviewed in the catchment areas of 12 target HCs showed satisfaction with the quality of counselling services for HIV/AIDS against 49.4% before programme implementation; 62.7% of 220 women interviewed around water points are satisfied with the dissemination of sanitation and hygiene education by HSAs/VHCs against 35.9% before programme implementation; and 8 out of 12 communities around target schools are satisfied with availability of learning materials such as exercise books against 2 out of 12 communities before the programme, while 7 out of 12 communities are satisfied with the attitude of teachers towards pupils against 5 out of 12 prior to programme implementation. These results are indications that there is progress towards achievement of the outcomes as well as progress towards the programme goal.

1.6.5 Programme Sustainability

The evaluation has revealed that so far there has been minimal activity towards incorporating programme interventions into government operational and administrative systems in preparation for the era beyond June 2016 when the current programme phases out. This remains an area for attention during the latter half of programme implementation. However, at community level various capacity strengthening interventions have been delivered to ensure some degree of community self-reliance beyond 2016 e.g. capacity enhancement of Water Point Management Committees (WPMCs) and establishment of a village maintenance fund in each beneficiary community to ensure that target communities have sustainable access to safe water beyond the programme's lifespan.

1.6.6 Capacity Enhancement

The MTE findings confirm that a number of capacity enhancement interventions have been delivered by the programme including training which has enhanced the delivery capacity of service providers especially at community level. However, the general observation is that the delivery of training in all sector programmes is not standardized in view that not all target participants have received similar training except in the water sector where consistency has been achieved based on the analysis of KIIs and FGDs with recipients of training. Our view is that standardized or harmonized training for the same category of personnel or community representatives based on training needs assessments has potential to add more value to the delivery capacities of community-level service providers in all the three sectors.

1.7 Overall assessment of programme performance

Based on MTE findings, there is evidence that the MBSP is making good progress towards achieving its immediate objectives and contribution towards the programme goal. Thus ICEIDA's investment in the MBSP to improve the living conditions of the people of Mangochi has started yielding desirable results. What is required in the remaining two years is to review the plans, re-prioritize and re-strategize, where appropriate, to ensure that the main outputs are achieved by the end of the current phase (June 2016). This is important for Mangochi District Council, MOLGRD, and Malawi as performance and experience gained during the current phase is necessary for negotiating another cooperative agreement with ICEIDA in order to extend and broaden the benefits to other areas in Mangochi not currently reached by the programme. The main areas that will need attention during the remaining two years include: a) completion of civil works mainly in Health and Education Programmes; b) MOLGRD to fully play its role as specified in the Partnership Agreement in order to re-enforce its programme support; and c) strengthening M&E capacity in ICEIDA's Mangochi Office to improve technical assistance delivery to the implementing sectors as well as the entire District Monitoring and Evaluation Committee (DMEC) that also provides information to implementing sectors where necessary.

1.8 Recommendations

Sector-specific recommendations are presented in Section 5 of the Report under *Evaluation Findings*. However there are four key recommendations based on MTE findings and these are:-

a. In light of slow progress in infrastructure development, we recommend that Mangochi District Council should approach ICEIDA, if necessary, to identify an independent consultant to facilitate and speed-up implementation of civil works particularly in Health and Education programmes.
b. The MOLGRD should identify a focal point person and operationalize the position to strengthen its roles as specified in the Partnership Agreement.
c. In light of limited M&E capacity in the implementing sectors and in ICEIDA's Mangochi Office to effectively provide technical assistance in M&E, we recommend that ICEIDA should strengthen its M&E function in the Mangochi Office to enable it provide the required technical assistance based on implementing sectors' needs.
d. The District Council with the implementing sectors should develop sustainability strategies to ensure gradual institutionalization of activities within the District Council and/or sector Ministries budgets.

1.9 Lessons learnt

a) An important lesson is that devolution of mandate to decentralized structures to manage development and make decisions without direct influence of the centre is an efficient and effective way of delivering basic social services to the rural poor and under-privileged communities. Direct funding to the District Council, capacity strengthening of implementing sectors, functional and transparent financial and procurement systems with checks and balances, time-bound operational plans and budgets and capacity building of community structures are pre-requisites of successful delivery of development to rural communities.

b) By improving the learning environment in schools through infrastructure development and provision of learning materials, and capacity enhancement of teachers, education managers, and school governance committees, there is high potential for improving the pass rate, retention rate, and selection rate in primary education. This scenario is becoming visible in target schools in Mangochi where comparative analysis between programme and non-programme schools has revealed higher performance indicator values for programme schools than for non-programme schools.

c) Building the capacity of existing community structure and mentoring them to steer their own development is a cost-effective way of delivering development to achieve broader community impacts and instill community ownership. Delivery of the MBSP at community level is premised on strengthening community institutions such as Village Health Committees (VHCs), Water Point Management Committees (WPMCs), and School Governance Committees (SMCs, PTAs ,and MGs) supported by frontline staff such as Health Surveillance Assistants (HSAs) and Health Centre (HC) personnel, Water Monitoring Assistants (WMAs), and Education Managers respectively. Utilization of strengthened community-based structures is not only effective in service delivery but also cost-effective as the programme does not incur administrative overheads apart from training costs – which means that the programme can broaden the impact area at least cost while distributing the benefits to a wider community.

1.10 Organization of the Report

Section 1.0 is the Executive Summary which has provided a synopsis of the Mid-term Evaluation Report; **Section 2.0** is Introduction/Background and presents the scope of the programme and evaluation; **Section 3.0** is the Programme Profile describing the context for the development in Mangochi as well as key aspects of ICEIDA's investment in the programme; **Section 4.0** is the Evaluation Profile outlining an overview of the evaluation including the methodology employed and performance expectations; **Section 5.0** presents Evaluation Findings that address the evaluation questions in terms of programme design, implementation, and performance; **Section 6.0** is the Conclusion and provides an overall assessment of performance; **Section 7.0** provides Key Recommendations based on evidence from programme performance; while **Section 8.0** is Lessons Learnt outlining best practices that could be replicated in similar interventions.

2.0 Introduction

2.1 Background

ICEIDA has been Malawi's development partner since 1989 and has a long history of project support in the country particularly in Mangochi District where it has been involved in fisheries, health, adult literacy, primary education, as well as water and sanitation. It was against this background that in 2010 ICEIDA approached Mangochi District Council for a partnership based on Program Approach as a new aid module. A new Country Strategy for ICEIDA in Malawi was formulated and approved emphasizing the district approach.

In 2012 a tripartite cooperation agreement was signed committing ICEIDA to provide program-based assistance to Mangochi District Council to support its development strategy in the areas of social services: Water and Sanitation, Education and Public Health. In addition the Program included capacity building at district level which has been incorporated into relevant areas of support. Program implementation started in stages: Health and Water and Sanitation started in July 2012 while implementation of the education component started in 2013. In early 2014 the Monitoring and Evaluation plans for the program were finalized and by mid-year the M&E Framework was in place for operationalization.

2.2 Evaluation Purpose

The Mangochi Basic Services Programme (MBSP) is implemented under a tripartite partnership agreement on funding, management, implementation and monitoring, between the Ministry of Local Government and Rural Development (MoLGRD) and Mangochi District Council on behalf of the Government of Malawi (GoM) and ICEIDA on behalf of the Government of Iceland. Thus the Mid-Term Evaluation (MTE) was commissioned to take stock of the first implementation steps in the new partnership between ICEIDA and Mangochi District Council (MHDC). The evaluation results will also inform the three implementing sectors on how to strengthen their implementation effort and /or use ICEIDA's support to broaden beneficiary impacts. In addition the MTE recommendations will feed into the management cycle of the latter half of the program (2014 – 2016) and also help to prepare interventions beyond 2016 if the program is successfully implemented.

2.3 Contribution to the Mid-Term Evaluation

The MTE has received support and valuable contribution from key stakeholders including: ICEIDA in Iceland, Lilongwe and Mangochi Offices; Ministry of Local Government and Rural development; Mangochi District Council and implementing partners and their support staff (at DHO, DWDO, DEM); and at community level: School teachers and members of school governance committees; Health Centre staff, HSAs, Village Health Committees, Water Monitoring Assistants, Water Point Management Committees, and beneficiary communities that were contacted during field work especially women and caregivers that were identified for interviews.

3.0 Programme profile

3.1 Mangochi District

3.1.1 Location, size, and population[1]

Mangochi district, the host location of the MBSP is situated in the Southern Region of Malawi (at the Southern end of Lake Malawi) and entirely surrounds the eastern tip of Lake Malawi. The district shares boundaries with other districts namely: Machinga in the South-East, Balaka, Ntcheu and Dedza in the South –West, Salima in the North and shares an international boundary with Mozambique in the East and North East. Mangochi District has a total land area of 6,273 square kilometers which is proportionately 19.8 percent and 6.7 percent of the Southern Region and Malawi's land area respectively. In the 2008 Census the population of Mangochi was estimated at 797,061 people and by the first year of MBSP implementation in 2012 the projected population was 909,236 people at an annual growth rate of 3.15%. The mid-year population for 2014 is therefore estimated at 967,515 people.

[1] Mangochi Socio-Economic Profile Report

3.1.2 Mangochi District Council

Mangochi District Council was established under the Local Government Act of 1998. Like other local authorities, after almost a decade the Council is now headed by the Chairperson elected from within ward councilors in the district which has 24 wards each represented by one elected member. The 12 Members of Parliament are ex-officio members of the District Council and have voting powers according to the 2010 Local Government Amendment Act. The 9 Traditional Authorities (TAs) are also ex -officio members of the District Council. The elected members appoint five additional interest group members.

Under the Local Government Act (1998)[2], the objectives of the Councils have been broadened and may be cited as: *"to further the constitutional order based on the democratic principles, accountability, transparency and participation of the people in decision- making and development process".* The Councils have the power to make by-laws to govern their operations and raise funds for carrying out their functions. Detailed functions of the District Councils are outlined in the Local Government Act of 1998.

Through its mandate the Mangochi District Council has the responsibility of improving services in the district and is leading the programme implementation process. The MBSP's operational work plans, financial management and M&E systems have been aligned to the district systems.

Since the MBSP is implemented by theDistrict Council, the role of Councillors in providing direction and support will be crucial to ensue that the programme remains on course as planned. Possibly a meeting on the context, objectives, MBSP implementation process , and potential role of councillors will be necessary to the newly elected councillors to ensure their buy-in and acknowledgement of the MBSP. The de-briefing could be presented jointly by ICEIDA and the District Coordinating Team (IMPLEMENTING SECTORS).

3.1.3 Equality, equity, and social inclusiveness

There are different ethnic groups in Mangochi and the predominant faiths are Islam (70%) and Christianity (28%). In implementing the MBSP, the diverse religious and ethnic backgrounds are being recognized and given special consideration to ensure equality and equity.

Similarly implementation of the MBSP has taken cognizance of the tradition and cultural values in the district; hence there are no conflicts with community norms. In addition the MBSP targets all ethnic groups in the districts as it covers all Traditional Authorities thus ensuring equitable access to social services.

3.2 Status of target social sectors in Mangochi district prior to MBSP implementation

3.2.1 Health care services

In the Health Programme Design Document a number of factors that negatively impact on the health of Malawians including availability and quality of health services, access to health services and environmental and behavioural issues were acknowledged including weaknesses that were identified in the Health Sector Strategic Plan (HSSP:2011). These included shortages of human resource and inequitable distribution, weak referral systems and overreliance on hospitals for primary health care delivery, poor performance of contractors in infrastructure, rising costs and donor dependency. The HSSP proposed to sharpen the focus on public health interventions including health promotion, disease prevention and community participation.

The 2010 Malawi Demographic and Health Survey (MDHS) indicated that Mangochi district lagged behind in many health areas. The contraceptive prevalence rate was low in Mangochi (26.6%), the lowest in Malawi. High utilization of antenatal care services (97.5%) was reported, but lower than average percentage of deliveries were attended by skilled health professionals (69.1%) or taking place in health facilities (67.3%). Mangochi

[2] Mangochi Socio-Economic Profile Report

scored below average in childhood immunization and care seeking in childhood illnesses. The prevalence of anemia in children was relatively high and Mangochi had the highest prevalence in Malawi for anemia in women. Some causes of infant mortality include malaria, poor diet, and repeated pregnancies and lack of care before and during delivery. Problems in accessing health care included: distance to health facility (Mangochi 66.5% of sampled women ; Malawi 55.5%); lack of drugs in health facilities (Mangochi 69.4%; Malawi 47.3%); need for transport to access health care (Mangochi 68.3%, Malawi 53.7%); and having money to pay for health care (Mangochi 65.6%, Malawi 51.6%). The HSSP (2011 - 2016) ranked Mangochi as the fourth lowest among Malawi's 28 districts with regard to access to health services. Based on Basic Priority Rating System (BPRS[3]) Mangochi district identified high maternal mortality and low immunization coverage as the most important health problems in the district.

Coordination of health services in the district is done by the District Health Office (DHO) and health service providers include Ministry of Health (MoH), Non-Governmental Organizations (NGOs), Christian Health Association (CHAM), and Private Practitioners. There are 42 main health care facilities in Mangochi and these include 25 government health facilities (of which 10 are government dispensaries and 2 hospitals), 15 Christian Health Association of Malawi (CHAM) health facilities of which 2 are hospitals, and 2 private clinics.

The referral system comprises of a three-tier arrangement: a) primary/community level - This is a health post managed by a Health Surveillance Assistant (HSA) who functions as a link between the community and the health system and reports to the Health Centre. The health post covers a number of villages with an average population of 2000 people and offers a number of services including: simple diagnosis and treatment of minor ailments, health education, sanitation, hygiene, disease prevention and control; b) primary/Health Centre - covers a wider area constituting a number of heath posts. The Health Centre provides managerial functions of health services in its catchment's area and is designed to cater for a population of 10,000 people. A medical assistant mans the Heath Centre supported by two nurses and one environmental health assistant. The Health Centre provides primary curative and preventive care, which includes diagnosis, treatment, immunization, macronutrient supplementation, maternal services, health education, and hygiene and sanitation promotion.; c) Secondary/District Hospital - The district hospital provides primary level health care to the surrounding community and secondary health care to the entire district. Patients from all health facilities in the district are referred to the district hospital. For effective and efficient health services delivery, the District Health Office has divided the district into 5 health zones namely: Chilipa, Mangochi Boma, Makanjira, Monkey Bay and Namwera.

3.2.2 Water and sanitation

At the programme design stage the water situation in Mangochi was described as poor and sanitation conditions worse. In 2010[4], only 82.4% of the district population had access to safe drinking water, an improvement from 73% in 2008. According to the Integrated Household Survey3 (IHS3: 2010 – 2011) definition '*a household is considered to have access to safe drinking water if the source of water is piped into the dwelling unit, piped into the yard or plot, communal stand pipe, protected public well, borehole and protected shallow well in rural areas'*. Based on the IHHS3 definition safe water distribution in the district varied widely between the Traditional Authorities (TAs) with some TAs having high coverage of around 95%, while others such as TA Chimwala having low coverage of about 50%; Mponda (60%); Makanjira (60%); and Namabvi (64%). In addition the operations of the District Water Development Office (DWDO) were constrained by inadequate manpower and facilities[5].

MDHS 2010 results also indicate that only 8.9% of households in Mangochi had an improved/not shared latrine, which was slightly higher than the national average of 8.2%. However, the majority 91.1% of households used

[3] Mangochi Socio-Economic Profile Report
[4] MDHS 2010
[5] ICEIDA Water and Sanitation Programme Design Document (2011).

non-improved latrines against a national average of 91.8%. Thus the commonest sanitation facilities in the district were traditional pit latrines, which are basically temporary structures for immediate or short term use.

3.2.3 Education

Mangochi district has 256 primary schools out of which 243 are public. The public schools are mostly owned by the Diocese of Mangochi (45%) and Local Education Authority (31%). The remaining schools are owned by various religious groups: Anglican, Muslim, Presbyterians and Lutheran. The district is divided into 17 education zones. Primary education is not compulsory in Malawi. According to projections from 2012, based on a 2008 census, Mangochi had a population of 916.274, roughly half of which was of primary school-going age. Only about 60% of these children, however, were enrolled in school, while the national primary school-going age enrolment rate stood at 75.4%[6].

Furthermore, EMIS2010 showed that the district had 1743 primary school classrooms (1623 permanent & 199 temporary) during 2009/10 prior to project implementation against 195,341 learners which resulted into a classroom : learner ratio of 1:112 for all classrooms and 1:120 for permanent classrooms. This was higher than the national average of 1: 101 and double the recommended standard ratio of 1 : 60. The EMIS2010 also indicated that the district had 655 permanent teachers' houses against 2027 teachers which meant that only 32.3% of teachers were housed in permanent housing structures while 67.7% of the teachers had to find accommodation in nearby villages, a situation that likely demotivated some of the teachers.

Other indicators derived from EMIS2010 data reflect poor learning environment in the district. For example: a) on average there were 4 pit latrines for boys and 4 pit latrines for girls at each school which resulted into 98 boys and 97 girls sharing a pit latrine respectively - a situation that potentially poses health and hygienic challenges in schools; b) The teacher : learner ratio was 1 : 98, which was second highest in the South East Division to Machinga district which had a ratio of 1 : 108; c) Mangochi district had a primary school retention rate of 84.1% for all classes, which was lower than the national average of 86.7% and also lower than the retention rates for all other South East Division districts; and d) access to safe water was also a challenge in primary schools with only 201 boreholes in the district representing 78.5% of primary schools with access to safe water. The remaining schools either had no water at the school or were dependent on unprotected water sources.

3.2.4 Capacity building

The Mangochi District Council Office faced various challenges in delivering its services at the time of programme design in 2011. It suffered from considerable lack of human resources as well as poor infrastructure. Therefore a fourth component of the cooperation between the District Council and ICEIDA is institutional support to the District Office to enable it build a capable workforce to successfully implement development projects. This is being formulated in a plan for the four year period. Capacity building is also incorporated into all areas of support that ICEIDA is providing and these are outlined in the respective Programme Documents.

3.3 ICEIDA's investment in addressing developmental challenges in Mangochi district

3.3.1 Investment in Public Health[7]

In order to address the challenges in the district health sector, the overall objective of the MBSP is to assist the Government of Malawi and the Mangochi District Council to improve the living standards in rural communities in the district. Specifically the MBSP – Health Programme is aimed at ***reducing maternal and child mortality rates*** in Mangochi District. The programme is premised on priorities and strategies identified by national and local health authorities during preparation of the 2011-2016 planning cycle. The broader focus of the Health

[6] EMIS and DEMIS 2011 quoted by ICEIDA in the Education Design Document (2011)

[7] Based on ICEIDA Health Design Document (2011)

Programme is on improvement of infrastructure in health facilities, expansion of infrastructure for high impact, quality reproductive health services, strengthening of health support and community health service delivery systems, and building and strengthening human resource capacity, with particular focus on health services organisation and management. The programme takes cognizance of the intentions of the Health Services Strategic Plan (HSSP) to prioritise expansion of services to the under-served and aims to improve not only access to health services but also the quality of health services and working environment of health personnel.
The immediate objective of the programme is: *Increased availability, access and utilisation of high impact, quality maternal and child health services in Mangochi District,* and the main outputs of the programme are:

1. **Improved health services infrastructure**
   1.1. General infrastructure in the network of the MoH health centres is strengthened
   1.2. Improved infrastructure and equipment in maternal and child health services in HCs
2. **Increased coverage of high impact, quality maternal and child health services**
   2.1. Improved referral services
   2.2. Strengthened Community based health services
3. **Improved capacity of the health system to deliver services**
   3.1. Improved working conditions for public health (PH) support staff at the DHO
   3.2 Institutional capacity strengthened at the DHO
   3.3 Improved health management information system

The primary target group for the health Programme is the population of Mangochi district with priority given to the poorest communities in rural areas. The community at large is expected to benefit from improved access and better health services, particularly women, children and families. Secondary beneficiaries are field workers, community development committees and various staff at the DHO through participation in programme activities, training, etc. that would enhance their delivery capacity.

3.3.2 ICEIDA's Investment in water and sanitation[8]

The Mangochi Rural Water, Sanitation and Hygiene Programme District Strategy and Investment Plan (DSIP) is the main framework for all water and sanitation efforts in the district, guided by the Malawi Growth and Development Strategy (MGDS), the National Water Policy from 2005, the National Sanitation Policy from 2008, and the National Decentralization Policy. ICEIDA is one of Mangochi District partners in funding the District Strategy and Investment Plan (2007 -2015) with support covering four years (July 2012 - July 2016). The Water, Sanitation and Hygiene (WASH) targets for 2007-2015, to which all potential donors and other actors in the water sector are/will be aligned are as follows:

a. Improved access to and sustained use of safe water supply up from 73% to 80% by 2015.
b. Improved access to and sustained use of adequate sanitation facilities up from 15% (2008) of households to, depending on demand, 80% by 2015.

The immediate objective of the Water and Sanitation programme is: *Increased and sustainable access to and use of improved safe water sources and improved sanitation practices in TA Chimwala[9].*

The main outputs of the water and sanitation programme are:

- At least 150 new boreholes constructed
- At least 100 protected shallow wells constructed
- At least 100 defunct boreholes rehabilitated

[8] Based on ICEIDA Water and Sanitation Design Document (2011)
[9] TA Chimwala is targeted by the programme because it has the lowest coverage of access to safe water compared to other TAs in the district.

- At least 350 water point management committees trained in community based management (operations and maintenance, sanitation and organization) in TA Chimwala
- At least 80% of households construct and use improved pit latrines and hand wash facilities in TA Chimwala
- District system strengthened for WASH service delivery
- Environmental aspects around water points and in relation to sanitation activities examined and addressed

The primary target group is the people in Mangochi's rural communities particulalry in TA Chimwala who have insufficient access to safe drinking water and inadequate sanitation facilities, some of whom are among the most vulnerable in the society. Secondary beneficiaries are the staff of the Mangochi District Water Development Office who are benefiting from capacity building interventions and appropriate equipment to improve service delivery to the rural communities of Mangochi.

As a result of this programme it is expected that the DWDO will have greater capacity to deliver WASH services and manage maintenance and operation of water points as well as improve sanitation. At least 80% of households will have access to safe improved water sources within 500m from their homes in TA Chimwala. It is also envisaged that by the end of the programme there will be a reduction in water borne diseases. Besides, as a result of implementing CLTS sanitation marketing and domeslab provision, it was projected that over 80% of the households would access improved sanitation facilities and practice improved sanitation and hygiene. However,as a government policy, the provision of domeslabs has been discontinued hence the 80% target for community access to improved sanitation no longer holds. Therefore a new target needs to be set for CLTS sanitation marketing as the only remaining delivery strategy for sanitation.

3.3.3 ICEIDAs investment in primary school education[10]

Based on the poor status of infrastructure in primary schools in the district, lack of textbooks and qualified teachers it was evident at the programme design stage that funding from ICEIDA allocated to primary education, would have limited benefit to each learner if the funds were evenly allocated across all the 256 schools in the district i.e. the interventions would have been thinly spread with limited impact.

Therefore, it was determined, in cooperation with district authorities and MoEST, to select three schools from each of the four education zones, twelve in total, to pilot a holistic intervention to improve the quality of education. This approach was based on thorough assessments and consultations with relevant stakeholders. ICEIDA contracted an external consultant, a specialist in education in Malawi, to assist in developing the programme. Two workshops were held, on 8 November and 12 December 2012, with the participation of representatives from the MoEST, Mangochi District and ICEIDA. At these workshop the approach and selection of target schools was discussed in detail, with selection criteria agreed upon by the stakeholders. The basic assumption of the programme rationale was that the selected interventions would lead to improvement in the quality of education environment and management, and consequently improve learners' performance in schools.

Selection of the 12 schools was based on poor learning facilities. There were almost 20,000 pupils enrolled in the 12 schools, but given that the net enrolment rate in the district as a whole was about 60%, it was estimated that 33-34,000 children of primary school going age lived in the catchment area of selected schools.

The immediate objective of the Education Programme is: *improved quality of education in target schools to reduce dropout and repetition, and promote effective learning,* and the main outputs of the Education Programme are:

1. Infrastructure and capacity strengthening in target schools.

[10] Education Programme Design Document

2. Enhanced equity and improved retention of girls and OVCs in target schools.
3. Improved management of target schools.

3.3.4 Gender equality

One aim of the MGDS II is to reduce gender inequalities and enhance participation of both women and men in socio-economic development. This includes meaningful participation of both women and men in decision making; wealth creation and poverty reduction. The MBSP is systematically enhancing gender mainstreaming in all the target sectors and is using monitoring indicators to evaluate progress towards gender equality. Besides, women are primary users of project outputs such as water points and improved health care services for themselves and their children, and more girls are enrolling in primary education with improved learning environment.

3.3.5 Environmental consideration

GOM's long-term goal is to conserve natural resource base through sustainable use and management of natural resources and the environment[11]. On its part ICEIDA has an environmental framework which provides guidelines on environmental management and protection in supported programmes. The ICEIDA document has not yet been translated into the English language and therefore could not be accessed during the course of the MTE.

Malawi Government policy is not clear on environmental issues with regard to standards and compliance in the construction industry. Burnt bricks continue to be used in the construction of health, school, and water and sanitation facilities. It was also evident from the discussions with implementing sectors and ICEIDA that at current prices, cement blocks are not cost-effective and if applied would heavily reduce the number of facilities that the programme has set to provide. However, the programme may explore the use of soil stabilizing blocks (SSB) as a low cost technology for civil works. There is also need to have a complementary 'green programme' which would provide seedlings to communities who have used their forestry resources in burning bricks to replant trees in their environment as replacement of depleted trees.

3.4 Organization of ICEIDA's investment

The Strategy for Iceland's Development Cooperation 2011-2014, was approved by the Icelandic Parliament in 2011. ICEIDA has aligned its development efforts with international agreements and declarations and has incorporated their principles into its operational procedures in Malawi. This has been formalized through a tripartite agreement (2012-2016) between ICEIDA, the Ministry of Local Government (MoLGRD) and Mangochi District Council (MDC).

In accordance with the Icelandic framework for development cooperation and the principles of the Paris Declaration on Aid Effectiveness, the Mangochi Basic Services Programme (MBSP) is supporting and following the overall development strategy of the District Council. This implies that:

- Priority issues identified by the District Council are addressed in a dialogue between the partners;
- Financial commitments are linked to the District Council result framework and budget cycle; and
- Full alignment is the basis for financial support.

ICEIDA adheres to the budget cycle of Malawi from 1 July in one year - 30 June the following year. Funds for the MBSP are channelled from ICEIDA through the District Development Fund (DDF), which is administered by the District Council with the MoLGRD and the Ministry of Finance (MoF) fully informed of planned and actual disbursements. At District Council level funds are disbursed to the implementing sectors: Health, Water and Sanitation, and Education respectively based on their work plans and budgets.

[11] MGDS I

*3.*5 Financial resourcing for the MBSP

The financial management system is government IFMIS-based and managed by Disctrict Council finance officers. Disbursement from ICEIDA is on quarterly basis but linked to submission of financial reports for the MBSP to ICEIDA while narrative (progress) reports are submitted to both ICEIDA and MOLGRD quarterly. ICEIDA provides feedback on the financial reports and if there are any variations these are explained and resolved before the next disbursement. Therefore with regard to financial reporting there is good compliance by the MBSP. So far there have been no disruptions to the financing arrangement mainly due to accountability and reporting compliance of the District Concil to ICEIDA.

3.6 Stakeholder participation

The main stakeholders as specified in the tripartite agreement (2012-2016) are: ICEIDA, the Ministry of Local Government and Mangochi District Council. ICEIDA's roles are as a donor, partner, and monitoring institution on behalf of the Government of Iceland; the MOLGRD is responsible for the tripartite agreement, has a supervisory role towards the Mangochi District Council, and is ICEIDA's main partner within the Government of Malawi at central level; while the Mangochi District Council is responsible for programme implementation, transparent financial administration, and adherence to procurement procedures and resource management. At operational level the stakeholders are: the implementing sectors, which are the district-level implementing agencies and these include: District Health Office (DHO), District Water Development Office (DWDO), and District Education Manager (DEM). The DHO, DWDO, and DEM frontline personnel provide the interface between government departments and the communities who are the ultimate/primary beneficiaries of the MBSP.

3.7 Milestones and Achievement to-date

Overall achievements are discussed under Evaluation Findings in Section 5.0. The programme is generally on course for some components but behind schedule in other aspects which may lead to cost - overruns and this could affect achievement of some outputs especially civil works.

3.8 Obstacles impacting on performance

There are no major obstacles to programme implementation per se to cause major disruptions to the programme but the main concern is slow progress on civil works. It is not necessarily related to the procurement process which on average takes about 2 – 3 months, but delays had been experienced from the outset due to late approval of facilities' designs documents (drawings) by the Ministries of Health and Education respectively and partly the supervision by the Buildings Department to issue certificates for completed work. On the other hand, there are no major challenges in the performance of contractors in the water and sanitation programme. There are also capacity gaps in the Finance Department at Mangochi District Council where some key positions remain unfilled, but these could be addressed by the Malawi Government Human Resources Department.

4.0 Evaluation profile

4.1 Purpose of the Evaluation

The MTE was conducted to assess programme performance of the initial two years of implementation in the new partnership between ICEIDA and Mangochi District Council. Major stakeholders are expected to utilize the evaluation results based on their needs.

4.1.1 Anticipated use of the evaluation findings by stakeholders

a. The Mangochi District Council and the three implementing sectors (Heath, Water and Sanitation, and Education) are expected to learn from the implementation process and utilize the evaluation findings to make relevant adjustments and strengthen their implementation efforts and/or use ICEIDA support to broaden programme benefits to the people of Mangochi.

b. Similarly ICEIDA is expected to use the evaluation findings to re-align its support where appropriate to enable the District Council achieve its planned outputs and objectives through a strengthened partnership.

c. It is also anticipated that the Ministry of Local Government and Rural Development (and line ministries implementing the programme), are likely to benefit from the evaluation by learning from the implementation process and using the findings to support and improve programme delivery; and

d. The evaluation has also assessed beneficiary perceptions (communities and community representatives) and has taken into account their diverse views that would require re-packaging into operational plans and budgets during the second half of programme implementation (Oct 2014 – July 2016) in order for the programme to address their needs.

Overall, the inherent value of the evaluation was to identify potential weaknesses in order to consolidate success in program management and to strengthen Mangochi District Council for effective delivery during the remaining half of the programme phase.

4.1.2 Linkages with other processes

There are possibilities that MTE findings may link with two other processes. Firstly, ICEIDA is planning a District Program in another partner country, Uganda. Therefore the evaluation findings may feed into the planning process of the Uganda program. Secondly, Mangochi District Council and ICEIDA may start discussions on the next phase beyond 2016 when the current programme phases out. Therefore the Mid-Term Evaluation results may be utilized as an input into Phase II planning.

4.2 Evaluation design process

The MTE evaluation design involved a number of stages including the following:-

4.2.1 Documentary review

This was accomplished in two stages: Stage 1 - evaluation design stage: All programme design documents were reviewed for: Health, Water and Sanitation, and Education. The literature review served two purposes: a) to provide an insight into the Partnership Agreement, project objectives, and key programme design features including: delivery strategies, procurement process, output and outcome indicators for measuring performance and impact, justification for ICEIDA's investment, and other relevant programme information; and b) the documentary review provided a basis for developing the evaluation tools for all programme stakeholders including ICEIDA, MOLGRD, Mangochi District Council and implementing sectors (Health, Education, and Water and Sanitation), as well as stakeholders at community level including community-based frontline personnel and programme committees.

4.2.2 Aligning evaluation questions in the TOR to the evaluation criteria

Based on the TOR, the MTE was premised on five standard evaluation criteria namely: programme relevance, efficiency, effectiveness, impact and sustainability. At this stage all evaluation questions in the TOR were aligned or re-distributed amongst the five evaluation criteria to facilitate the development of relevant tools, data capture and analysis. In addition, this stage entailed identification of stakeholders in line with the five evaluation criteria.

4.2.3 Developing the Evaluation Matrix

This was an input into the Inception Report for the evaluation. The task involved developing a framework for the MTE in terms of: a) outlining the key evaluation questions for each evaluation criterion, b) defining indicators for measuring progress or achievement under each evaluation criterion, c) defining the source of information for the indicators – e.g. stakeholders or documentary review; and d) defining the tools for gathering relevant information/data for the indicator. Hence the Evaluation Matrix was developed as follows:-

Table 1: Key evaluation questions			
Key questions for the evaluation criteria:	Indicators for measuring achievement (output level) or change (outcome level)	Source of Information / Data	Tools for gathering data
Relevance: ***How does the project relate to the main objectives of development priorities of ICEIDA and at national and implementing levels?***			
Effectiveness: ***To what extent have the expected outcomes and objectives of the project been achieved?***			
Efficiency: ***Was the project implemented efficiently, in line with international and national norms and standards?***			
Impact: ***Are there indications that the project has contributed to, or enabled progress towards, achievement of programme goal ?***			
Sustainability: ***To what extent are the financial, institutional,, socio-economic, and/or environmental risks to sustaining long-term project results?***			

4.2.4 Developing the evaluation tools

Each evaluation question has corresponding indicators for measuring performance. Therefore for each indicator an appropriate tool was developed targeting stakeholders at different levels as source of information. The evaluation had 13 tools administered at different stakeholder levels covering all the five evaluation criteria. The tools were grouped into five categories namely: documentary review; Key Informant Interviews (KIIs); Focus group Discussions; Beneficiary/Househousehold Survey; and primary data collection sheets. These are elaborated in the next paragraphs.

4.2.5 Utilization of tools for data collection

The evaluation Team used the evaluation tools to collect data at different stakeholder levels outline in the next paragraphs**.** Four Research Assistants were hired to facilitate community-level interviews and discussions while a Financial Technician was hired to collate financial records and output achievement rates by 2014 Second Quarter (Q2). The Consultant provided overall stewardship but also conducted key interviews both at the centre in Lilongwe and with implementing sectors in Mangochi.

4.2.5.1 Additional documentary review

The second Stage of documentary review was done as a tool for: a) gathering relevant information for analysis from programme documents such as Quarterly Reports and financial records obtained from relevant officials in the implementing sectors; and b) facilitating comparative analyses between baseline and MTE indicator values. All sector Programme Design Documents had well elaborated Log Frameworks which specified baseline indicators and targets. In the analysis MTE results or values were therefore compared to baseline and targets values. Apart from progress and financial reports, HMIS and DEMIS were also used as data sources. However, the water and sanitation programme does not yet have a management information system installed.

4.2.5.2 Key Informant Interviews with stakeholders at the centre and District level

Key stakeholders included: MOLGRD, ICEIDA, Mangochi District Council, and implementing sectors at district level. Appointments with line Ministries did not materialize therefore no meetings were held as some officials were not available while others had travelled outside the country. The KII tool was designed to assess among other aspects: stakeholder roles, level of participation in programme implementation, perceptions on programme performance and impact, challenges being experienced etc. Mulitple-meetings were also held with

officials in ICEIDA, Mangochi District Council, and implementing sectors - some impromptu but necessary to seek clarity and/or get additional information especially with Managaement Information Systems Officers. The stakeholder consultations were conducted as follows: -

Table 2: Stakeholder consultations	
	Number of Key Informant Interviews conducted
MOLGRD	1
ICEIDA including Mangoci Sub-Office	2 - 3
Line Ministries	0
Mangochi District Council	Several consultations
District-level Implementing Sectors	Several consultations

4.2.5.3 Key Informant Interviews at Community level

At community level KIIs were conducted with HSAs, WMAs, Teachers and Health Centre staff. The interviews were done with each staff category as a group and not as individuals, which enabled them to share their perceptions and programme experiences with the the Evaluation Team. The aim was to get frontline staff views on programme delivery, self-assessment of their performance after training, perceived change in the community resulting from capacity building interventions, and the challenges they experience in the course of delivering services to the community. Therefore KIIs were conducted as follows:-

Table 3: Key Informant Interviews		
	Number of Key Informant Interviews	Number of people who participated
HSAs (Health Programme)	12	45 (24M, 23F)
Health centre staff	12	23(14M, 9F)
WMAs/HSAs (Water and Sanitation)	10	14 (9M, 5F)
Teachers	12	73 (41M, 32F)

4.2.5.4 Focus Group Discussions at Community Level

FGDs tools were developed to facilitate conversations with community representatives in various committees and also directly with community members. The aim was to get community assessment and perceptions on project delivery, performance and change resulting from programme interventions. The tools were also designed to enable the communities compare the current situation (with programme) and the situation before the project. Stakeholders included: VHCs, WPMCs, school governance committees, and learners. Initially it was planned that ADC and AEC menbers would be interviewed but after the initial meeting with District Council officials it was realized that these committees are not actively involved in programme implementation. Our view was that the designed tool would not generate relevant information, therefore the ADC/AEC were dropped from the list of stakeholders to be contacted . The FGDs were therefore conducted as follows:

Table 4: Focus Group Discussions		
	Number of Focus Group Discussions	Number of participants in FGDs
VHCs (Health Programme)	8	74 (22M, 52F)
WPMCs (shallow wells)	12	66 (25M, 41F)
WPMCs (boreholes)	10	56 (12M, 44F)
Learners (Standard 7)	12	114 (55Boys, 59 Girls)
Community/Parents	12	127 (47, 80)
School Management Committee	}	50 (30M, 20F)
Parent Teacher Association	12}	42 (17M, 25M)
Mother Group	}	25 F

4.2.5.5 Household surveys – Mothers and Women

There were two Household Surveys in Health, and Water and Sanitation programmes respectively. The Health Programme Household survey covered 249 households (Mothers) in 12 Health Centres interviewing 20 Mothers in 2 villages randomly selected in the catchment area of each HC. The interviews targeted Mothers with at least 2 children: one born before programme implementation i.e. before 2012, and one born during programme implementation mainly 2013 – 2014. The aim was to explore Mothers' perceptions on maternal services e.g. whether a child was born at a HC and the deliverery was assisted by skilled health workers in either scenario.

For the Water and Sanitation Programme the Household Survey covered 220 Women who draw water from 20 water points provided by the programme (10 boreholes and 10 shallow wells). The interviews were targeted 11 Women aroung each water point. The aim was to get Women's perceptions on access to safe water compared to the period before MBSP implementation.

The main focus in the Household surveys was to assess change in the Immediate Objectives (Outcome Indicators) for the two programmes: Health, and Water and Sanitation respectively. In addition the Household Survey assessed impact from women's perspective e.g. women's satisfaction with services delivery in their areas or communities. The survey targeted women because these are primary users of health services and water resources respectively while in schools the primary beneficiaries are learners. Field data collection for the Household surveys was as follows:-

Table 5: Household Survey

Programme	Number of Facilities covered	Number of Respondents
Health	12 Health Centres	249 Mothers
Water and sanitation	20 Water Points	220 Women

4.2.5.6 Data capture sheets for Health Centres and Schools

In the selected Health Centres the survey team gathered data related to outcome indicators such as pregnant women attending antenatal services and tested for HIV; child immunization coverage, etc. The idea of collecting this data directly from HCs was two fold: a) to generate and analyse HC-specific MBSP outcome indicators in view that HMIS analysis is largely district-based; and b) to assess HC staff capacity to organize and collate MBSP–related indicators at HC level. Therefore data was collected from 11 HCs while one HC did not return the completed data sheet. However, the completion of the data sheets was not satisfactorily done as they had a number of gaps.

Another data sheet was designed for the Education Programme to capture data at school level focussing on outcome indicators such as pass rate, droupout rate, reapeter rate and selection rate to secondary schools. The tool was administered in all the 12 programme schools and 8 Non-programme schools as control for comparative analysis. Reasons for direct data gathering from programme schools were also two-fold: a) to assess schools' capacity in organising and collating MBSP indicators, and b) to complement DEMIS data whose analysis was mainly zone- and district-based.

4.3 Data analysis

Data entry and analysis for Caregivers Questionnaires (Health, and Water and sanitation) was done in SPSS with Frequency Tables as the main outputs. FGDs and KIIs were analyzed in Excel Spreadsheet based on common response domain. The methodology for qualitative data analysis is demonstrated in **Annex 3.**

4.4 Challenges during the MTE process

The Evaluation Team did not encounter major challenges, however the wide geographical spread of interventions in the district posed a logistical challenge related to transport as there was only one vehicle to cover all the areas. In many instances field work was concluded close to sunset and travelling back to Mangochi proper was usually in the evening. Nonetheless, this did not disrupt the data gathering exercise.

4.5 The Evaluation Team

The Evaluation was led by Gilbert Mkamanga (Socio-Economist and M&E Specialist), who has considerable project management expertise and experience. The Lead Consultant has over 20 years hands-on experience in conducting project evaluations, socio-economic baseline studies, developing tailor-made monitoring systems for local NGOs, as well as conducting socio-economic studies. Initially the team composition included a financial analyst but due to other commitments he was not available for the MTE, instead a financial technician was engaged to collate financial data. The Four Research Assistants were professionals in their own right in the sectors of Education, Health, and Water and Sanitation. On board was also a Data Processing Technician with relevant experience in data base applications. Therefore the Team was professionally constituted to carry out the assignment.

5.0 EVALUATION FINDINGS

The presentation of evaluation findings is based on the five evaluation criteria for assessing programme performance and/or achievements and these are: programme relevance, efficiency, effectiveness, impact and sustainability.

5.1 Programme Relevance

The key question that the evaluation has addressed is: *How does the project relate to the main objectives of development priorities of ICEIDA and at national and implementing levels?*

Based on documentary review and discussions with stakeholders, it is evident that the programme design took cognizance of the new ICEIDA Country Strategy for Malawi, incorporated Malawi Growth and Development Strategy priorities in the three target sectors, and also incorporated Mangochi District Development Plans for the three sectors namely: Health, Water and Sanitation, and education.

A new Country Strategy for ICEIDA in Malawi was formulated and approved in 2011 emphasizing the district approach. The new approach is aimed at strengthening the District Council's capacity to achieve its development goals by using local systems and structures in the implementation process which is promoting programme ownership. By providing more integrated support under a single comprehensive programme, ICEIDA is contributing towards programme sustainability where capacity and infrastructure development are being incorporated within the local delivery system.

Mangochi's development framework is based on the Malawi Growth and Development Strategy (MGDS II) which is the overarching national development strategy that has guided the development of the District Development Plan (DDP) at district level.[12] The DDP (2007-2011) had outlined 14 priorities for development in Mangochi district. ICEIDA is providing funds to address 3 of the 14 vulnerabilities namely: a) Low access to potable water; b) High morbidity and mortality rate (infant & maternal mortality); and c) Low access to quality education, and high illiteracy rate in the district.

Therefore MTE findings indicate that overall, the MBSP is relevant and consistent with ICEIDA's programming priorities for Malawi and government policies outlined in the MGDS II for the three target sectors. It is also important to note that the vulnerabilities that were identified at the programme design stage remain valid and are being addressed through the implementation process. The MBSP is also justified on the basis of addressing these vulnerabilities.

5.2 Programme Efficiency

The key question under programme eficiency is: *Was the project implemented efficiently, in line with international and national norms and standards?*

Programme efficiency has been assessed on the basis of four indictors: a) ICEIDA compliance with funds disbursement, b) programme funds utilization rate by the Mangochi District Council, c) District Council Compliance with reporting requirements, and d) appropriateness of community-based structures in programme delivery.

[12] In the DDP 2007-2011, the main objective is reducing poverty under the poverty line of US$ 1 per day from 60,7 % to 58,7.

5.2.1 ICEIDA compliance with funds disbursement schedule

Compliance with funds' disbursement was identified as an efficiency indicator in view that delays in disbursing funds to the District Council may affect and/or disrupt the programme implementation process. Article 6.1 of the Partnership Agreement between the GOM and ICEIDA states that: *'the grant will be disbursed quarterly upon receipt of written requests from the District Council based on the financial needs and approved work plans and budgets*'. It is worth noting that ICEIDA has a flexible approach where planned activities may be shifted forward or backward depending on need as long as the activities are within the annual plan for the year, which provides implementing sectors an opportunity to reschedule implementation plans to meet immediate programme needs. However, at times there are some delays in the disbursement of funds where ICEIDA requires clarification on expenditure on some budget lines, but these cases have been few and have not led to major delays in programme funding. The MTE findings therefore show that there is good compliance by ICEIDA in the disbursement of funds to the District Council for the latter to implement the programme based on work plans and budgets.

The other dimension to funds' disbursement is financial monitoring by ICEIDA. This is an on-going process and is done on monthly basis after receipt of summary expenditure returns from the District Council. ICEIDA reviews the summary reports and validates them to ensure that the funds have been utilized in accordance with planned activities and corresponding budgets. Although there have been a few instances where variances between the budget and actual expenditure have been noted, these have been explained by the District Council and have not impacted on programme funding. Our assessment of financial monitoring is that ICEIDA's approach to conducting monthly reviews of financial transactions is deepening transparency and accountability and with time these values are being institutionalized within the Mangochi District Council financial management system. The monthly financial monitoring system has also led to closer conversations between ICEIDA and the implementing sectors through informal discussions where best practices are being shared on financial matters. However these conversations need to be systemized as formal feedback systems.

5.2.2 Funds utilization rate

One indicator of programme efficiency has been to measure the utilization rate of disbursed funds by the Mangochi District Council. This has been done under the assumption that a low-utilization rate could affect achievement of programme objectives and outputs. The rates are derived for expected outputs based on indicative programme budgets for the period up to the second quarter (Q2) 2014 and corresponding expenditure for the same period. The analysis has been done separately for each sector programme followed by an overall summary.

a) Public Health Programme

MTE findings for the Public Health Programme (**Table 6**) show that the funds utilization rate ranges from 47.6% (for Output 3.1) to 93.5% (for Output 2.1) with Output 3.1 having the lowest utilization rate. Overall about 67.9% of the budgeted funds for the period 2012 – June 2014 have been utilized with about 30% of the funds unused. This means that the programme will have to utilize 130% of programme funds during the second half of programme implementation (2014 – 2016). This is likely to put pressure on the implementation process in the second half (2014 – 2016) in order to make up for the slippage in the first half especially for civil works for Health and Education. Therefore there is need for prioritizing and re-strategizing on the implementation process to ensure that all outputs are achieved by 2016 to maximize programme benefits to the people of Mangochi.

Table 6: Indicative Funds Utilization Rates- Health Programme			
OUTPUTS	**Budgeted Funds up to June 2014** (Million MK)	**Expenditure up to June 2014** (Million MK)	**% Funds Utilized**
1.1.General infrastructure in the network of the MoH health centres is strengthened	187.806	149.444	**79.6**
1.2 Improved Infrastructure and equipment in maternal and neonatal care services in HCs	866.477	536.258	**61.9**
2.1 improved referral services	71.9	67.212	**93.5**
2.2. Strengthened Community based health services	71.205	62.959	**88.4**
3.1. Improved Working Conditions for Public Health (PH) Support Staff at the DHO	25.2	12.000	**47.6**
3.2 Institutional capacity strengthened at the DHO	49.000	24.500	**50.0**
3.3.Improved/Strengthened Health Management Information System	43.127	39.939	**92.6**
Total	**1314.715**	**892.312**	**67.9**

b) Water and Sanitation Programme

MTE findings (**Table 7)** indicate that, overall, the Water and Sanitation Programme has utilized almost all the budgeted funds (99.6%) for the period 2012 – June 2014. This is consistent with the schedule for the provision of water points in TA Chimwala.

Table 7: Indicative Funds Utilization Rates - Water and Sanitation Programme			
OUTPUTS	**Budgeted Funds up to June 2014** (Million MK)	**Expenditure up to June 2014** (Million MK)	**% Funds Utilized**
1. At least 150 new boreholes constructed	119.932	119.597	99.7
2. At least 100 protected shallow wells constructed	30.006	30.657	**102.2**
3. At least 100 defunct boreholes rehabilitated	39.418	39.265	**99.6**
4. At least 350 water point management committees trained in CBM (operations and maintenance, sanitation and organization) in TA Chimwala	12.437	12.383	**99.6**
5. At least 80% of households in TA Chimwala construct and use improved pit latrines and hand wash facilities	8.449	7.919	**93.7**
6. System strengthening for WASH service delivery	76.735	75.845	**98.8**
7. Environmental aspects around water points and in relation to sanitation activities have been examined and addressed	4.659	4.821	**103.5**
Total	**291.636**	**290.487**	**99.6**

c) Education programme

Implementation of the Education Programme started in 2013, a year later, unlike the Health and Water and Sanitation Programme whose implementation started in 2012. However, apart from the provision of new infrastructure in schools where only 17.9% of the funds have been utilized and rehabilitation of infrastructure (47.9%), it has registered a high utilization rates in 60% of the outputs (6/10) (**Table 8**). Overall, the funds utilization rate stands at 66% which is close to the rate achieved by the Health Programme. The main concern really is the pace at which infrastructure development is progressing as the programme has already been affected by a year's delay in its implementation. This is an area that needs particular attention during the second half of programme implementation (2014 – 2016).

Table 8: Indicative Funds Utilization Rates - Education Programme

OUTPUTS	Budgeted Funds up to June 2014 (Million MK)	Expenditure up to June 2014 (Million MK)	% Funds Utilized
1.1 Capacity building of teachers and school managers	72.876	68.405	**93.9**
1.2 Teaching and learning materials provided in target schools	116.546	76.866	**66.0**
1.3 Community mobilized for educational support	46.672	45.848	**98.2**
2.1 New infrastructure and equipment in target schools	65.04	11.65	**17.9**
2.2 Infrastructure rehabilitated in target schools.	120.084	57.498	**47.9**
3.1 Strengthen the role of Mother Groups in the Schools	2.250	2.25	**100.0**
3.2 Strengthen the status of girls in schools	2.000	2.000	**100.0**
3.3 Support to OVCs	8.909	8.605	**96.6**
4.1 Capacity building and training in education and management	18.248	17.637	**96.7**
4.2 Strengthening of DEM's office operations	78.774	59.887	**76.0**
Total	**531.399**	**350.646**	**66.0**

d) Overall funds utilization rate and its implications

The indicative average funds utilization rate for the three sector programmes during the first half of programme implementation (2012 – 2014) is 71.7% (**Table 9),** an average largely pulled upward by Water and Sanitation utilization rate. The 71.7% utilization rate is a mid-way achievement between average and high. This means that during the next half (2014 – 2016) Mangochi District Council will have to utilize about 30% of the funds on backlog activities besides programmed activities for the same period. This will be a major task for the District Council to accomplish in light of Article 3.2 in the tripartite agreement which succinctly states that *'unspent disbursed funds will be returned to ICEIDA upon completion of the programme*'. The implication is that if there will be unspent funds by June 30, 2016 the people of Mangochi will not have fully benefitted from the programme as designed. Therefore a re-think of the strategies for

improving programme implementation is necessary to ensure that all outputs are achieved by the phase-out date. Some recommendations to improve delivery are presented under programme effectiveness.

Table 9 : Overall Indicative Funds Utilization Rate

Programme	**Budgeted Funds up to June 2014** (Million MK)	**Expenditure up to June 2014** (Million MK)	**% Funds Utilized**
Education	531.3999	350.646	66.0
Health	1314.715	892.312	67.9
Water and Sanitation	291.636	290.487	99.6
Total	**2137.7509**	**1533.445**	**71.7**

5.2.3 District Council Compliance with reporting requirements

Compliance with reporting requirements has been assessed based on two Partnership Agreements, articles 8.2 and 8.3: -

Article 8.2: '*A financial report comparing the use of funds with planned budgets and explaining major deviations from plans shall be submitted no later than the 15th day of the following month'*.

Article 8.3: *The District Council shall submit progress reports to ICEIDA bi-annually not later than 15 days before any bi-annual meeting'.*

MTE findings show that the IFMIS system is functional with no major issues on financial reporting. Both financial and narrative reports are produced as scheduled although some delays are experienced in the submission of progress reports from implementing sectors to the Secretariat (Council). Thus, to a larger extent there is compliance with the reporting requirements and schedule. Where there is variance between budget and actual expenditure, these have been explained to ICEIDA and resolved. However, there is need to improve the narrative Quarterly Output Report to include some analysis of programme performance.

5.2.4 Utilization of community-based structures in programme delivery

Delivery efficiency has also been assessed through analysis of how the programme delivers its services to the communities at least-cost but achieving medium to high impact. The MTE has revealed that use of existing community structures for project delivery instead of the programme creating its own new structures to facilitate programme implementation is an efficient way of achieving cost-effectiveness in programme delivery. For example the programme is building the capacities of VHCs, school governance committees, and WPMCs as community-based development actors or facilitators. These are community volunteers who reside within the communities and have no overheads on the programme apart from investing mainly in their training. If the programme purely utilizes government structures, or creates new structures, the delivery cost to the communities could have been enormous due to overhead expenses – transport, allowances, etc. and this could probably have diverted some funds from sector programmes to meet administrative overheads.

5.3 Programme Effectiveness

This is the largest part of the evaluation. Programme effectiveness has addressed the key question: *To what extent have the expected outcomes and objectives of the project been achieved?* Firstly, the evaluation has looked at the roles of various stakeholders in the programme implementation process as they contribute to the achievement of objectives. Secondry the MTE has assessed the extent to which programme outputs are being achieved, and thirdly, programme effectiveness has assessed progress towards achievement of sector outcomes.

5.3.1 Role of the MOLGRD

The responsibilities of the MOLGRD are specified in Article 5 of the Partnership Agreement. Basically the Ministry's role include: a) exercising supervisory role over the District Council through Local Government Finance Committee, b) ensuring that the grant is reflected in national plans, budgets, and books of accounts, c) ensuring auditing of programme accounts, d) alerting ICEIDA of any changes in government policies that may have a bearing on successful programme implementation, and e) overseeing procurement procedures.

Discussions with the MOLGRD, ICEIDA, and the District Council revealed that the Ministry's participation in programme implementation has been minimal, largely confined to participating in bi-annual meetings and responding to emerging issues where necessary. The District Council has, in its place, carried out most of the responsibilities on behalf of the Ministry including procurement. However, through regular communication with both ICEIDA and the District Council, the Ministry has been able to respond to emerging issues. According to the Ministry, Article 5 does not provide for the operationalization of their responsibilities in the programme's work plans and budgets, therefore they have been constrained to effectively pursue their roles in the programme.

The MTE Team's perception is that since the MBSP does not have direct government financial contribution, the MOLGRD responsibilities could have been built-in in the Ministry's Operational and Recurrent Transactions as a contribution towards programme supervision. This is the first large-scale programme to be implemented through a decentralized approach and its success is likely to project Mangochi District Council as a model in Malawi. The Ministry has also acknowledged that the programme has proven that there is capacity in decentralized government structures to manage and implement multi-sectoral development programmes. Therefore it is anticipated that the Ministry puts aside financial and other resources to ensure that its role is fully implemented as designed.

Recommendations

In view of the limited role that the MOLGRD has played in the past 2 years in fulfilling its responsibilities as specified in the Partnership Agreement, we recommend that: -

> The MOLGRD should identify a focal point person to operationalize the Ministry's role in programme support under the directorship of Local Government Services with the Ministry's financial support.

5.3.2 Role of line Ministries - Health, Education and Water Development

The role of line (technical) ministries in programme implementation is not specified in the Partnership Agreement and this has, to some extent, put limitations on line ministries in terms of their participation in providing direct technical support to the respective implementing sectors. Ideally line ministries ought to ensure

that the design, operational standards or specifications are in line with government's national standards through periodic checks or supervision.

Through discussions with stakeholders, it also transpired that line ministries are not represented at bi-annual meetings. Although the Partnership Agreement does not directly provide for their participation, Article 7.1 could be evoked to enable them participate in the meetings as it reads: '*Each of the Parties may include others to participate as observers or advisors to their delegation*'. The MOLGRD can use this provision to invite line ministries to bi-annual meetings. Decentralization is a very important aspect to allow the District Council to manage the implementation process at district level with decision-making authority at that level. However, the bi-annual meetings would provide a window for technical ministries to provide their inputs as they respect the observer status and avoid over-shadowing district sector teams. The fact that technical ministries do not participate in these meetings is a missed opportunity to share their technical observations including their perceptions about MBSP adherence to set standards and specifications.

Recommendation

In light of the minimal or background role that line ministries play in programme implementation, we recommend that the MOLGRD should encourage sector Ministries to supervise the programme using normal government systems and also invite representatives from line ministries to the bi-annual meetings where they would be able to contribute on technical and policy aspects from their Ministries' perspectives.

5.3.3 Role of ICEIDA – Country Office

ICEIDA's role is outlined in Article 3 of the tripartite agreement and includes: providing funds to the programme, support the District Council with technical assistance, monitoring and evaluation support, and providing monthly disbursements information to the Ministry of Finance. Another responsibility of ICEIDA is to call for bi-annual meetings and to co-chair the meetings with the District Commissioner for Mangochi as stipulated in Article 7.3 of the tripartite agreement.

The evaluation findings indicate that ICEIDA is adequately fulfilling all its obligations: funds are being disbursed to the District Council based on work plans and budgets as scheduled, technical assistance is being provided to the District Council where appropriate and an M&E Framework is in place to support sectors' management information systems, while funds disbursement reports are being submitted to the Ministry of Finance as scheduled. In addition, an effective system of communication has been established between ICEIDA, MOLGRD, and Mangochi District Council whereby all emerging issues are circulated via e-mail to all stakeholders so that each one is kept abreast of all emerging issues. ICEIDA, through the programme, has also funded the installation and, to some extent, overheads for maintaining the e-mail system to sustain the communication.

Partnership meetings co- chairing: Mangochi District Council and ICEIDA

These are held bi-annually, in March and October each year as per the tripartite agreement. The main purpose is to review progress/performance and budgets of each of the three programmes. Stakeholders have rated these meetings as useful/important for learning as they provide an opportunity for analysis and direction to the programme from the highest policy level. The Mangochi District Council and ICEIDA jointly set the agenda for the meeting.

M&E system

ICEIDA is almost through in developing the M&E system, which is quite elaborate to capture output and outcome indicators' data. For each sector programme, data capture tools have been developed and are being tested since 2013 on annual basis. However, there are a few details to be finalized before the system is fully operationalized and able to produce reports, although currently summary reports have been produced on trial basis. The significance of the ICEIDA-developed M&E Framework is that is it able to generate time series data which can be used for assessing programme effectiveness and impact in light that the implementing sectors'

main focus is mainly capturing output data. The convergence point between the implementing sectors data and ICEIDA's M&E system is at output level where implementing sectors' data would feed into the M&E Framework.

Our perception of the M&E Framework developed by ICEIDA is that because of its complexity and the level of data details that it requires, it may not be able to produce timely reports in supporting the implementing sectors' needs and decisions to prompt relevant adjustments to the implementation process in order to achieve planned results. However, the M&E Framework is particularly relevant in generating time series outcome data that can be used for impact analysis each year and also for end of current phase evaluation. It should also be acknowledged that there is limited M&E capacity within the implementing sectors to analyze data and interpret the results. It is also important to note that the DWDO does not have a functional monitoring system to capture and analyze programme performance indicators. Therefore there is also need for M&E support to the Water and sanitation sector.

Recommendations on M&E

Based on our assessment of the M&E Framework and the implementing sectors' M&E capacity we recommend the following:-

a) In accordance with Article 3 of the Partnership Agreement, ICEIDA should provide technical assistance in M&E including building the capacity of implementing sectors. Capacity building would be in the form of: developing primary data collection tools/registers and to orient the implementing sectors to data management including capture, organization, basic analysis, interpretation, and reporting. Although HMIS and DEMIS are capturing the data, our observation at HCs and schools generally showed that data is not well organized to reflect MBSP indicators and that there is no basic analysis done at that level to enable them measure their own progression. In some HCs it was completely impossible for HC staff to extract information from the HMIS indicator book and organize the data. A desirable situation would be where: a) the implementing sectors are fully complacent with basic monitoring tools, indicators, and analysis, and b) field-based staff such as HC staff, school teachers, or WMAs also understand the same and are able to capture data using primary registers, organize, and aggregate information on monthly basis. This, to a larger extent, is missing.

b) ICEIDA should focus more on the analysis of output indicators reported in quarterly reports and provide timely feedback to the implementing sectors to enable them utilize the information to make appropriate adjustments to their delivery services within their work plans and budgets. The current reports from the implementing sectors have limited analysis and interpretation of results, therefore capacity building of the implementing sectors in this domain is necessary as mentioned above. The Mangochi ICEIDA Office should also be engaged in validating some of the programme outputs through random site visits and interviews with beneficiary communities to re-enforce performance and impact assessment .

c) ICEIDA should also focus on analysis of outcome data generated annually through its M&E Framework. The analysis would help the implementing sectors to make judgement as to whether ICEIDA's investment in the sectors is making a positive change to the community in Mangochi or not, and if not be able to re-strategize so as to achieve desirable results. The outcome data would also feed into impact assessment in the final evaluation. It should also be noted that a single-handed District M&E Officer cannot be deeply engaged in one programme as he has all the district sectors to service. Therefore ICEIDA should effectively support the M&E function in terms of technical assistance delivery.

5.3.4 Role of ICEIDA – Mangochi Office

The establishment of ICEIDA's Mangochi Office is crucial in that it provides direct interface between the District Council and the implementing sectors on one hand and ICEIDA on the other. ICEIDA attends monthly or quarterly implementing sectors' meetings, procurement meetings, and follows up on issues, and to some extent validates some of the reported progress in the three sector programmes. The monthly meetings are particularly important in that they provide updates on progress and identify areas of collaboration with ICEIDA during subsequent months. However, it was noted that these meetings are sometimes not held regularly as they should be.

While the Mangochi ICEIDA Office is well placed to work in collaboration with the District Council and implementing sectors, the technical M&E capacity at the office needs strengthening in order to provide effective technical assistance to the implementing sectors e.g. to assist the DWDO to set up a monitoring system based on output and outcome indicators in the Log Framework, analyze programme data, and provide regular feedback to the implementing sectors.

Recommendation
ICEIDA should strengthen the M&E function at Mangochi District Office to enable it provide effective programme monitoring services as well as conduct data analysis for review with implementing sectors.

5.3.5 Role of the Mangochi District Council

The Tripartite Agreement (Article 4.1) provides the mandate for decision-making for the MBSP to the District Council, which is consistent with decentralization and devolution of powers to the Council rather than the MOLGRD. This arrangement is also ideal to support capacity building within the decentralized structures. While there is need for the MOLGRD to facilitate and provide technical and administrative support as a parent body, decision making on programme issues should indeed be dealt with at District Council level. However, for emerging issues that need policy direction the MOLGRD is expected to support the Council to ensure that there is no disruption to the programme implementation process.

The responsibilities of the District Council include:- a) financial accountability, b) procurement, c) M&E and d) preparation of financial and progress reports.

5.3.5.1 Financial accountability

Financial accountability is embedded in Article 4.7 of the tripartite agreement premised on GOM Public Finance Management Act (2003). In accordance with the Act the District Council operates separate ledgers for the programme in order to isolate financial transactions from other accounts. Each activity has a budget against which expenses are debited. The monthly summary reports are submitted and vetted by ICEIDA. Therefore in terms of financial accountability there are functional control systems in place.

5.3.5.2 Procurement

Procurement is based on government procedures and guidelines. There is a procurement plan and an Internal Procurement Committee (IPC) currently chaired by the District Education Manager (DEM) with ICEIDA representation in the meetings. Tender documents are prepared at district level and follow the guidelines as specified in the ODPP procedures. Both the ODPP and ICEIDA provide no objection status prior to procurement and the cycle takes 2 – 3 months to complete.

Therefore the procurement system is functional and the MTE findings acknowledge that procurement per se is not a factor that affects programme delivery. Although there are some delays being experienced these are not significant. What is required is to make regular follow up with the ODPP through the MOLGRD where necessary in order to minimize the delays.

5.3.5.3 Civil works

The Buildings Department (BD) is currently providing technical support to civil works in the programme. Their involvement has received mixed reception at the Council due to: a) there is little information flow emanating

from the BD to the Council as minutes of site meetings are not shared with the Council; b) progress reporting and emerging issues from civil works have not been regularized and systemized into the District Council's reporting system, and c) there is currently no forum where the District Council, Buildings Department; and Contractors converge to review progress on civil works and jointly address emerging issues.

Our perception is that civil works are the backbone of the MBSP as some interventions also depend on completion of the structures to be effective e.g. improved maternal and child health depend on completion of maternity wards, guardian shelters, health posts, etc.; while improved learning environment in schools also depend on completion of facilities such as school blocks, teachers' houses, improved latrines, etc. Since there is a backlog of construction work, there is need to serious review the situation during the forthcoming bi-annual meeting. It should also be acknowledged that the Buildings Department works with several programmes and projects in Malawi, and therefore their capacity is also thinly spread across the country and is therefore constrained in terms of providing equitable services nation-wide.

Recommendation on civil works

Based on slow progress in the completion of civil works particularly for Health and Education, we recommend that Mangochi District Council, if necessary, prepares a request to ICEIDA for the identification an independent consultant (preferably an Architect) to facilitate completion of all civil works. The consultant should be reporting directly to the District Council and provide monthly updates through a forum to be defined by the District Council in which ICEIDA would also be represented.

5.3.5.4 M&E and Progress reporting

The district staff establishment provides for one M&E Officer to manage M&E functions supported by the District Coordination Committee comprised of sector heads at district level. Each sector collects data, aggregates and submits to the M&E officer for consolidation, analysis, and preparation of district reports. The M&E Officer has undergone a number of capacity building programmes facilitated by government and technical backstopping to the M&E Officer is provided by the Department of Economic Planning and Development.

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However, there are challenges with the District M&E system: a) the M&E capacity of the implementing sectors is limited in that the officers are sector specialists with little grounding in data management including analysis, b) there are usually delays in submission of sector data to the M&E Officer, this sometimes delays preparation and submission of consolidated district reports; c) the Quarterly Output Based Report provides a good summary of progress on outputs for all programme activities but falls short of providing an analysis on how outputs are linked to project objectives and outcomes e.g. how are trained teachers performing compared to non-trained teachers, and what positive changes are learners in programme schools experiencing as a result of training the teachers (e.g. improved pass rates?) - this applies to all capacity building interventions in the programme, and d) the M&E system lacks a feedback system where progress reports are critically reviewed with/between relevant stakeholders (implementing sectors, ICEIDA and MOLGRD) in order to address shortfalls as well as emerging issues in the interim prior to bi-annual meetings.

Health Management Information System (HMIS)

This is the district's management information system for health services. HMIS has been in place for some time now but still experiences challenges in its data management mainly due to lack of capacity at HC level to collate data. Officially, each HC is supposed to have a statistical clerk who is well trained in data management but currently only 9 out of the 42 positions are filled, reflecting that Senior HSAs and/or Medical Assistants are temporary focal point persons for HMIS. By July 2014, 42 focal point persons had been identified, one for each of the 42 health facilities but these have not yet been trained in data management – that is why there are challenges in collating data at HC level as experienced during the MTE.

One observation in HCs on HMIS was that the MIS is perceived as an additional task to normal duties and therefore limited attention is paid to it. The HMIS is a very important MIS tool for gathering district health services delivery indicators and therefore needs well trained and motivated personnel to implement it, otherwise if inaccurate data is generated through the HMIS wrong conclusions on project effectiveness and impact could be drawn in the final evaluation.

Recommendations on HMIS

a) All the 42 HMIS focal point persons should be trained in data management to enhance their capacity in data capture, basic analysis, organization and reporting including MBSP indicators. The trained focal point persons will also need regular supervision and mentoring to ensure that they are collecting accurate data using HMIS tools. ICEIDA should therefore provide technical assistance to improve HMIS data management.
b) There is need to establish a feedback system within the district health delivery structures in terms of circulation of analyzed data to enable HC personnel compare results with other HCs that could trigger motivation to work hard if they observe that their HC is trailing behind others. For example the HMIS should circulate quarterly data on <1 year child immunization, pregnant women attending antenatal services in the first trimester of pregnancy, testing for HIV, etc.

District Education Management Information System (DEMIS)

Normal data collection from schools is done at the beginning and end of school year. At district level data from all primary schools is fed into the district database from where it is utilized to produce district reports. Compiled data include: dropout rate, repetition rate; pass and selection rates. In theory each school has a data management officer, who is not a head teacher but in practice head teachers tend to cling to the position.

Initially through the MBSP head teachers and PEAs were trained in data management for them to orient their data management officers in their schools to data collection tools. This approach has not worked as expected because most head teachers have deliberately avoided delegating the task to responsible officers. Submission of reports to DEM's office has not been regular partly because the responsible officers have not been engaged in DEMIS. Besides, training has only been provided to head teachers and not data managers. Thus, some delays have been experienced in submitting Education reports to the District M&E Officer.

During the MTE it was also observed that in some schools data was well organized and displayed on the board while in other schools teaching staff struggled to provide the information. Therefore there is need to improve data management in all programme schools. The DEM needs to regularize the appointment of data managers in all the 12 schools who are not head teachers for them to get relevant training and engage in data management.

Recommendations on DEMIS

In view of the challenges being experienced in data management, we recommend that:

a) Data management officers should be appointed in all the 12 programme schools and oriented to data management including: completion of primary data registers, basic analysis particularly for MBSP performance indicators as laid down in the Log Framework. However, it is also important to include head teachers and one other teacher in the training so that they backstop the data management officer when need arises.

b) There is also need for feedback to programme schools where analyzed results based on MBSP indicators are circulated on quarterly basis to inform schools on performance and to motivate them where their schools are doing poorly.

Overall Recommendations on M&E

In light of the challenges that the M&E is experiencing, we recommend the following: -

a) Due to limited M&E capacity in the implementing sectors, we recommend that the implementing sectors should be oriented to basic M&E concepts, data collection tools, basic analysis, and interpretation for them to appreciate the monitoring function and to enable them do basic comparative data analysis in their respective sectors to reflect progress towards targets.

b) The Quarterly Based Output Report format be reviewed to include analysis and interpretation of information besides output achievements. The Water and Sanitation sector also needs assistance so that it presents the indicators in the Quarterly Report as they appear in the Log Framework.

c) The programme should introduce formal feedback forums where progress reports can be reviewed and decisions reached to resolve emerging issues. These should not necessarily be new forums but the agenda for DEC meetings could be used to incorporate feedback on progress reports.

d) The Water and Sanitation Programme is behind other sectors in programme monitoring and data management. We therefore recommend that technical assistance should be provided to Water and Sanitation Programme to develop an M&E system and train personnel in data management to improve programme monitoring based on Log Framework indicators.

e) If appropriate the Quarterly Based Output Report should be an Annex to the narrative/analytical report.

5.3.5.5 District Council and implementing sectors staff capacity

The District Council and implementing sectors are endowed with qualified and experienced professional and administrative staff. Therefore there is adequate delivery capacity within the council and implementing teams. However, based on the discussions with the District Council and implementing sectors, it was indicated that some of the senior positions remain vacant while qualified personnel have been acting in these positions for long durations. The DPD, DOF, and DOA are positions that have no substantive incumbents. To some extent this is a disincentive that may affect delivery if the officers remain in acting capacities for another too long a period. These positions are important for programme implementation and therefore need to be regularized.

Recommendation on staff capacity

The MOLGRD should take up the issue with the Department of Human Resources in order to regularize the situation by recommending and justifying the promotion of incumbent officers into substantive positions in order to motivate the officers and maintain the delivery steam.

5.3.6 Role of ADC/AEC

Basically the ADC/AEC are important decentralized local government structures that facilitate development initiatives at TA or Sub-TA level. However, based on the discussions with District Council officials, utilization of the ADCs/AECs was indeed necessary at the programme design stage which entailed prioritization of activities. Thereafter their role has been minor because ADCs/AECs operate at a higher level (TA level) , while programme

implementation is at GVH/village level. The other element is that major works are out-sourced from contractors hence village-level structures such as GVH/VDCs are directly responsible for mobilization at community level. In terms of MBSP implementation, key community structures are VDCs which mobilize the community to provide human and material resources especially for construction work. For example in borehole drilling the VDCs are involved in site selection. Therefore the current arrangement where ADCs/AECs are only involved at the design stage is ideal for programme implementation.

However, ADCs/AECs play a supervisory role in LDF-funded projects in terms of monitoring resource utilization to ensure transparency and accountability and are also potential quality assurance structures for the MBSP. With ward councilors' election, their role should possibly be considered jointly with potential roles of ADCs/AECs.

5.3.7 PLANS VERSUS ACHIEVEMENT OF OUTPUTS

Program Effectiveness has also been used to measure the extent to which the objectives have been achieved in sector programmes as well as progress towards achievement of outcomes. Focus is on the realization of planned program outputs and their contribution towards achievement of outcomes.

5.3.7.1 Public Health Programme

Table 10 shows that on average the Health programme has an outputs achievement rate 70.3% with zero completion rate for improved infrastructure and equipment in maternal and neo-natal care services – apparently construction is underway for maternity wards but not Health Posts and waiting houses and staff houses. There are also low achievement rates under general infrastructure (55.8%) and improved referral services (60%). The implication is that if infrastructure is not in place, improved maternal and child care services would be difficult to deliver and achieve e.g. provision of vaccine fridges, equipment and beds await completion of infrastructure.

Outputs – Outcome linkage

The immediate objective (Outcome) of the Health Programme is: *Increased availability, access and utilisation of high impact, quality maternal and child health services in Mangochi District*. In order to achieve the immediate objective there must be good progress in all the 3 Outputs. If there is low achievement in any one or more outputs, there is a likelihood of low achievement of the immediate objective. However, construction work is in progress for maternity wards and it is expected that work on other facilities will be started before the end of the year. Therefore, the overall assessment is that once Output 1 is addressed, the programme will be making good progress towards achievement of the outcome.

Table 10 : Achievement of Outputs – Health Programme

Narrative Summary	Mid-Term Achievement Rate (%) Over 2012 -2016 Targets
OUTPUTS	
1. Improved health services infrastructure	
General infrastructure in the network of the MoH health centres is strengthened	55.8
Improved Infrastructure and equipment in maternal and neonatal care services in HCs	0.0
2. Increased coverage of high impact, quality Maternal and Child health services	
Improved referral services	60.0
Strengthened community based health services	109.4
3. Improved Capacity of the health system to deliver services	
Improved Working Conditions for Public Health (PH) Support Staff at the DHO.	87.5
Institutional capacity strengthened at the DHO	87.5
Improved/Strengthened Health Management Information System	92.1

Overall Achievement Rate for Health Programme	**70.3%**

5.3.7.2 Water and Sanitation Programme

The Achievement Rate for Water and Sanitation is about mid-way (55.1% - **Table 11**) of the 4-year plan. There is also a backlog of villages to be verified as ODF, with a mid-term achievement rate of 11.6%, followed by Output 6, which is systems strengthening for WASH services delivery at 20.1% achievement. These three areas need more attention in the next half of programme implementation. One challenge is the way the programme was designed because drilling was not equally distributed in each year thus more drilling is expected in the next half phase. However, it should be noted that both ICEIDA and DWDO have confidence that all water points will be provided by the end of the programme phase based on the experiences of the first two years of implementation. Nonetheless, there will is still need to intensify the verification process for ODF and installation of WASH systems.

Outputs – Outcome linkage

The immediate objective (Outcome) of the Water and Sanitation Programme is: *Increased and sustainable access to and use of improved safe water sources and improved sanitation practices in TA Chimwala.* Since the mid-term achievement rate of 55.1% is not necessarily due to delayed implementation of water points but rather to programme design (schedule), it is expected that the water outcome will be achieved. However, in terms of sanitation there is need to improve on implementation progress as the ODF rate is still very low at 11.6%.

Table 11: Achievement of Outputs – Water and Sanitation Programme

Narrative Summary	Mid-Term Achievement Rate (%) Over 2012 – 2016 Targets
OUTPUTS	
1. At least 150 new boreholes constructed	37.3
2. At least 100 protected shallow wells constructed	33
3. At least 100 defunct boreholes rehabilitated	43
Mean	**37.7%**
4. At least 350 WPMCs trained in CBM (operations and maintenance, sanitation and organization) in TA Chimwala	37.7
5. least 80% of households in TA Chimwala construct and use improved pit latrines and hand wash facilities	
# Extension workers trained in CLTS	89.5
# Community leaders trained in CLTS	77.8
# of villages triggered	100
Proportion of villages verified as ODF	11.6
Mean	**70**
6. System strengthening for WASH service delivery	20.1
6.1 DWDO has increased capacity and is better equipped to perform its work	100
7. Environmental aspects around water points and in relation to sanitation activities have been examined and addressed	100
Overall Achievement Rate for Water and Sanitation Programme	**55.1%**

5.3.7.3 Education Programme

The Education Programme has the highest achievement rate at 76.4% (**Table 12**) despite the fact that its implementation started a year later in 2013 while the other two started in 2012. The programme has achieved high rates in most of the outputs but has also registered low achievement in terms of school infrastructure and equipment whereby only 38.1% has been achieved.

Output - Outcome linkage

The immediate objective (outcome) of the education Programme is: *improved quality of education in target schools to reduce dropout and repetition, and promote effective learning*. The challenge really is infrastructure, but on the basis of its mid-term achievement the education programme is making good progress towards achievement of the outcome by the end of the programme phase.

Table 12 : Achievement of Outputs – Education Programme

Narrative Summary	Mid-Term Achievement Rate (%) Over 2012 – 2016 Targets
OUTPUTS	
1. Improved capacity and support to learners in target schools	
1.1 Capacity building of teachers and school managers	89.0
1.2 Teaching and learning materials provided in target schools	118.0
1.3 Community mobilised for educational support	66.7
2. Improved teaching and learning environment	
2.1 New infrastructure and equipment in target schools	38.1
2.2 Infrastructure rehabilitated in target schools – general maintenance	175.0
3. Enhanced equity and improved retention of girls and OVC's in target schools	
3.1 Strengthen the role of Mother Groups in the Schools	37.5
3.2 Strengthen the status of girls in schools	50.0
3.3 Support to OVCs	95.3
3.4 Increase enrolment of special needs learners into the target schools.	0.0
3.5 Increased attendance and participation of learners	11.1
4. Improved management of target schools	
4.1 Capacity building and training in education and management	106.2
4.2 Strengthening of DEM's office operations	130.4
Overall Achievement Rate for the Education Programme	**76.4%**

5.3.7.4 Overall achievement of Outputs and progress towards achievement of outcomes

Table 13 summarizes overall programme achievement rates. Overall 67.2% of programme outputs have been achieved, which is an indication that the MBSP is making good progress towards achievement of its immediate objectives (outcomes) and the programme goal. The main issue is construction work which is pulling back the average achievement rate despite advances made in other activities. This is likely an agenda topic during the bi-annual meeting.

Table 13 : Overall Achievement Rate of Outputs	
Narrative Summary	**Mid-Term Achievement Rate (%) Over 2012 – 2016 Targets**
Health Programme	**70.3%**
Water and Sanitation Programme	55.1%
Education Programme	76.4%
Overall Achievement Rate	**67.2%**

5.3.8 Capacity strengthening

A fourth component of the cooperation between the District Council and ICEIDA is institutional support to the District Council to assist it build a capable workforce to successfully implement development projects. Capacity building has also been incorporated into all areas of support that ICEIDA provides to the MBSP. Our focus here is on capacity building in sector programmes particularly training with details presented in **Annex 3 - Training delivered through MBSP**.

The general observation is that delivery of training mainly in Education and Health programmes seem not to have been standardized as different modules were delivered to different community groups or programme personnel. In addition it was noted that Training Reports are not being submitted to ICEIDA to provide basic information such as:

- Training objectives
- Facilitators
- Training modules delivered
- Venue and training duration
- Number of participants by gender
- Participants' expectations
- Training assessment results
- Expected improvement in service delivery by participants after training, etc.

In the absence of Training Needs Assessment Reports and Training Reports it is difficult to conduct an in-depth analysis linking capacity gaps, training modules to address the gaps, and performance of those trained after training. The MTE gathered information mainly through FGDs and KIIs from stakeholders as presented in **Annex 3.**

It is, however, important to note that the training need not to be one-off events but rather a process to ensure that those trained can effectively use the knowledge and skills gained from the training. This could be achieved by e.g. at the end of the first training, each participant is assisted to develop an Action Plan indicating how the knowledge and skills would be used say in the next month. After one month a follow up training is conducted to review implementation of the Action Plan in terms of what worked/did not work and why, and how the

community benefitted from the newly acquired skills. Following the review and sharing of experience with fellow participants, second Action Plans are developed and this can continue to the third time if necessary to ensure that participants are able to utilize the skills gained from the training. Furthermore it should be acknowledged that adults need experiential learning which mainly entails learning by doing and therefore the training should be as much as possible be easy to apply and hands-on where appropriate.

The following Sections describe how capacity building has been delivered in each sector programme: -

5.3.8.1 Health Programme

To improve the delivery capacity in the Health Programme, a number of interventions have been undertaken at district and community level. At district level, the DHO's Office has been renovated, staff trained and research projects supported. The HMIS has received support in computer and internet services, training in HMIS data management, and Village Health Registers have been institutionalized.

However, during the discussions with HSAs and VHCs it was observed that the training has not been harmonized. Training sessions vary between groups, in some groups it takes 2 – 3 days while in other groups 4 – 5 days, the number of participants also varies, and sometimes no proper venues for the training have been used as highlighted by field staff and community committees during KIIs and FGDs respectively.

At community level HC personnel, HSAs, HACs, and VHCs, have received training to strengthen their capacity for improved services delivery as presented in **Table 14** below. From the Table it is clear that the training has not been comprehensively delivered to all HCs, HSAs and VHCs respectively based on FGDs and KIIs.

Health Centre (HC) personnel

The MTE question was as follows: *' Have you received any training from government between 2012 and 2014? If yes, what type of training have you received?*' The answer was '*Yes'* in all 10 HCs. The question did not ask who sponsored the training as most of them would not distinguish between the MBSP from other sponsors. The same applies to all other personnel or village committees. CMAM, ART and life skills have been delivered to HC personnel located in at least 5 Health Centres (50%) of HCs covered by the MTE with other types of training delivered to HC personnel located in ≤4 HCs. Most of HC staff has received only one type of training based on MTE results in **Table 14**.

Table 14: Delivery of training - Health Programme

Health Surveillance Assistants (HSAs)

The MTE question was similar to the question posed to HC personnel. All 12 groups of HSAs acknowledged to have received the training. CMAM is the only training that has been delivered to the majority of HSAs groups (8/12) with the rest of the training delivered to ≤ 4 HSA groups.

Training delivered to HC staff as reported by HC staff during KIIs	# of HC staff Groups out of 10 HC staff Groups Interviewed	Training delivered to HSAs as reported by HSAs during KIIs	# of HSA Groups out of 12 HSA Groups interviewed	Training delivered to VHCs as reported by VHCs during FHDs	# of VHCs Out of 7 VHCs during FGDs
CMAM	5	CMAM	8	Sanitation and hygiene	6
ART	5	CB MNH	4	Safe Motherhood	3
Lifesaving skills	5	CLTS	3	Six food groups	2
Family planning	4	HTC	3	ART	1
Obstetric complications	4	EPI	3	Growth monitoring	1
DBS sample collection	2	Village Health Register	2	Immunizations	1
Infection prevention	1	Safe Motherhood	2	HIV/AIDS	1
HBB,KMC	1	Rapid SMS	1	Dangers of malnutrition	1
Sign language	1	Family Planning	1		
HMIS	1	Youth Friendly Services	1		
ETAT	1	Nutrition	1		
STI/SMA	1	Zero Stock Out	1		

Village Health Committees (VHCs)

For VHCs the MTE question was: *'What training has the VHC received and how is the VHC utilizing the knowledge and skills gained from the training?* 7 of the 8 VHCs contacted indicated to have received the training. Sanitation and hygiene is the main training delivered to VHCs ((6/7) with other training only reaching one to three VHCs.

Improvement in services delivery after training based on KIIs and FGDs

In addition to asking about whether or not training was delivered at different stakeholder levels, the MTE also wanted to find out if the training has contributed to change in the way services are delivered. These are presented below for the Health Programme. **Table 15** shows the type training and application of skills and knowledge gained from the training.

Health Centre personnel

The MTE question was: *' How has the training changed the way you deliver services at the Health Centre? Please give examples of how the training has improved your delivery capacity?*

Table 15 presents MTE findings based on KIIs with HC personnel. There are mixed results e.g. while CMAM has been delivered to HC staff in 5 HCs (**Table 14)**, only in 2 HCs (**Table 15**) has its personnel that indicated direct application of CMAM in the assessment of mother and child nutritional status, with family planning and early HIV diagnosis being the main activities. Overall, there is some application of skills and knowledge gained by HC personnel, the only challenge is that the training is not evenly distributed across target HCs and that there are no monitoring reports to validate how the training is being applied/utilized.

HSAs

For HSAs the question was the same as the question posed to HC personnel. **Table 15** shows that HSAs reported improvement in services delivery mainly in the areas of: identification of malnourished children in 7 out of 12 HCs where HSAs are based, and delivery of CMAM and CLTS in 5 out of 12 HCs. Other services have not been widely applied but this is also a reflection of the training coverage.

VHCs

The question is also the same as the one presented to HC personnel. Similar trends in services delivery are applicable to VHCs i.e. they have delivered what they have gained from the training e.g. 6 VHCs have been trained in sanitation and hygiene and 5 VHCs are promoting sanitation and hygiene, and this is applicable to all the training.

Overall assessment of improved health services delivery after training

It is clear from the findings that health personnel, HSAs and VHCs are able to apply what they have learnt. The main challenge is that training is not evenly distributed to all HCs for HC personnel, HSAs and VHCs. Therefore increasing the coverage of HCs in training is likely to broaden the application of skills and knowledge across target HCs for the benefit of rural communities. It is also important to monitor how the training is being utilized at programme personnel and community committees' level as well as how the community is benefiting from enhanced capacity.

Table 15 : Services delivery after Training – Health Programme

HCs' service delivery after training	# of HC staff Groups out of 12 HC staff Groups Interviewed	HSAs service delivery after training	# of HSA Groups out of 12 HSA Groups interviewed	VHCs' service delivery after training	# of VHCs Out of 7 VHCs during FGDs
Family planning services e.g. Jadelle	4	Identify malnourished children	7	Promote use of toilets, rubbish pits, bathrooms	5
Early infant HIV diagnosis	3	Delivery of CMAM and CLTS	5	Women attend antenatal services and deliver at H/Centers	4
Basic obstetric - manual vacuum respiration	3	Sensitize/mobilize mothers to go to the clinic	4	Promote hygiene e.g 2 cup system and hand washing	4
Provision of ART services	3	Follow up visits sanitation and hygiene	4	Sensitize the community on disease prevention	3
Promoting sanitation in communities	2	Encourage pregnant women to eat nutritious	4	Identify malnutrition cases in the village	2
Proper plotting of labour graph	2	Rapid SMS as reminder for due immunization	3	Discuss HIV/AIDS voluntary testing with the community	1
Assessing child/mother nutritional status	2	Provide HTC services at the HC	2	Disseminate importance of Growth Monitoring	2
Cases referred immediately to District Hospital	2	Encourage the youth to patronize HC services	2	Encourage defaulters to restart taking ARVs	1
Checking thermometer before treatment	1	Able to identify women with fistula problems	2	Encourage the community to eat 6 food groups	1
Improved STI treatment	1	Prevention of diarrheal diseases	1	Constructed soak away pit at the borehole	1
		Easy diagnose of children born with HIV	1	Conduct immunizations campaigns	1
		Give or inject DEPO	1	Assist HSAs in distributing Vit A, de-wormers, & chlorine	1
		Train communities on sanitation and hygiene	1	Safe Motherhood campaigns	1

	Confirmatory testing before initiating ARVs	1	
	Provide family planning services	1	

5.3.8.2 Water and Sanitation Programme

Capacity building in Water and sanitation has included strengthening of the DWDO with additional vehicles and motorcycle and hiring of 16 additional WMAs from the previous ICEIDA programme in TA Nankumba. At community level training has been conducted for WMAs, and WPMCs. WMAs have also been trained by NCIC. In sanitation CLTS training has been conducted for WMAs, HSAs, and communities. However, training in data management has not been conducted. **Table 16** summarize the training that has been delivered to WMAs/HSAs, and WPMCs.

WMAs/HSAs training

The question was: *'What training in relation to sanitation have you received and how is the training utilized for the benefit of the communities?* **Table 16** shows good coverage of the CLTS technology training: 9 out of 12 groups (one group in each village) have been trained.

WPMCs – boreholes

For WPMCs, the question was: *'what training have you received since 2012 and how is the training being utilized by the WPMC?* There is also good coverage of MPMCs training as 9 out of 10 WPMCs covered by the MTE have been trained in hygiene and borehole maintenance; and 10 out of 12 WPMC for shallow wells have also been trained in hygiene and shallow well maintenance as presented in **Table 16** .

Table 16 : Delivery of Training – Water and Sanitation Programme

Training delivered to WPMCs – boreholes - as reported by WPMCs during FGDs	Out of 10 WPMCs	Training delivered to WPMCs – Shallow wells as reported by WPMCs during FGDs	Out of 12 WPMCs	Training delivered to WMAs/HSAs in sanitation as reported by WMAs and HSAs during KIIs	Out of 12 WMA / HSA Groups
Hygiene around the borehole	9	Sanitation around the s/well	10	CLTS	9
Borehole maintenance	9	Shallow well maintenance	10	Hygiene and sanitation	4
Hygiene and sanitation in homes	4	Hygiene and sanitation in homes	7	Borehole / shallow well siting	3
How to prevent cholera	1			Community ownership of borehole	2
HIV/Aids awareness	1			CBM/VLOM	1

Improvement in services delivery after training based on KIIs and FGDs

The question was: *'After training what are you able to do that you could not do before training?* Based on MTE results in **Table 17**, it is clear that with training communities are able to do maintenance to water facilities as well as promote sanitation and hygiene. The programme M&E system needs to confirm the effectiveness of training if periodic surveys and conversations are conducted in target villages in TA Chimwala.

Table 17: Service delivery after training - Water and Sanitation Programme

Services delivery by WPMCs after training - boreholes – as reported by WPMCs	Out of 10 WPMCs	**Services delivery by WPMCs after training - shallow wells - as reported by WPMCs during FGDs**	Out of 12 WPMCs	**Services delivered by WMAs and HSAs after training as reported by WMAs and HSAs during FGDs**	Out of 12 WMA / HSA groups
Community maintenance of borehole s by WPMCs	9	Shallow wells maintenance by WPMC s	**9**	Conduct sanitation awareness meetings	**9**
Promotion of borehole area sanitation	7	Mobilize shallow well maintenance funds	8	Monitor adoption of sanitation facilities	6
Constructed drainage and fence	5	Promote hygiene around shallow well	4	Promote community participation in borehole and shallow well construction	4
Establishment of maintenance fund	5	Sweeping at the shallow well	4	Conduct ODF campaigns	3
				Assist in borehole site identification	2
				Door to door sanitation campaigns	2

5.3.8.3 Education Programme

Capacity building has been delivered at various levels: at DEM's office: a vehicle for the DEM's office and motorcycles for zonal managers have been delivered, education managers have been trained, the office has been rehabilitated, and data management training has been conducted. At community level teachers and school governance committees have received training through the programme as presented in **Table 18**.

Training of primary school teachers

The question to teachers was: ' *What training have you received from government since 2013?* Results show that teacher training coverage has been extensive for: teaching skills (covering all 12 schools) and leadership (10 schools) as shown in **Table 18** while the rest of the training has only targeted a few schools.

Training of School governance committees

The question posed to school governance committees was: ' *What training have the committees attended and how are the committees utilizing the knowledge from training to improve education services in the area?* The question was put forward to each committee (SMC, PTA, and MG) separately and their responses are presented in **Table 18**. Results show that training was only delivered to committees in ≤5 schools out of 12 school governance committees – therefore based on MTE finding most school committees have not yet been trained. It was also noted during the discussions that some committee members could not remember the type of training that has been delivered and requested for another training. Other committees indicated that some of their members who received training were no longer serving in the committees, hence the need for another round of training.

Table 18 : Delivery of Training – Education Programme

Training delivered to teachers as reported by teachers during KIIs	**Out of 12 programme schools**	**Training delivered to school governance committees as reported by school committees during FGDs**	**Out of 12 programme schools**
Teaching skills Std 5 - 8: English, maths, chichewa and expressive arts	12	**MG**: Care for girls in schools	5
Leadership skills	10	**MG**: Re-enforcing re-admission policy	3

Physical Education	3	**MG**: HIV/AIDS	1
Assessment skills Std 1 - 8	3	**PTA**: Help in construction works	5
Social empowerment	2	**SMC**: Help in school construction, and monitor teaching and learning	4
Interpretation of music	1	**SMC:** Leadership and development	3
Community sensitization	1		

Improvement in services delivery after training based on KIIs and FGDs

Apart from asking what training g was received, teachers and school governance committees were also asked: 'what *change/value addition has the training brought to the way your services are delivered?* The results are summarized in **Table 19a** .

Teachers

For teachers, it was clear during KIIs that the training has strengthened their confidence levels in the way they understand and deliver lessons and this was acknowledged in all 12 programme schools, followed by re-discovered roles and responsibilities (9/12 schools), and improved learners assessment skills (7/12). Teachers also indicated that the training has been timely and has helped to motivate them in their teaching profession.

School governance committees

For Mother Groups, enforcement of the re-admission policy for school dropouts especially girls has wide coverage (10/12) than any other application of training derived from the MBSP. For SMCs, moulding of bricks was reported in 8/12 schools as contribution to school development followed by enrolment campaigns in 5/12, while PTAs focused on parent-teacher relations in ≤ 4 schools. One other aspect that came out of FGDs with school committees was low literacy levels to enable them articulate their roles and responsibilities. Therefore for the school governance committees there is need for mentoring so as to help them realize and play their roles effectively, and this role could be played by PEAs.

Table19a : Service delivery after training – Education Programme

Service delivery after training as reported by teachers		**Service delivery after training as reported by School Governance committees**	
Teaching English composition, Maths, and musical songs in expressive arts with confidence	12	**SMCs**	
Teachers know roles & responsibilities	9	Moulding bricks	8
Doing learners' assessment as scheduled	7	Encourage enrolment through sensitization	5
Integrating grades professionally	5	Help construction of teachers house	3
Do music interpretation	4	Monitor teaching and learning	2
Guiding learners with leadership skills	4	**PTAs**	
Teaching and working as a team	3	Sensitize parents on teachers conduct	4
Doing subject revisions after training	2	Promote collaboration: teachers and parents	4
Section Heads assisting Management	1	Sensitize parents on absenteeism	4

Construction: pit latrines & teachers house	3
Moulding bricks	3
Mothers Groups	
Re-admission policy enforcement	10
Monitoring dressing of learners	2

Table 19b. : Change in learning environment with programme implementation - As reported by Standard 7 learners during FGDs

	Number of schools out of 12 Programme schools
Notebooks/text books for all classes	**10**
Provision of desks for std 5-7	**8**
New school blocks	**7**
Writing ICEIDA examinations	**6**
Blackboards	**3**
Provision of boreholes	**2**
Received two additional teachers	**1**

Moulding bricks	1
Making brooms for learners' use	1
Fund raising for 2-Wheel chairs for children with disability	1

Learners' perceptions of change in their schools with MBSP implementation

FGDs were conducted with 114 Standard 7 learners in 12 programme schools to get their perceptions on notable change with programme implementation. The question was; *'what changes in school and learning environment have you experienced since 2013?*

For learners (**Table 19b**) , availability of notebooks/text books (10/12 schools), desks (8/12), new school blocks (7/12) and sitting for ICEIDA examinations (6/12) were the most visible changes they noted in their schools. It is therefore worthy noting that even learners have started to see positive change in the form of programme outputs.

Provision of dusters	**1**
Received buckets and footballs	**1**

Overall Recommendations on Training

Based on KIIs and FGDs there is a definite need to improve the delivery of training. We therefore recommend the following: -

a) Training should be standardized to ensure equitable access at all levels: HCs, HSAs, VHCs, WPMCs, WMAs, school governance committees, and teachers.

b) Implementing sectors should conduct and submit Training Needs Assessment Reports prior to training for ICEIDA's assessment and approval, justifying why the training is necessary. If approved by ICEIDA the training should be delivered thereafter implementing sectors should submit Training Reports to ICEIDA within 14 days following end of each training. The report should among other contents include detailed information outlined in the bullet points in the introductory paragraph of **Section 5.3.8** to ensure transparency and accountability in the delivery of training.

c) ICEIDA should use the training reports to assess change in programme delivery as well as its effects and impact at community level emanating from additional knowledge and skills gained by trained personnel or community representatives.

d) For school governance committees, because of low literacy level, there is need to mentor them through regular conversations with PEAs so that they understand their core roles or functions to enable them perform effectively. This will also make them realize that molding bricks is not a core function for a school governance committee.

5.4 Programme Impact

Programme impact has mainly been assessed in terms of positive primary and secondary long term effects produced by the program interventions, directly or indirectly. The analysis is premised on change between baseline outcome and Mid-Term indicators. It should also be noted that this is the second year of programme

implementation and therefore impacts are not highly visible, but results have actually shown emerging impacts within the short programme implementation duration. The overall goal of the MBSP is: *to assist the Government of Malawi and the Mangochi District Council to improve living standards in the rural communities in Mangochi District*. This section analyses progress in the achievement of outcome indicators and their contribution towards the programme goal. It is worth noting that in terms of HMIS and DEMIS outcome indicators are not reported separately for the district and target HCs or schools. The reporting needs to be changed to isolate programme indicators versus district achievement. For Water and sanitation the MIS still remains to be developed.

5.4.1 Impact of the Health Programme

The Health programme has four outcome indicators. MTE findings in **Table 20** show that the proportion (%) of pregnant women starting Antenatal Care in the first trimester at district level is lower (7.6%) than baseline (9.6%) and not close enough to the 20% target. The MTE findings also show that the proportion of births attended by skilled health personnel (60%) is lower than baseline (68%) and even lower than the target (80%) at district level. However, MTE survey results (July 2014) indicate that 96.8% of the births in the programme area were delivered at a health facility attended to by a skilled health personnel. Mothers indicated that the safe motherhood campaigns by VHCs and HSAs, improved maternal care in health facilities, and community bye-laws that penalize women delivering at home or at Traditional Birth Attendants encourage all pregnant women to deliver at health facilities.

The District-level <1 year immunization rate at 74.5% for 2013/14 is higher than the baseline (69%) but lower than the MTE July 2014 survey result (83.8%). The higher result is mainly due to campaigns by enlightened HSAs and VHCs trained by the programme who are engaged in immunization campaigns spearheaded by the DHO. Similarly the proportion of pregnant women being tested for HIV is higher than the baseline due to improved awareness creation through HSAs, VHCs, and HC staff in target/programme areas. It is therefore evident from analysis of outcome indicators that there is progress in the achievement of outcomes and the health programme and it can be acknowledged that the Health programme is contributing towards the programme goal. However, the achievement has to be consolidate e.g. through completion of heath infrastructure and related facilities.

Recommendation

The HMIS should present 2 sets of analyses of programme outcome indicators: a) at district level, and b) at programme level for target HCs. It is important that parallel outcome indicators are presented to facilitate comparative analyses of change between the district and target HCs indicator values.

Table 20 : Analysis of Outcome Indicators for the Health Programme

Narrative Summary	Objectively Verifiable Indicators	Source	Baseline 2011- 2012	2013/2014 District level data	MTE Survey Results in target area July 2014 (n=249)	Target 2015 - 2016
Immediate Objective (Outcome)						
Increased availability, access and utilisation of high impact, quality maternal and child health services in Mangochi District.	• Pregnant women (%) starting ANC in first trimester of pregnancy	HMIS	9.6%	**7.6**	-	20%
	• Proportion of births attended by skilled health personnel (MDG indicator 5.2)	HMIS	68%	**60.0**	**96.8**	80%
	• Percentage of under 1 children fully immunized	HMIS	69%	**74.5**	**83.8**	85%
	• Pregnant women tested for HIV	HMIS	68%	**79.5**	-	85%

Capacity strengthening and perceived benefits to the community - Health Programme

Impact measures changes in outcome indicators. However, in this paragraph we are assessing '*perceived benefits*' to the community as a form of *'impact'* for the capacity building programme component as presented in **Table 21** below. The questions were: *'With training and enhanced capacity, how are members of the community you are serving benefitting from the skills and knowledge that you have gained? What benefits are the communities enjoying as a result of your training?'*

MTE results in **Table 21** show a number of perceived benefits to the community resulting from enhanced skills and knowledge of HC personnel, HSAs, and VHCs respectively from their own perspective. One observation is that the perceived benefits to the communities are not evenly distributed, obviously resulting of uneven distribution of training as discussed under Programme Effectiveness. The perceived benefits can be validated through the monitoring system using special surveys not only in the Health Programme but in the other two programmes as well.

Table 21 : Perceived benefits to the community with trained HC staff, HSAs and VHCs – Health Programme

HC staff – perceived benefits to the community with trained HC staff – as reported by HC staff	Out of 10 HCs	HSAs – perceived benefits to the community with trained HSAs – as reported by HSAs	Out of 12 HCs	VHCs – perceived benefits to the community with trained VHCs – as reported by VHCs	Out of 8 villages
More services available at HC than before	9	Through health talks during U5 clinics	6	Access to sanitation and hygiene messages	5
Early HIV diagnosis for babies	8	Disease prevalence reduced due to sanitation	4	Diarrhea diseases have reduced	2
HIV/AIDS counselling and TB testing - adults	5	Deliveries at Health Centres not homes	4	Pregnant women get assistance from VHCs	2
Malnourished people are identified and assisted	3	Malnourished children given nutritious food	3	Improved access to Vitamin A through door to door campaign	1
Disease prevention is ensured e.g . cholera	2	2 cup system when drinking or washing hands	2	More women delivering at HCs	1
Babies born <2.5 kg survive due to basic obstetric	1	Couples tested and initiated on ARVs	2	Improved access to medication for bilharzia and worms	1
Community improved access to family planning	1	Kangaroo mother care being adopted	1	Lactating mothers adopting exclusive breastfeeding	1
		Every child is reached for vaccination	1		

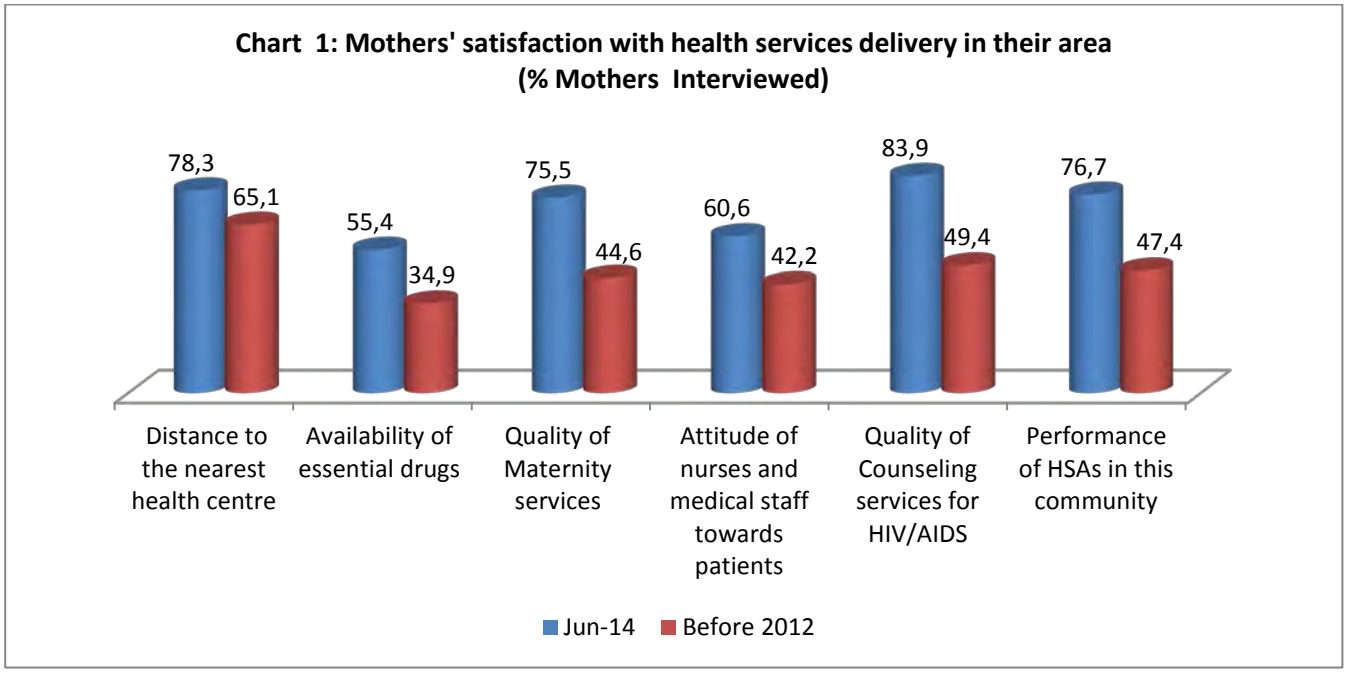
Community satisfaction with health services delivery in their areas

Satisfaction with services delivery was assessed through the Household Questionnaire where 249 women/caregivers were asked the following question: *How satisfied are you with the following aspects of health services provided to the citizens in this community? Compare the situation in 2014 to the situation before 2012 i.e. before programme implementation.*

a) Distance to the nearest health centre
b) Availability of essential drugs
c) Quality of maternal services
d) Attitude of nurses and medical staff towards patients
e) Quality of counseling services for HIV/AIDS; and
f) Performance of HSAs in the community

The question had three optional responses: 1=Satisfied, 2=Neither Satisfied Nor Dissatisfied, and 3=Dissatisfied for each of the elements a) to f). All other results including actual numbers of respondents out of 249 Mothers that were interviewed for each element a) to f) above are presented in **Annex 2.**

Chart 1 presents community satisfaction with health delivery services in their areas comparing the situation before 2012 and July 2014 representing programme implementation era. The results presented here only relate to code 1 of the optional responses, which is **satisfaction** with health services delivery. Results **1** show that all 2014 indicator values are above pre-programme values, an indication that the communities have confidence with health services delivery in their areas even before all the outputs are delivered. The improved delivery capacity of HC staff, HSAs, and VHCs combined seems to be impacting well on community wellbeing coupled with other health services interventions such as improved referral systems. However, availability of essential drugs (55.4%) and attitude of nurses and medical staff (60.6%) received less than 70% rating reflecting that more needs to be done in these areas.



5.4.2 Impact of the Water and sanitation programme

Impact assessment of outcome indicators is a challenge for the Water and Sanitation programme in the absence of outcome indicators' data as some indicators are supposed to be captured by HMIS and some by the DWDO – the two programmes have yet to synchronize outcome data capture and reporting. One other challenge is that the total number of households in the target area has yet to be determined.

Based on available information presented in **Table 22**, 11.6% of the villages have been declared as ODF up from zero value at the beginning of programme implementation. The proportion of households with improved latrines has marginally improved from 1% at baseline to about 1.4% still far below the 30% target. However, MTE's Women's Household survey of 220 Women indicate that 99.1% of the caregivers have access to safe water compared to 62.6% before programme implementation in 2012; of course the survey was conducted in the catchment areas of boreholes and shallow wells provided by the MBSP, which is an indication that if all water points are provided as planned, access to improved water sources will be close to 100% in target villages. Therefore apart from access to safe water and ODF verification, overall impact is difficult to ascertain due to lack of outcome indicators' data.

In our view the Water and Sanitation Programme needs assistance to develop a monitoring system based on Log Framework indicators in liaison with HMIS officials as other data sets are supposed to be reported through the HMIS.

Table 22 : Analysis of Outcome Indicators for Water and Sanitation Programme					
Narrative Summary	**Indicators**	**Source**	**Baseline 2011 - 2012**	**Achievement 2013 - 14**	**Target**
Immediate Objective (Outcome)					
Increased and sustainable access to and use of improved potable water sources and improved sanitation practices in target area	• % of households with access to potable/safe water (target: 80% in target area) (MDG 7.8)	HMIS (Baseline) DWDO (2013/14)	50 households/WP 53% 40 households /WP 42%	7037 Households accessing safe water provided by the programme	80% in target area
	• % of households with access to improved sanitation facility (MDG 7.9) (target: 80% in target area)	Baseline) DWDO (2013/14)	1%	Indicator data not yet collected by DWDO MTE survey: 1.4%	80% in target area
	• Number of villages verified as ODF (target: 30 % in target area)	HMIS (Baseline) DWDO (2013/14)	0	11.6% (target area) (DWDO data)	30% in target area
	• Reduction in waterborne diseases in target area (target: 50% reduction in target area)	HMIS (Baseline)	=	Data not available	50% reduction
	• Time savings in min/hours per day by women and girls as a result of new water points (Target: measurable time savings)		4000 cases Baseline to be determined in survey	Data not collected	Data not collected

Capacity strengthening and perceived benefits to the community – Sanitation and Water Programme

With only about two years of programme implementation, there are a number of perceived benefits to the community as acknowledged by WPMCs, WMAs, and HSAs as presented in **Table 23**. Commonly mentioned benefits included improved sanitation and hygiene as some villages are declared as ODF, maintenance of water facilities by the communities on their own, and establishment of maintenance fund including resource mobilization for sustainable maintenance of water facilities.

Table 23: Perceived benefits to the community with trained committees and WMAs/HSAs – Water and Sanitation programme					
Perceive benefits to the community as reported by WPMCs - boreholes	**Out of 10 villages**	**Perceive benefits to the community as reported by WPMCs - shallow wells**	**Out of 12 villages**	**Perceive benefits to the community as reported by WMAs/HSAs**	**Out of 12 villages**
Improved sanitation and hygiene	8	Community-based shallow well maintenance	8	Construction of pit latrines rising	5
Improved access to clean water	6	Maintenance fund established	8	Reduction of water-borne diseases	4
Community-based borehole maintenance	5	Good hygiene around shallow well	5	Community adopting good hygiene	3
Community maintenance fund	4	Hand washing after visiting pit latrines	1	Clean water point surrounding	2
2 cup system being adopted	4	Safe water is always available	1	Adoption of hand washing facilities	2
				Villages declared as ODF	2
				No prevalence of diarrhea	1
				Adoption of other sanitation facilities	1

Community satisfaction with Water and Sanitation delivery of services in their areas

Satisfaction was measured through interviews with 220 women who collect water from boreholes and shallow wells constructed or rehabilitated by the programme. *The question was: How satisfied are you with the following aspects of water and sanitation provided to the citizens in this community? Compare the situation in 2014 with the situation before 2012 i.e. before programme implementation.*

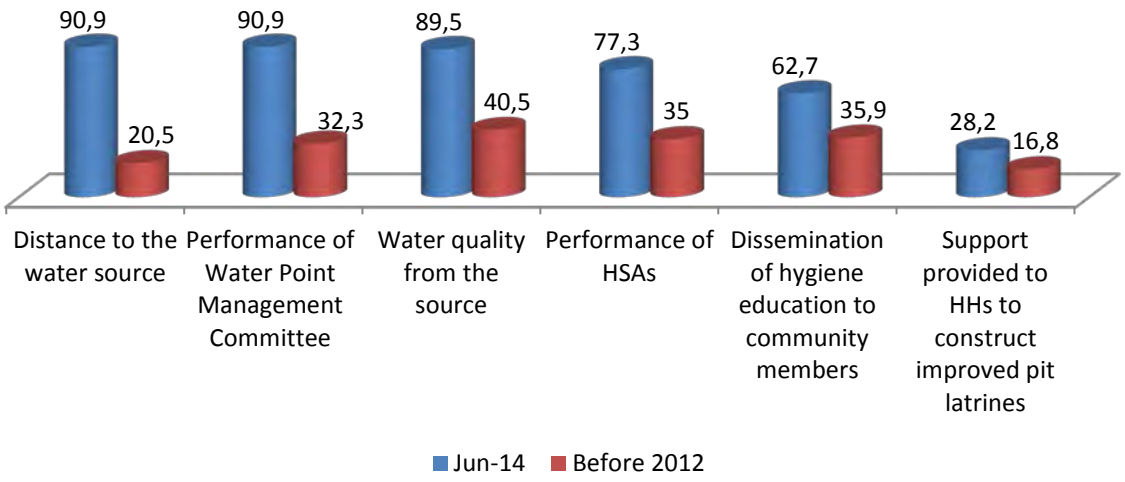
a) Distance to the water source
b) Water quality from the source
c) Performance of Water Point Management Committee
d) Performance of HSAs
e) Support provided to household to construct improved pit latrines; and
f) Dissemination of hygiene education to community members

The question also had three optional responses: 1=Satisfied, 2=Neither Satisfied Nor Dissatisfied, and 3=Dissatisfied for each of the elements a) to f). All results are presented in **Annex 2**.

Overall, **Chart 2** shows that there is community satisfaction with the Water and Sanitation Programme with 62.7% - 99.9% rating apart from programme support to construct latrines which has a very low rating of 28.2% - of course there is no intervention that provides for pit latrine construction only sensitization meetings are delivered by the programme through CLTS sanitation marketing. Compared to the period before 2012, it is evident that communities' access to safe water has improved with programme implementation. Therefore there is progress towards the programme goal but is limited because only about 37.7% of the water facilities have been completed (**Annex 1**). When all the water points are provided, communities in TA Chimwala will definitely enjoy improved access to safe water as one of their basic rights.

Chart 2: Community satisfaction with water services delivered to the community in the area

(% Women Interviwed)



5.4.3 Impact of the education programme

Impact of the education programme has been measured through comparative achievement of three outcome indicators respectively against: a) baseline values and b) non-programme schools as a control group. Retention rate as derived from DEMIS (**Table 24**) shows an increase (87.6%) over baseline (80%) and is also higher than the rate in non-programme schools (85.8%). Pass rate at 70.1% is also higher than baseline (65%) and non-programme schools (67.9%). There is also an improvement in the selection rate to secondary school at 66% over the baseline value of 41% and non-programme schools (60%). Good achievement in programme schools over baseline and non-programme schools performance is mainly due to ICEIDA's support provided through MBSP such as: school managers and teachers training, text books, improved learning environment in some schools, improved performance of school governance committees, and other support which has strengthened the delivery of services. The situation is likely to improve further when all infrastructure and other support are in place. Thus only in one year of programme implementation there is already good progress towards the programme goal.

Table 24 : Analysis of Outcome Indicators for the Education Programme

Outcome Indicator	Source	Baseline	2013/14 DEMIS Prog Schools	MTE July 2014 MTE : Non- Prog Schools	Target
Retention rate of learners in target schools	DEMIS	**80%**	**87.6%**	**85.8%**	85%
Pass rate, % of learners at each grade level passing/taking exams	DEMIS	**65%**	**70.1%**	**67.9%**	75% (by gender)
Selection rate for secondary school (% of learners in std.8 who get selected)	DEMIS	**41%**	**66%**	**60.0%**	50%

Perceived benefits to the community – Education Programme capacity building interventions

Based on KIIs with programme-trained school teachers and FGDs with school governance committees (**Table 25)** there are a number of benefits being derived from the education Programme based on teachers' and school committees' perceptions. The benefits include: improved learners' performance, increased girls' enrolment, and reduced absenteeism.

Table 25: Perceived learners' benefits with teachers and school committees' training – Education Programme

Perceived learners' benefits arising from trained teachers - As reported by teachers during KIIs	Out of 12 programme schools	Perceived benefits derived by learners from trained school governance committees - As reported by members of school governance committees during FGDs	Out of 12 programme schools
Improved learners' performance	11	More girls going school	6
Learners practice exams on printed copies	5	Improved access to soap and pads by girls	5
learners work hard to pass Iceida exams	4	Reduced absenteeism	2
Improved relationship between	2	K3000 girls' management fund established	2
teachers and learners		Reduced early marriages	1
Learners oriented to crocheting	1		

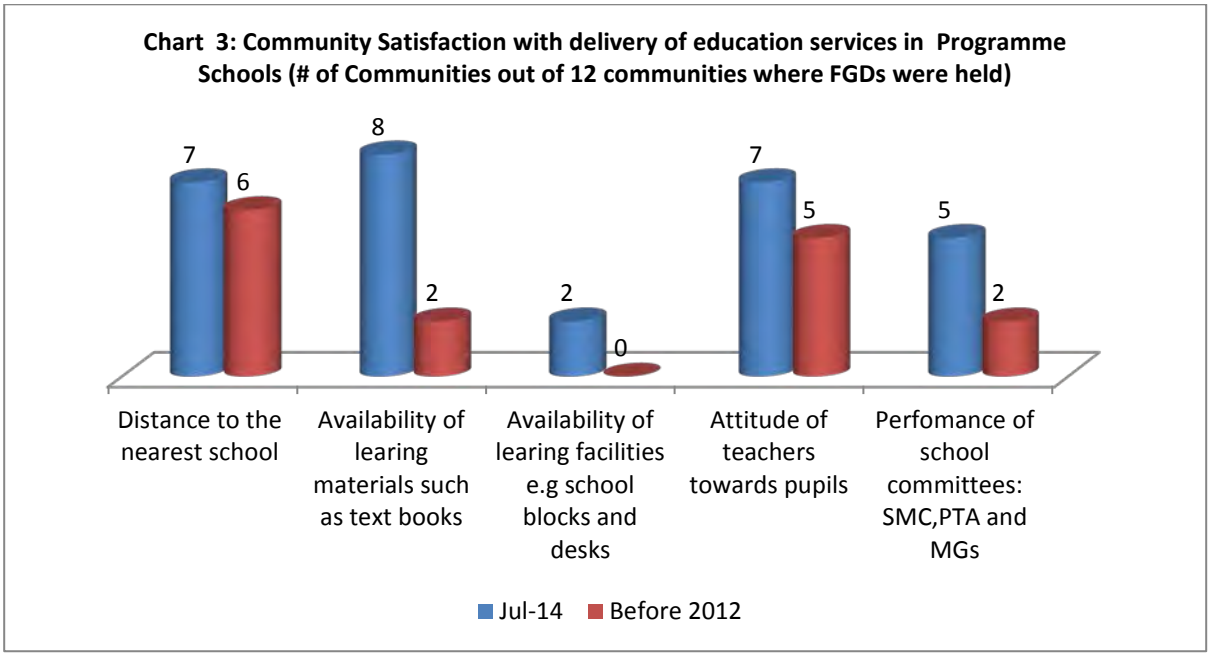
Community satisfaction with delivery of education services in their areas

Community satisfaction was assessed through FGDs with a community surrounding each of the 12 programme schools. Twelve communities were asked the following question: *How satisfied are you with the following aspects of education services provided to your children in the area? Compare the situation in 2014 with the situation before 2013 i.e. before programme implementation.*

a) Distance to the nearest school
b) Availability of learning materials such as text books
c) Availability of learning facilities e.g. school blocks and desks
d) Attitude of teachers towards pupils; and
e) Performance of school management by SMC, PTA, and Mother Group.

The question also had three optional responses: 1=Satisfied, 2=Neither Satisfied Nor Dissatisfied, and 3=Dissatisfied for each of the elements a) to f). All results are presented in **Annex 2**.

Results in **Chart 3** show that communities were mainly satisfied with: availability of learners' materials (8 out of 12 communities); attitude of teachers towards pupils (7/12); and distance to the nearest school (7/12). However communities were not satisfied with availability of learning facilities such as school blocks and desks (2/12). This result confirms that infrastructure development remains key in improving the learning environment in schools. Performance of school governance committees was also not highly rated (5/12), which means that refreshers and other support are necessary for the committees to perform satisfactorily.



5.5 Programme Sustainability

The key question is: *To what extent are the financial, institutional, socio-economic, and/or environmental risks to sustaining long-term project results?*

The three programmes are sector-specific interventions therefore parent Ministries should be responsible to absorb them into their Operational and Recurrent Transactions (ORT) like all other government programmes. As at the time of the MTE the process of institutionalizing the activities had not yet started. While the Ministry of Education through SIP funds is able to support school improvement including maintenance, it is acknowledged that the fund is not sufficient to cover major maintenance work. Other sectors of health and Water and Sanitation are yet to develop sustainability strategies.

One aspect of sustainability has been capacity strengthening at District Council, implementing sectors, and community level in the form of human resource development, improved facilities and systems such as financial, communication, and to a limited extent monitoring. All these are embedded in the operational systems at district or community-facility level, which can be productively utilized in future. However, the issue that comes up is sustainable maintenance of these facilities and systems, which needs to be addressed, One aspect of sustainability is community willingness to establish water facility maintenance fund and their capacity to maintain water facilities at community level by using the maintenance fund. If this can be sustained it is a good example of sustainability at community level.

Recommendation

In view that sustainability strategies have not been developed yet, we recommend that sector programmes should start developing sustainability strategy mechanisms to ensure smooth transition into government operations or community-level full ownership. The process should start during the last Quarter of 2014 after the bi-annual meeting.

6. 0 Conclusion

The Mid-Term Evaluation has revealed both strengths and challenges in the implementation process. The major strengths are: the MOLGRD through the Mangochi District Council and utilizing District Council and implementing sectors strengthened capacity is satisfactorily implementing a programme of the MBSP magnitude using decentralized structures. This is a remarkable achievement and a plus for the District Council, the MOLGRD, and Malawi as a country and for ICEIDA for advancing the new financing arrangement. Also strengthening the capacity of community-based structures has proven to be an effective delivery approach to reach-out to the communities in target areas, while effective cooperation between key tripartite partners has provided a productive oversight to the MBSP implementation process.

The MTE findings have also shown that the MBSP remains relevant in addressing the vulnerabilities in Mangochi as prioritized in the District Development Plan. The programme is also consistent with the programming priorities of ICEIDA for Malawi and also with Malawi Growth and Development Strategy and MDGs. Programme efficiency, though not highly rated, is acceptable bearing in mind that the project implementation process faces a number of teething problems to take-off but with time these are smoothened and implementation gets back on course with improving sector-led services delivery. Similarly programme effectiveness is not highly rated at output level where a backlog of outputs has to be cleared particularly infrastructure. However, in terms of strengthening delivery capacity, the programme has made good progress especially for frontline staff that directly interfaces with primary beneficiaries who are rural communities. Programme impact is yet to be consolidated but early indications show positive change in outcome indicators, which reflects progress towards the programme goal albeit at slow progression due to a medium achievement rate and/or delayed completion of some of the basic infrastructure to support other infrastructure-dependent activities and services; at community level program impacts are already being felt e.g. reduced water-related diseases where the programme has provided safe water, and in programme-supported schools there is improvement in retention, pass, and selection rates compared to non-programme schools. Programme sustainability remains an issue for discussion in the next half of programme implementation to ensure that project-initiated activities are mainstreamed in government operational systems.

Nonetheless, there are areas that need redress mainly the issue of completion of delayed civil works, the role of the MOLGRD as specified in the Partnership Agreement, M&E capacity issues as well as capacity strengthening of implementing sectors and community-level structures or representatives.

All-in-all the MBSP is making good progress towards achieving its immediate objectives as well as progress towards the overall goal; what remains is to review the plans, re-prioritize, and re-strategize to ensure that key activities are completed by the end of the current phase (June 2016). This is important for Mangochi District Council, MOLGRD, and Malawi as performance and experience gained during the current phase could be utilized to request and justify another cooperative agreement with ICEIDA in order to extend and broader the benefits to other areas in Mangochi not currently reached by the programme. Thus ICEIDA's investment in the MBSP to improve the living conditions for the people of Mangochi is on course and is likely to be accomplished by the end of the programme phase.

7.0 Recommendations

Sector-specific recommendations are presented in **Section 5.0** of the Report- Evaluation Findings. However there are four recommendations based on the analysis of programme performance and progress and these are:

a. In light of slow progress in infrastructure development and a corresponding low to medium achievement rates, we recommend that Mangochi District Council should liaise with ICEIDA, if necessary, to identify an independent consultant to speed-up and facilitate implementation of the civil works programme particularly in Health and Education.

b. The MOLGRD should identify a focal point person and operationalize the position to strengthen its roles as specified in the Partnership Agreement.

c. In light of limited M&E capacity in the implementing sectors and in ICEIDA's Mangochi Office to effectively provide technical assistance in M&E, we recommend that ICEIDA should strengthen its M&E function in the Mangochi Office to enable it provide the required technical assistance to the District Council as specified in the Tripartite Agreement.

d. The District Council with the implementing sectors should develop sustainability strategies to ensure institutionalization of activities within the District Council and sector Ministries' ORT budgets.

8.0 Lessons learnt

There are a number of lessons learnt from implementation of the MBSP:

a) An important lesson is that devolution of mandate to decentralized structures to manage development and make decisions without direct influence of the centre is an efficient and effective way of delivering basic social services to the rural poor and under-privileged communities. Direct funding to the District Council, capacity strengthening of implementing sectors, functional and transparent financial and procurement systems with checks and balances, time-bound operational plans and budgets and capacity building of community structures are pre-requisites of successful delivery of development to rural communities.

b) By improving the learning environment in schools through infrastructure development and provision of learning materials, and capacity enhancement of teachers, education managers, and school governance committees, there is high potential for improving the pass rate, retention rate, and selection rate in primary education. This scenario is becoming visible in target schools in Mangochi where comparative analysis between programme and non-programme schools has revealed higher performance indicator values for programme schools than for non-programme schools.

c) Building the capacity of existing community structure and mentoring them to steer their own development is a cost-effective way of delivering development to achieve broader community impacts and instill community ownership. Delivery of the MBSP at community level is premised on strengthening community institutions such as Village Health Committees (VHCs), Water Point Management Committees (WPMCs), and School Governance Committees (SMCs, PTAs ,and MGs) supported by frontline staff such as Health Surveillance Assistants (HSAs) and Health Centre (HC) personnel, Water Monitoring Assistants (WMAs), and Education Managers respectively. Utilization of strengthened community-based structures is not only effective in service delivery but also cost-effective as the programme does not incur administrative overheads apart from training costs – which means that the programme can broaden the impact area at least cost while distributing the benefits to a wider community.

Annex 1: Achievement of Programme Outputs

Annex 1.1 : Achievement of Outputs - Public Health Programme

	Planned Targets	Mid-Term Achievement	Achievement Rate (%)
OUTPUTS			
1. Improved health services infrastructure			
1.1.General infrastructure in the network of the MoH health centres strengthened			
Safe water supply installed in at least 13 HCs	13	5	38.4
Sanitation (latrines) installed in at least 13 HCs	13	9	69.2
Electricity and power supply installed in at least 7 HCs (ESCOM Power)	7	5	71.3
Electricity power installed in at least 12 HCs (Solar Power)	12	4	33.3
Sanitation (latrine/placenta/incinerator) installed in at least 13HCs	13	9	69.2
General maintenance done in at least 13 health facilities	13	7	53.8
Buildings and equipment through maintenance fund.	Not specified	0	o.0
Mean			**55.8**
1.2 Improved Infrastructure and equipment in maternal and neonatal care services in HCs			
At least 4 maternity wards constructed including Mangochi District Hospital	5	3 Under construction	0
Beds provided for in at least 6 maternity wards	6	0	0
Equipment provided for in at least 6 maternity wards	6	0	0
At least 11 Waiting homes constructed	11	0	0
At least 10 Staff houses constructed	10	0	0
At least 10 Health posts constructed and provided with electricity	10	0	0
At least 20 vaccine fridges provided at health posts and other health facilities	20	0	0
At least 5 health facilities provided with furniture	5	0	0
Mean			**0.0**
2. Increased coverage of high impact, quality Maternal and Child health services			
2.1. improved referral services			
At least 5 ambulances purchased and in operation with operational guidelines in place	5	4	80
At least 8 bicycle ambulances purchased and in operation with operational guidelines in place	8	0	0
A Feasibility assessment on the effective communication strategy between health facilities and between the facilities and the ambulance services done and implemented	1	1 (study done, tender documents prepared)	100
Mean			**60**
2.2. Strengthened Community based health services			
At least 35 HSAs trained in initial training	35	35	100
At least 550 bicycles provided for HSAs	550	555	100.9
HSAs provided with required equipment	550	550	100.9
At least 874 VHCs trained in Primary Health Care management	874	226	25.8
At least 30 HA Committees trained on their roles and responsibilities.	30	33	110
Mean			**109.4**

3. Improved Capacity of the health system to deliver services			
3.1. Improved Working Conditions for Public Health (PH) Support Staff at the DHO.			
Public Health Office at DHO renovated	1	1	100
Public Health office is equipped	1	1	100
One (1) 4x4 vehicle for supervision for Public Health office provided and operational	1	1	100
At least 12 motorcycles for supervision for Public Health office purchased and operational.	12	6	50
Mean			**87.5**
3.2 Institutional capacity strengthened at the DHO			
At least 10 staff trained in accordance with the needs assessment with scholarships from the education fund	10	8	80
At least 12 research projects funded and research findings disseminated to relevant parties.	12	8	66.7
Computer lab established	1	1	100
Mean			**87.5**
3.3. Improved/Strengthened Health Management Information System			
Computer and internet service installed at the DHO and in 4 health zones (5 in all).	5	5	100
Training and capacity building in HMIS for coordinators and health centre management teams.	80	70	87.5
Village Health Registers procured.	874	874	100
At least 35 HSAs and supervisors trained in VHRs	373	571	153
Data collection week conducted using VHR: # of data collection weeks	4	2	50
VHR institutionalized in the district : Number of review meetings conducted	8	5	62.5
Mean			**92.1**

Annex 1.2: Achievement of Outputs – Water and Sanitation Programme

	Planned Targets	**Mid-Term Achievement**	**Achievement Rate (%)**
OUTPUTS			
1. At least 150 new boreholes constructed	150	56	37.3
2. At least 100 protected shallow wells constructed	100	33	33
3. At least 100 defunct boreholes rehabilitated	100	43	43
4. At least 350 water point management committees (WPMCs) trained in CBM (operations and maintenance, sanitation and organization) in TA Chimwala	350	132	37.7
5. At least 80% of households in TA Chimwala construct and use improved pit latrines and hand wash facilities			
# Extension workers trained in CLTS	105	94	89.5
# Community leaders trained in CLTS	284	221	77.8
# of villages triggered	137	137	100
# of villages verified as ODF	137	16	11.6
Mean			**70**
6. System strengthening for WASH service delivery			

# Follow up visits made	1807	1459	80.7
Management system for O&M in place	1	0	0
M&E system in place	1	0	0
Strategy for availability of spare parts in place	1	0	0
Mean			**20.1**
6.1 District Water Office has increased capacity and is better equipped to perform its work			
# additional WMAs employed	16	16	100
DWO and staff properly equipped		Done	100
2 Motorcycles and 2 vehicles in place	4	4	100
Mean			**100**
7. Environmental aspects around water points and in relation to sanitation activities have been examined and addressed			
Proposal assessment	1	1	100
Implementation plan	1	1	100
Mean			**50.5**

Annex 1.3 : Achievement rate for the Education Programme

	Planned Targets	**Mid-Term Achievement**	**Achievement Rate (%)**
OUTPUTS			
1. **Improved capacity and support to learners in target schools**			
1.1 Capacity building of teachers and school managers			
MIE training for teachers on what to teach and how to teach	118	118	100
Train School managers on school management according to MIE programme and modules	Not specified	72	100
Identify, support and hire 60 candidates for teacher training from the local area	60	40	66.7
Mean			**89**
1.2 Teaching and learning materials provided in target schools			
Establish TALULR centres (Teaching and Learning Using Locally Available Resources) at each of the target schools	No target	12	100
Procure and distribute school textbooks for three subjects in standards 1-4 and 6 subjects for standards 5-8 at a ratio of 1:1	No target	47982	100
Acquisition of supplementary books according to MIE list	No target	4000	100
Provision of basic sports equipment	48	96	200
Provision of notebooks for all learners in target schools	No target	367500	100
Acquire and distribute teachers' guides for all primary school subjects		Included in supplementary text books	
Acquire and apply standardized tests (Exams administered)	4000	4322	108
Mean			**118**
1.3 Community mobilised for educational support			
Train School committees to enhance their performance	No target	312	100

	Planned Targets	Mid-Term Achievement	Achievement Rate (%)
Organise theatre for development	No target	3	100
Role models visit schools and give talks for learners (Role modelling) once per term	No target	0	0
Mean			**66.7**
1. Improved teaching and learning environment			
2.1. New infrastructure and equipment in target schools			
At least 52 new classrooms constructed	52	8	15.3
At least 36 teacher's houses constructed	36	0	0
At least 48 improved and secure latrines constructed	48	0	0
At least 96 water and sanitation facilities installed	96	192	200
School furniture provided in at least 200 classrooms	2640	0	0
Teacher's tables and chairs provided in at least 220 classrooms	440	216	49
Situational analysis of requirements for feeder and secondary schools in target zones	No target	0	0
Mean			**38.1**
2.2. Infrastructure rehabilitated in target schools.			
General maintenance of classrooms, teachers' houses, latrines, water and sanitation through maintenance fund.	8	14	175
3. Enhanced equity and improved retention of girls and OVC's in target schools			
3.1 Strengthen the role of Mother Groups in the Schools			
Provide 2 pushbikes for each Mother Group	24	24	100
Provide two trainings for each Mother Group during the life of the programme, to make their work productive	2	1	50
Introduce the Mother Group members to Village Savings and Loan Scheme	12	0	0
Organise exchange visits for members of the Mother Groups	12	0	0
Mean			**37.5**
3.2 Strengthen the status of girls in schools			
Form and train the girls' clubs	12	12	100
Hold interface meetings (speak out) with the school authorities	12	0	0
Mean			**50**
3.3 Support to OVCs			
Provide bursaries to OVCs	86	82	**95.3**
3.4 Increase enrolment of special needs learners into the target schools.			
Identify and provide management support for children with special needs.	0	0	0
Provide special needs teaching and learning materials such as Braille materials, assistive devices and training on use.	0	0	0
Establish or rehabilitate resource centres for children with	0	0	0

	Planned Targets	Mid-Term Achievement	Achievement Rate (%)
special needs			
Mean			**0**
3.5 Increased attendance and participation of learners			
Train teachers to administer deworming and bilharzia prevention tablets	0	0	0
Procure and distribute deworming and bilharzia prevention tablets (# of procurements)	3	1	33.3
Monitor and supervise the deworming and bilharzia prevention exercise	0	0	0
Mean			**11.1**
4 Improved management of target schools			
4.1 Capacity building and training in education and management			
Develop data management training package	1	1	100
Train 18 PEAs in data management according to training by the education planning directorate from the MoE	18	18	100
Train staff at DEM's office in the use of ICT by the MoEST ICT department	20	20	100
PEAs trained by MIE	4	5	125
Mean			**106.2**
4.2 Strengthening of DEM's office operations			
Conduct a needs assessment and strategy for hardware and software: Data management training developed	1	1	100
Procure ICT equipment based on needs assessment	29	24	82.7
Procure a vehicle for use at DEM's office with operational guidelines	1	1	100
Rehabilitate the DEM's office	1	1	100
Procure one motorcycle for each TDC in the target zones	4	4	100
Provide additional fuel for motorcycles	80	240	300
Mean			**130.4**
Overall mean			**76.4**

Annex 2:

Community satisfaction with services delivery in their areas: Health, Water and Sanitation, and Education – With MBSP (July 2014) and Before MBSP in 2012

Annex 2.1a : Community satisfaction with Health services delivery in their area - With MBSP					
	% Mothers/Caregivers Interviewed				
With MBSP - July 2014	Satisfied	Neither Satisfied Nor Dissatisfied	Dissatisfied	**Total**	n=
Distance to the nearest health centre	78.3	6	15.7	**100%**	249
Availability of essential drugs	55.4	21.7	22.9	**100%**	249
Quality of Maternity services	75.5	12.9	11.6	**100%**	249
Attitude of nurses and medical staff towards patients	60.6	16.9	22.5	**100%**	249
Quality of Counseling services for HIV/AIDS	83.9	9.2	6.9	**100%**	249
Performance of HSAs in this community	76.7	8	15.3	**100%**	249
	Actual Number of Women Respondents				
Distance to the nearest health centre	195	15	39	249	
Availability of essential drugs	138	54	57	249	
Quality of Maternity services	188	32	29	249	
Attitude of nurses and medical staff towards patients	151	42	56	249	
Quality of Counseling services for HIV/AIDS	209	23	17	249	
Performance of HSAs in this community	191	20	38	249	

Annex 2.1b : Community satisfaction with Health services delivery in their area - Before MBSP					
	% Mothers/Caregivers Interviewed				
Before MBSP - Before 2012	Satisfied	Neither Satisfied Nor Dissatisfied	Dissatisfied	**Total**	Sample size n=
Distance to the nearest health centre	65.1	8	26.9	**100%**	249
Availability of essential drugs	34.9	34.1	30.9	**100%**	249
Quality of Maternity services	44.6	28.1	27.3	**100%**	249
Attitude of nurses and medical staff towards patients	42.2	25.7	32.1	**100%**	249
Quality of Counseling services for HIV/AIDS	49.4	25.3	25.3	**100%**	249
Performance of HSAs in this community	47.4	20.5	32.1	**100%**	249
	Actual Number of Women Respondents				
Distance to the nearest health centre	162	20	67	249	
Availability of essential drugs	87	85	77	249	
Quality of Maternity services	111	70	68	249	
Attitude of nurses and medical staff towards patients	105	64	80	249	
Quality of Counseling services for HIV/AIDS	123	63	63	249	
Performance of HSAs in this community	118	51	80	249	

Annex 2:2a: Community satisfaction with water services delivery in their area - With MBSP					
	% Women Interviewed				
With MBSP - July 2014	Satisfied	Neither Satisfied Nor Dissatisfied	Dissatisfied	**Total**	Sample size n=
Distance to the water source	90.9	0.9	8.2	100%	220
Water quality from the source	89.5	5.5	5	100%	220
Performance of Water Point Management Committee	90.9	2.7	6.4	100%	220
Performance of HSAs	77.3	11.8	10.9	100%	220
Support provided to HHsto construct improved pit latrines	28.2	24.5	47.3	100%	220
Dissemination of hygiene education to community members	62.7	16.8	20.1	100%	220
	Actual Number of Women Respondents				
Distance to the water source	200	2	18	220	
Water quality from the source	197	12	11	220	
Performance of Water Point Management Committee	200	6	14	220	
Performance of HSAs	170	26	24	220	
Support provided to HHsto construct improved pit latrines	62	54	104	220	
Dissemination of hygiene education to community members	138	38	44	220	

Annex 2:2b: Community satisfaction with water services delivery in their area - Before MBSP					
	% Women Repondenta				
Before MBSP - Before 2012	Satisfied	Neither Satisfied Nor Dissatisfied	Dissatisfied	**Total**	Sample size n=
Distance to the water source	10.5	15	74.1	100%	220
Water quality from the source	40.5	17.3	42.3	100%	220
Performance of Water Point Management Committee	32.3	33.6	34.1	100%	220
Performance of HSAs	35	30	34.5	100%	220
Support provided to HHs to construct improved pit latrines	16.8	14.1	69.1	100%	220
Dissemination of hygiene education to community members	35.9	24.8	39.5	100%	220
	Actual Number of Women Respondents				
Distance to the water source	23	33	164	220	
Water quality from the source	89	38	93	220	
Performance of Water Point Management Committee	71	74	75	220	
Performance of HSAs	77	66	76	219	
Support provided to HHs to construct improved pit latrines	37	31	152	220	
Dissemination of hygiene education to community members	79	55	87	220	

Annex 2.3 : Number of community responses out of 12 communities in Programme schools			
With MBSP - With MBSP (july 2014)	Satisfied	Neither Satisfied Nor Dissatisfied	Dissatisfied
Distance to the nearest school	7	2	3
Availability of learing materials such as text books	8	1	3
Availability of learing facilities e.g school blocks and desks	2	7	3
Attitude of teachers towards pupils	7	3	2
Perfomance of school management by SMC,PTA and Mother Groups	5	4	3
Before MBSP	**Number of communities**		
Distance to the nearest school	6	3	3
Availability of learing materials such as text books	2	4	6
Availability of learing facilities e.g school blocks and desks	0	5	7
Attitude of teachers towards pupils	5	1	6
Perfomance of school management by SMC,PTA and Mother Groups	2	4	6

NB: these values were determined through concensus in each of the 12 communities

ANNEX 3: Training delivered through MBSP

Methodology used to analyze data

The data was collected through either Key Informant Interviews (KIIs) with frontline staff or Focus Group Discussions (FGDs) with community-based committees. Templates were developed in Excel Spreadsheet for each question and a response was give Code 1. Starting from the first KII or FGD response sheet, Code 1 was recorded because that is the first response that set the pace for subsequent sheets for Code 1if the response was similar to the response in sheet one and coded zero (0) if there was no similar response in the subsequent sheets. Similarly new responses were recorded 1 if different from the first response and was this was repeatedly done for all response sheets.

Example: A question to HSAs at a Health Centre: What training have you attended between 2012 and to-date (July 2014)? The responses were recorded as follows in the Excel Spreadsheet: 1=Training Received; 0=Training not received

	Jalasi HC	Katuli HC	Malombe HC	Nankhumba HC	**Total for All HCs**
CMAM	1	1	0	1	**3**
Family Planning	0	0	1	1	**2**
CLTS	1	1	1	0	**3**

Interpretation

Training of CMAM was delivered to HSAs in 3 HCs , family planning in 2 HCs and CLTS in 3 HCs. Therefore all the three training modules were not delivered to all HCs.

Annex 3.1 Training delivered to Health Centre personnel

Name of Health Centre	Mtimabi	Chilipa	Namwera	Nancholi	Katuli	Malombe	Chikole	Nangalamu	Nankumba	Jalasi	Total
CMAM				√	√	√			√	√	**5**
ART		√		√	√		√		√		**5**
Life saving skills		√			√	√		√	√		**5**
Family planning	√						√	√		√	**4**
Obsteric complications			√			√	√	√			**4**
DBS sample collection	√							√			**2**
Infection prevention		√									**1**
HBB,KMC			√								**1**
Sign language				√							**1**
HMIS					√						**1**
ETAT									√		**1**
STI/SMA										√	**1**

Annex 3.2 : Training delivered to Health Surveillance Assistants (HSAs) - As Reported by HSAs

Health Centre	Mtimabi	Chilipa	Monkey Bay	Namwera	Nancholi	Katuli	Malombe	Chikole	Nangalamu	Kukalanga	Nankumba	Jalasi	Total
CMAM	√	√	√	√	√	√	√					√	**8**
CB MNH			√		√						√	√	**4**
CLTS	√	√								√			**3**
HTC				√							√	√	**3**
EPI								√	√		√		**3**
Village Health Register				√			√						**2**
Safe Motherhood								√	√				**2**
Rapid SMS			√										**1**
Family Planning				√									**1**
Youth Friendly Services						√							**1**
Nutrition											√		**1**

Zero Stock Out											√		**1**

Annex 3.3 : Training delivered to Village Health Committees (VHCs) - As Reported by VHCs during FGDs

Health Centre	Jalasi	Kukalanga	Malombe	Katuli	Nancholi	Chilipa	Mtimabi	Monkey Bay	
Village:	**Balakasi**	**Mwalija**	**Sili**	**Katuli**	**Tambala**	**Chilipa**	**Lusewa**	**Jogo**	**Total**
Sanitation and hygiene	√	√		√	√		√	√	6
Safe Motherhood				√	√			√	3
Six food groups	√					√			2
ART	√								1
Growth monitoring				√					1
Immunizations				√					1
HIV/AIDS						√			1
Dangers of malnutrition							√		1

Annex 3.4 : Improved services delivery by HC personnel after training - As reported by HC personnel during KIIs

Health Centre	**Mtimabi**	**Chilipa**	**Namwera**	**Nancholi**	**Katuli**	**Malombe**	**Chikole**	**Nangalamu**	**Nankumba**	**Jalasi**	**Total**
Family planning services e.g jadelle	√		√					√		√	**4**
Early infant HIV diagnosis	√				√			√			**3**
Basic obstetric - manual vacuum respiration		√	√					√			**3**
Provision of ART services		√			√	√					**3**
Promoting sanitation in communities		√		√							**2**
Proper plotting of labour graph			√	√							**2**
Assessing child/mother nutritional status						√			√		**2**
Cases referred immediately to District Hospital							√		√		**2**
Checking thermometer before treatment							√				**1**
Improved STI treatment										√	**1**

Annex 3.5 : Perceived benefits to the community arising from trained HC personnel - As reported by HC personnel during KIIs											
Health Centre	**Mtimabi**	**Chilipa**	**Namwera**	**Nancholi**	**Katuli**	**Malombe**	**Chikole**	**Nangalamu**	**Nankumba**	**Jalasi**	**Total**
More services available at HC than before	√	√		√	√	√	√	√	√	√	**9**
Early HIV diagnosis for babies	√		√	√	√	√	√	√		√	**8**
HIV/AIDS counselling and TB testing - adults		√		√		√		√	√		**5**
Malnourished people identified and assisted							√		√	√	**3**
Infection prevention is ensured e.g cholera		√			√						**2**
Babies born <2.5 kg survive due to basic obstetric			√								**1**
Community improved access to family planning	√										**1**

Annex 3.6 : Improved services delivery by HSAs after training - As reported by HSAs during KIIs

Health Centre	Mtimabi	Chilipa	Monkey Bay	Namwera	Nancholi	Katuli	Malombe	Chikole	Nangalamu	Kukalanga	Nankumba	Jalasi	Total
Identify malnourished children	√	√	√	√	√		√					√	**7**
Improved delivery of CMAM and CLTS	√	√			√		√	√					**5**
Sensitize/mobilize mothers to go to the clinic			√		√	√		√					**4**
Follow up visits sanitation and hygiene	√	√								√	√		**4**
Encourage preganant women to eat nutritious					√	√		√			√		**4**
Rapid SMS as reminderfor due immunization			√					√			√		**3**
Provide HTC services at the HC				√		√							2
Encourage the youth to patronize HC services						√						√	**2**
Able to identify women with fistula problems									√			√	**2**
Prevention of diarrhearrial diseases		√											**1**
Easy diagnose of children born with HIV			√										**1**
Give or inject DEPO				√									**1**
Train communities on sanitation and hygiene										√			**1**
Comfirmatory testing before initiating ARVs												√	**1**
Provide family planning services				√									**1**

Annex 3.7 : Perceived benefits to the community arising from trained HSAs - As reported by HSAs during KIIs

Health Centre	Mtimabi	Chilipa	Monkey Bay	Namwera	Nancholi	Katuli	Malombe	Chikole	Nangalamu	Kukalanga	Nankumba	Jalasi	Total
Through health talks during U5 clinics	√	√			√		√	√		√			**6**
Disease prevalence reduced due to sanitation		√		√			√			√			**4**
Deliveries at Health Centres not homes			√			√					√	√	**4**
Malnourished children given nutritious food					√				√			√	**3**
2 cup system when drinking or washing hands	√						√						**2**
Couples tested and initiated on ARVs			√	√									**2**
Cangaroon mother care being adopted						√							**1**
Every child is reached for vaccination								√					**1**

Annex 3.8 : Services delivery by VHCs after training - As reported by VHCs during FGDs									
Health Centre	Jalasi	Kukalanga	Malombe	Katuli	Nancholi	Chilipa	Mtimabi	Monkey. Bay	
Village	**Balakasi**	**Mwalija**	**Sili**	**Katuli**	**Tambala**	**Chilipa**	**Lusewa**	**Jogo**	**Total**
Promote use of toilets, rubbish pits, bathrooms	√	√			√		√	√	**5**
Women attend antanatal services and deliver at H/Centers				√	√		√	√	**4**
Promote hygiene e.g 2 cup system and hand washing		√		√		√	√		**4**
Sensitize the community on disease prevention				√	√	√			**3**
Identify malnutrition cases in the village						√	√		**2**
Discuss HIV/AIDS voluntary testing with the community	√					√			**1**
Disseminate importance of Growth Monitoring				√		√			**2**
Encourage defaulters to restart taking ARVs	√								**1**
Encourage the community to eat 6 food groups	√								**1**
Constructed soak away pit at the borehole		√							**1**
Conduct immunizations campaings								√	**1**
Assist HSAs in distributing Vit A, dewormers, & chlorine	√								**1**
Safe Motherhood campaigns								√	**1**

Annex 3.9 : Perceived benefits to the community arising from trained VHCs - As reported by VHCs during FGDs									
Health Centre	Jalasi	Kukalanga	Malombe	Katuli	Nancholi	Chilipa	Mtimabi	Monkey. Bay	
Village	**Balakasi**	**Mwalija**	**Sili**	**Katuli**	**Tambala**	**Chilipa**	**Lusewa**	**Jogo**	**Total**
Access to sanitation and hygiene messages	√	√		√		√	√		**5**
Diarrhoea diseases have reduced				√			√		**2**
Pregnant women get assistance from VHCs					√			√	**2**
Improved access to Vit A through door to door campaign	√								**1**
More women delivering at HCs					√				**1**
Improved access to medication for bilhazia and worms						√			**1**
Lactating mothers adopting exclussive breastfeeding								√	**1**

Annex 3.10: Training delivered to WPMCs - As reported by WPMCs during FGDs Boreholes											
Villages in TA Chimwala	**Msauka**	**Changali**	**Mtanga**	**Mwalija**	**Mwachikumba**	**Mpinganjira 2**	**Limbula**	**Changali**	**Ngunga**	**Hotelo**	**Total**
Hygiene around the borehole	√	√	√	√	√	√	√	√	√		9
Borehole maintenance	√	√	√	√	√	√	√	√	√		9
Hygiene and sanitation in homes	√			√			√	√			4
How to prevent cholera						√				√	1
HIV/Aids awareness			√								1

Table 3.11 : Services delivered by WPMCs after training - As reported by WPMCs during FGDs Boreholes											
Villages in TA Chimwala	**Msauka**	**Changali**	**Mtanga**	**Mwalija**	**Mwachikumba**	**Mpinganjira 2**	**Limbula**	**Changali**	**Ngunga**	**Hotelo**	**Total**
Community able to repair borehole	√	√		√	√	√	√	√	√	√	9
Promote borehole area sanitation	√	√	√	√			√		√	√	7
Constructed drainage and a fence	√	√	√	√			√				5
Established a maintenance fund	√	√						√	√	√	5
Planted flowers around borehole	√	√	√	√							4
Conduct sensitization meetings	√		√				√	√			4
Sweeping around the borehole					√				√	√	3
Erected a fence around borehole		√									1

Annex 3.12 : Perceived benefits to the community arising from trained WPMCs - As reported by WPMCs during FGDs Boreholes											
Villages in TA Chimwala	**Msauka**	**Changali**	**Mtanga**	**Mwalija**	**Mwachikumba**	**Mpinganjira 2**	**Limbula**	**Changali**	**Ngunga**	**Hotelo**	**Total**
Improved sanitation and hygiene	√	√	√	√		√	√	√	√		8
Improved access to clean water	√	√	√	√			√	√			6
Community-based borehole maintenance		√		√		√		√		√	5
Community maintenance fund	√	√						√	√		4
2 cup system being adopted									√		4

Annex 3.13 : Training delivered to WPMCs - As reported by WPMCs during FGDs Shallow wells

Villages in TA Chimwala	Tangwa	Mwaza	Stephen	Kawejere	Chisumbi	Mwachikumba	Changamire	Ukalanga	Changali	Ndege	Mpinganjira	Hotelo	Total
Sanitation around the s/well	√		√	√	√	√	√	√	√	√	√		**10**
Shallow well maintenance	√	√	√	√	√	√	√		√	√	√		**10**
Hygiene and sanitation in homes	√	√		√			√		√	√	√		**7**

Annex 3.14 : Services delivered by WPMCs after training - As reported by WPMCs during FGDs Shallow wells

Villages in TA Chimwala	Tangwa	Mwaza	Stephen	Kawejere	Chisumbi	Mwachikumba	Changamire	Ukalanga	Changali	Ndege	Mpinganjira	Hotelo	Total
Do shallow well maintenance	√			√	√		√	√	√	√	√	√	**9**
Mobilize shallow well maintenance funds		√	√		√	√	√	√	√		√		**8**
Promoting hygiene around shallow well		√							√	√	√		**4**
Sweeping around the shallow well			√					√		√		√	**4**

Annex 3.15: Perceived benefits to the community arising from trained WPMCs - As reported by WPMCs during FGDs Shallow wells

Villages in TA Chimwala	Tangwa	Mwaza	Stephen	Kawejere	Chisumbi	Mwachikumba	Changamire	Ukalanga	Changali	Ndege	Mpinganjira	Hotelo	Total
Community-based shallow well maintenance	√	√	√	√	√			√		√	√		8
Maintenance fund is available	√	√		√		√	√	√		√			8
Good hygiene around shallow well			√			√	√	√		√			5
Hand washing after visiting pit latrines						√							1
Safe water is always available									√				1

Annex 3.16 : Training delivered to Water Management Assistants (WMAs) and HSAs - As reported by WMAs/HSAs during KIIs												
	Msauka	**Mpembena**	**Ndege**	**Changamire**	**Mwachikumbata**	**Stephen**	**Changali**	**Changali**	**Mwalija**	**Ngunga**	**Mkaonga**	**Total**
CLTS	√	√	√			√	√	√	√	√	√	**9**
Hygiene and sanitation					√	√				√	√	**4**
Borehole / shallow well siting				√		√			√			**3**
Community ownership of borehole				√						√		**2**
CBM/VLOM										√		**1**
Basics- borehole drilling & construction						√						**1**

Annex 3.17: Services delivered by WMAs/HSAs after training - As reported by WMAs/HSAs during KIIs												
	Msauka	**Mpembena**	**Ndege**	**Changamire**	**Mwachikumbata**	**Stephen**	**Changali**	**Changali**	**Mwalija**	**Ngunga**	**Mkaonga**	**Total**
Conduct sanitation awareness meetings	√	√	√			√	√	√	√	√	√	**9**
Monitor adoption of sanitary facilities	√	√	√			√	√			√		**6**
Promote community participation in borehole & shallow well construction				√	√	√			√			**4**
Conduct ODF campaigns			√						√	√		**3**
Assist in borehole site idenfication				√		√						**2**
Door to door sanitation campaigns					√	√						**2**

Annex 3.18 : Perceived benefits to the community arising from trained WMAs/HSAs - As reported by WMAs/HSAs during KIIs												
	Msauka	**Mpembena**	**Ndege**	**Changamire**	**Mwachikumbata**	**Stephen**	**Changali**	**Changali**	**Mwalija**	**Ngunga**	**Mkaonga**	**Total**
Construction of pit latrines rising					√	√		√	√	√		**5**
Reduction of water-borne diseases	√						√		√		√	**4**
Community adopting good hygiene				√				√		√		**3**
Clean water point sorrounding							√			√		**2**
Adoption of handwashing facilities	√						√					**2**
Villages declared as ODF		√								√		**2**
No prevalence of diarrhoea			√									**1**
Adoption of other sanitation facilities						√						**1**

Annex 3.19 : Perceived community adoption of CLTS technology -- As reported by WMAs/HSAs during KIIs												
	Msauka	**Mpembena**	**Ndege**	**Changamire**	**Mwachikumbata**	**Stephen**	**Changali**	**Changali**	**Mwalija**	**Ngunga**	**Mkaonga**	**Total**
Its cheap technology, easy to adopt	√		√				√	√	√	√		**6**
Community is self-reliant with no assistance from Government	√				√		√			√		**4**
Community declared ODF		√		√							√	**3**
CLTS adoption is till low						√						**1**

Annex 3.20: Messages disseminated by WMAs/HSAs on sanitation and hygiene - As reported by VHCs

Villages	Tangwa	Mwanza	Stephen	Kawejere	Chisumbi	Mwachikumba	Changamire	Ukalanga	Changali	Ndege	Mpinganjira	Hotelo	Total
Each HH should have sanitary facilities	√		√		√	√	√		√	√	√		**8**
Hand washing		√									√		**2**
Proper rubbish disposal		√											**1**
Chlorination of drinking water		√											**1**
Drinking water care (2 cup system)						√							**1**
No messages disseminated								√					**1**

Annex 3.21: Changes in learning environment with programme implementation - As reported by Standard 7 learners during FGDs

	Milimbo	Changamire	Chimwala	Lupetele	Chikomwe	Chimbende	Mtengeza	St Josephy	Makawa	Luwanga	Koche	Changali	Total
Notebooks/text books for all classes		√	√	√	√	√	√	√		√	√	√	**10**
Provision of desks for std 5-7			√	√		√	√	√	√		√	√	**8**
New school blocks				√		√	√		√	√	√	√	**7**
Writing ICEIDA examinations	√	√	√				√		√			√	**6**
Blackboards		√			√			√					**3**
Provision of boreholes			√								√		**2**
Received two additional teachers				√									**1**
Provision of dusters							√						**1**
Received buckets and footballs								√					**1**
Construction of pit latrines										√			**1**

Annex 3.22: Learners' benefits derived from changes in learning environment - As reported by learners during FGDs

	Milimbo	Changamire	Chimwala	Lupetele	Chikomwe	Chimbende	Mtengeza	St Josephy	Makawa	Luwanga	Koche	Changali	Total
Improved learning - books/classrooms	√				√	√	√	√			√	√	**7**
Confidence to pass MANEB exams	√	√	√				√		√			√	**6**
Improved notes taking in exercise books		√		√	√	√		√				√	**6**
No more learning outside				√			√		√		√		**4**
Improved reading - adequate text books							√	√				√	**3**
Low school drop out cases	√									√			**2**
Teachers are working hard		√								√			**2**
Learning improved with more teachers	√												**1**
Improved access to safe water			√										**1**
Balls for physical fitness/recreation				√									**1**
Reduced congestion in toilets											√		**1**
With school desks - learners love school									√				**1**
Reduction in early marriages, early pregnancies										√			**1**

Annex 3.23: Training delivered to teachers in programme schools - As Reported by teachers during KIIs

	Milimbo	Changamire	Chimwala	Lupetele	Chikomwe	Chimbende	Mtengeza	St Joseph	Makawa	Luwanga	Koche	Changali	Total
Teaching skills Std 5 - 8: English, maths, chichewa and expressive arts	√	√	√	√	√	√	√	√	√	√	√	√	**12**
Leadership skills	√		√	√	√	√	√		√	√	√	√	**10**
Physical Education	√			√	√								**3**
Assessment skills Std 1 - 8	√		√				√						**3**
Social empowerment		√	√										**2**
Interpretation of music								√					**1**
Community sensitization			√										**1**

Annex 3.24: Services delivered by teachers in programme schools after training - As reported by teachers during KIIs

	Milimbo	Changamire	Chimwala	Lupetele	Chikomwe	Chimbende	Mtengeza	St Joseph	Makawa	Luwanga	Koche	Changali	Total
Teaching English composition, Maths, and musical songs in expressive arts with confidence	√	√	√	√	√	√	√	√	√	√	√	√	**12**
Teachers know roles & responsibilities	√	√	√	√	√	√		√	√		√		**9**
Doing learners' assessment as scheduled	√		√		√	√	√	√		√			**7**
Integrating grades professionally	√						√		√	√		√	**5**
Do music interpretation		√			√			√		√			**4**
Guiding learners with leadership skills						√		√		√	√		**4**
Teaching and working as a team			√				√				√		**3**
Doing subject revisions after training					√				√				**2**
Section Heads assisting Management			√										**1**

Annex 3.25 : Perceived learners' benefits arising from trained teachers - As reported by teachers during KIIs

	Milimbo	Changamire	Chimwala	Lupetele	Chikomwe	Chimbende	Mtengeza	St Joseph	Makawa	Luwanga	Koche	Changali	Total
Improved learners' performance	√	√	√	√	√	√	√	√		√	√	√	**11**
Learners practice exams on printed copies	√		√			√			√	√			**5**
learners work hard to pass Iceida exams	√		√				√			√			**4**
Improved relationship between teachers and learners				√		√							**2**
Learners oriented to croacheting					√								**1**

Annex 3.26 : Training delivered to school governance committees - As reported by members of school governance committees during FGDs

	Milimbo	Changamire	Chimwala	Lupetele	Chikomwe	Chimbende	Mtengeza	St Joseph	Makawa	Luwanga	Koche	Changali	Total
MG: Care for girls in schools	√	√		√	√			√					**5**
MG: Re-enforcing re-admission policy								√		√	√		**3**
MG: HIV/AIDS								√					**1**
PTA: Help in construction works	√	√							√		√	√	**5**
SMC: Help in school construction, and monitor teaching and learning	√	√		√					√				**4**
SMC: Leadership and development					√	√						√	**3**

Annex 3.27 : Services delivery by trained school governance committees - As reported by members of school governance committees during FGDs

	Milimbo	Changamire	Chimwala	Lupetele	Chikomwe	Chimbende	Mtengeza	St Joseph	Makawa	Luwanga	Koche	Changali	Total
SMCs													
Moulding bricks	√	√	√	√			√		√	√		√	**8**
Encourage enrolment through sensitization	√	√	√				√	√					**5**
Help construction of teachers house	√		√									√	**3**
Monitor teaching and learning										√	√		**2**
PTAs													
Sensitize parents on teachers conduct	√							√	√		√		**4**
Promote collaboration: teachers and parents					√		√	√				√	**4**
Sensitize parents on absenteeism	√	√										√	**4**
Construction:pit latrines & teachers house	√		√								√		**3**
Moulding bricks		√	√							√			**3**
Mothers Groups													
Re-admission policy enforcement	√	√	√		√	√	√	√	√		√	√	**10**
Monitoring dressing of learners					√					√			**2**
Moulding bricks	√												**1**
Making brooms for learners' use	√												**1**

2-Wheel chairs fund raising for children with disability												√	**1**

Annex 3.28 : Perceived benefits derived by learners from trained school governance committees - As reported by members of school governance committees during FGDs

	Milimbo	**Changamire**	**Chimwala**	**Lupetele**	**Chikomwe**	**Chimbende**	**Mtengeza**	**St Joseph**	**Makawa**	**Luwanga**	**Koche**	**Changali**	**Total**
More girls going school		√	√		√				√		√	√	**6**
Improved access to soap and pads by girls	√	√	√						√			√	**5**
Reduced absenteeism	√		√										**2**
K3000 girls' management fund				√					√				**2**
Reduced early marriages						√							**1**

Terms of Reference

for the

Mid-term Evaluation

of the Project:

Mangochi Basic Services Programme 2012-2016

Project No.: MAL16050-1201

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1. Background

1.1 Overview of the project

Country:	Malawi
Project Title:	Mangochi Basic Services Programme 2012-2016
Sector:	Decentralization and rural development
Project Period:	2012-16
Sector – DAC:	
Type of Aid:	Program Based Approach
The Partners:	ICEIDA, Ministry of Local Government and Rural Development (MoLGRD) and Mangochi District Council
Implementing Institution:	District Council of Mangochi
Total Estimated Cost:	Maximum USD 13 million
Donor: ICEIDA	
ICEIDA contribution:	Up to USD 13 m
Target population:	Up to one million

1.2 Links with ICEIDA´s and Government strategy and plans

The Mangochi Basic Services Programme is subject to the tripartite partnership agreement on funding, management, implementation and monitoring, between the Ministry of Local Government and Rural Development (MoLGRD) and Mangochi District Council on behalf of the Government of Malawi (GoM) and ICEIDA on behalf of the Government of Iceland. ICEIDA has been a development partner of Malawi since 1989 and has a long history of involvement through various projects in Malawi. In Mangochi ICEIDA has been involved in fisheries, health, adult education and primary education, as well as water and sanitation. It was against this background in Manghoci that ICEIDA decided in 2010 to approach the District Council proposing a new partnership and an aid module based on Program Approach. A new Country Strategy for ICEIDA in Malawi was approved, emphasizing district approach. After extensive consultation of various stakeholders this program was formalized in 2012, with first steps taken in the implementation process by the District Council with the aid of ICEIDA.

1.3 The project, history and current status

In 2012 a tripartite cooperation agreement was signed, stating that ICEIDA will provide program based assistance to the District Council of Mangochi to achieve the goals of its development strategy in areas of social services: Water and Sanitation, Education and Public Health. The Program includes capacity building at district level which is incorporated into relevant areas of support. Specific program component documents have been developed and signed to describe the intervention in public health, water and sanitation and education, respectively. A special document covering the direct support to District administration is pending. Interventions pertaining to these (three) documents, along with the Master Document for the Program as a whole are the subject of this mid-term evaluation.

In 2012 the water and sanitation component and the public health component gradually started through the implementation efforts of the District Council. In 2013 the education intervention started after the completion of a program document.

In all the documents there is a provision for the creation of a specific Monitoring and Evaluation plan for each component and the program as a whole. This plan has been developed and integrated into the implementation process as of mid-2014. The M and E plan is also subject for this mid-term evaluation.

1.4 Changes made to the programme since the implementation start.

The program implementation started in steps in July 2012 with water and sanitation and public health. The starting of the education component took place in 2013. In early 2014 monitoring and evaluation plans for the program were finalized, but these were lagging behind the completion of program documents and initial implementation steps. A document outlining capacity building within the District structure is still not completed, but various measures in this respect have been taken as agreed between the parties. This assistance is also subject to this evaluation.

2. Evaluation Purpose

2.1 Rationale

The mid-term evaluation is planned to take stock of the first implementation steps in the new partnership between ICEIDA and Mangochi District. It will benefit all major stakeholders in assessing the progress made since the program was initiated. Recommendation will feed into the management cycle of the latter half of the program. From inception it has been the understanding of all parties that if successfull the program will continue beyond 2016. This evaluation will help prepare intervention beyond 2016.

2.2 Use and value of the evaluation

The District office and sub-offices in the three sectors will be able to use the evaluation findings to learn how they can better strengthen their implementation efforts or use ICEIDA support for a greater benefit of the end-beneficiaries of the program, the people of Mangochi. If there are any weaknesses in the District approach to the relationship with ICEIDA these can be analysed for improvement. ICEIDA will in a similar mould be able to improve its relationship with the District, in accordance with findings. Therefore, the partners may be given an opportunity to strengthen cooperation for success by having an independent, external look at how the program is managed.
The third party, the Ministry of Local Government and Rural Development (plus additional line ministries), will benefit from this exercise by observing how the program is progressing and by having a critical look at own performance within it.

It is important for this program that the interests of beneficiaries (communities and community representatives) be included in the evaluation and diverse views within communities be represented.

The inherent value of an exercise like this is to identify potential weaknesses and consolidate success in the program management and make the partners better equipped to continue the

relationship in the future. As regards community interests it will be of value for program management to have these represented in the evaluation.

2.3 Linkages with other processes

ICEIDA is already well under way in planning a District program in another partner country, Uganda. The evaluation may feed into the planning process of this program. Soon the District of Mangochi and ICEIDA may want to start discussions of what will follow after the 2012-2016 period. A mid-term evaluation will be a part of such future planning with findings that may prove beneficial in such respect.

3. Scope and focus of the evaluation

The mid-term evaluation will focus mainly on the initial implementation stages of the program as a whole from the perspective of administration, management and roles and responsibilities.

Community representation in the evaluation is also of high importance.

The evaluators must verify that activities, inputs and outputs have been delivered according to plan during the first half of the program period.

3.1 The thematic approach of the evaluation is the following:

- For the District:
- How relationships between key partners have evolved and how the administrative structure of the program is serving its purpose.
- In particular the evaluation must address the current capacity of the District Council to implement program plans in the near future, and,
- How the District is performing in relation to financial transparency and reporting as well as in relation to sound procurement practices.

- For ICEIDA:
  In respect to ICEIDA the evaluation should assess its overall competency in fulfilling its role as a donor and partner. The role of the Country office in Lilongwe and the District Office of ICEIDA in Mangochi Boma should be taken into consideration
- The role of ICEIDA as a donor with fiscal responsibilities and adherence to transparent procurement procedures shall be addressed as this is an important part of the Country Office accountability to HQ and eventually the Ministry for Foreign Affairs in Iceland.
- Given ICEIDA‘s role in monitoring and evaluating the program the evaluation should report on the strengths and potential weaknesses in its monitoring and evaluation system.

- Other stakeholders:
  The role Ministry of Local Government and Rural Development (MoLGRD) is

subject to the evaluation, and, to a lesser degree, the role of line ministries related to the program.

- The interests and views of community representatives and frontline staff of the program shall be explored and analysed, especially in relation to active involvement, and feedback to management from bottom-up through formal channels.

3.2 Specific research questions evolve around how different agents within the program have acted in relation to their roles and responsibilities as stipulated by the Master Document.

These are based on the following definition of roles and responsibilities of the Master Document:

1) **The Ministry of Local Government and Rural Development (MoLGRD)** is responsible for the tripartite agreement and will liaise with ICEIDA at central level. It has a supervisory role towards the Mangochi District Council and is ICEIDA's major partner within the GoM at central level. Therefore its role needs analysis.

Question 1.1: Has the Ministry of Local Government and Rural Development (MoLGRD) been active in its supervisory role, both in respect to liaising with the District Council and ICEIDA? Have the lines of communications been effective?

Question 1.2: Has relationship with line ministries been adequate for the progress of the program in the judgement of key informants like the District management and ICEIDA country office representatives?

2) **ICEIDA** is responsible for funding of the MBSP, providing effective partnership and monitoring on behalf of the Government of Iceland.

   Question 2.1: Has ICEIDA Country Office funded the program according to plans? Has ICEIDA effectively contributed to the monitoring of the program? Are there sufficient mechanisms for program evaluation in effect (like quality data gathering, baselines, reporting)? Has the process for financial contribution and supervision been effective? Has the program employed correct and effective measures for procurement of goods and services to satisfy ICEIDA's reporting responsibilities to HQ?

   Question 2.2: What is the role and effectiveness of ICEIDA Mangochi office in relation to the program implementation and how do the partners perceive and value the presence of this office in close proximity to the implementation offices?

3) **Mangochi District Council** implements program activities and is responsible for transparent financial administration, adherence to procurement rules and resource management.

   Question 3.1: Is there overall capacity of the District Council to effectively implement program plans? Has the District fulfilled its role as a reporting agency to

ICEIDA primarily, and the Ministry? Have procurement rules been followed? Are financial reports of the handling of ICEIDA funding transparent and in order?

4) **Several bodies** within the District Council structure have diverse roles and responsibilities in the implementation of the program. These are: The Partnership Committee which is the highest decision making body of the MBSP; District Executive Committee (DEC) which is the technical and advisory body; and Management and coordination teams in various sectors.

   Question 4.1: Have these bodies been effective in overseeing the three program components and giving direction according to their function? Has ICEIDA had any role as a donor in the work of these bodies?

5) **Technical units of the District**. The District Water Office, the District Health Office and the District Education Office are responsible for implementation at community level, and reporting in collaboration with communities, VDCs and ADCs. Correspondence and guidance takes place through Area Executive Committees (AECs), on which various extension workers serve.

   Question 5.1: These units are the ´´frontline" of the program in relation to the real beneficiaries of the program, the people of Mangochi in the communities. Of special interest here is the input of Area Executive Committees (AECs) and bodies of community representatives, VDCs and ADCs. Are the defined processes for these bodies in effect in relation to the program? It is imperative for this evaluation to address this relationship directly in order to assess the level of involvement and ownership at local level.

6) **Deliverables** according to program documents: At the present stage of the program the three program components (health, water/sanitation and education) are at different stages of maturity. Program documents are specific about expected and time based activities, inputs and outputs.

   Question 6: Has the program performed according to plans in respect to log frame activities, inputs and outputs?

3.3 Sub-questions related to program objectives can be classified as a) general and b) program component specific:

3.3.1

The following general areas of concern should be addressed:

Refer to gender checklist used in ICEIDA´s planning for a gender sensitive evaluation; similarly refer to environment document used in ICEIDA´s planning. Level of local ownership over the program deliverables and expectations about the future of the outputs/outcomes of the project needs to be analysed in terms of transparency, equitable access to services and accountability to communities.

Furthermore: Program documents stipulate that an M and E scheme will be worked out after implementation starts: Is there a working monitoring and evaluation plan in effect for the program and its components and can the evaluators establish that

sound baselines are in order for later evaluation of each of the program components?

3.3.2 The following specific areas of concern should be addressed in relation to separate program components. Given the relatively short time since implementation started the evaluators are expected to focus on deliverables at activities, inputs and output level.

A) In the public health program:

In addition to output quantification and performance analysis the evaluators should do the following to reach crucial program parts:

a) A sample of VHCs should be surveyed to evaluate local level participation, expectations and involvement in the program for the benefit of communities.
b) A sample of HSAs should be surveyed to address the importance and effect of the support to this frontline staff.
c) Sample of staff of health posts and clinics should be surveyed to evaluate the importance and effect of the program on its service delivery.
d) Staff of the DHO should be interviewed to evaluate how it is affected by the program, if supervisory role has been strengthened, how program deliverables are affecting service delivery (like ambulance services, cool-storage chain, skilled attendance to deliveries etc.)
e) For the monitoring and evaluation part of this component the key indicator of success related to reduction of maternal morbidity should be given consideration by assessing the compatibility of the ICEIDA supported baseline study of Florence Makandawire in Mangochi (2011-2012) and the District plans for enhanced capturing of maternal health data starting in 2014. [i]

B) In the water and sanitation component of the program a series of sub-questions must be addressed in addition to output quantification:

a) Is the capacity of the water district office sufficiently enhanced to effectively implement the program?
b) Is there evidence that the sanitation sensitization of communities is carried out in a manner that suits the importance of the sanitation aspect of the program? [ii]
c) A sample of WPC should be interviewed to evaluate how communities are affected by the programme.
d) A sample of HSAs should be surveyed for information on the effects of the programme on the health and general wellbeing of community members, as well as how the programme has affected sanitation practices. This can be combined with a-b) above.
e) A sample of women at water points should be interviewed to evaluate the programme's impact on their daily routines.

Care should be taken that communities provided with shallow wells, boreholes and rehabilitation of boreholes are covered in the cases of c-e)

C) In the education component of the program the following sub-questions must be addressed:

a) Is there evidence of involvement and ownership among school staff affected by the intervention? The same issue should be raised in relation to students and parents.[iii]
b) A sample of parents in programme schools surveyed to gather information on effects of programme interventions
c) A sample of students in programme schools surveyed for in order to evaluate effects of interventions
d) Several members of School Management Committees and Mother Groups interviewed
e) Dropout rates and retention rates in the programme schools should be checked and compared with figures from other non-affected schools in the district.

4. Issues to be covered

- Evaluators should use standard OECD/DAC criteria (relevance, efficiency, effectiveness, sustainability and impact).

The evaluation shall document, assess and analyze the program with reference to the following factors:

- **Relevance**. Examining relevance in to the context of:
    - National policy goals of the partner concerning the sector.
    - Refer to gender checklist used in ICEIDA's planning manual and use as a reference for a gender sensitive evaluation.
    - Refer to environment document used in ICEIDA's planning manual and use as a reference for an environment sensitive evaluation.
- **Efficiency**. Assessing the use of financial and human resources available to the program.
  Impact. By definition of a mid-term evaluation an impact assessment will have a limited bearing on this evaluation given the brief period since implementation started.
- **Effectiveness**. Examining the extent to which the Project's objectives are achieved, taking into account their relative importance and brief implementation period.
- **Sustainability.** Assessing if net benefits are likely to continue after the completion of the assistance is probably not possible except in general terms. However, the evaluators should keep this issue in mind when observing the donor – benefactor relationship. Sustainability of the institutions may be examined in terms of their absorption and retention capacity of the expertise developed under the program.

5. Methodology

The evaluators must consult available documents on the program: Agreements between partners, program Master document and the three respective component documents. In addition they must consult progress reports and additional documents that have been

developed during inception including minutes of meetings. The M and E plan of the program must be analysed.

The evaluators are expected to judge if disbursements during the inception period have been according to plan.

The evaluators are expected to interview key informants like senior staff at the District Council and in ICEIDA Country Office in-depth about program administration, management structure, communication channels, roles and responsibilities of partners.

The evaluators are expected to solicit the views of beneficiaries of the program in communities, both staff within sectors and people at community level. In this respect Area Development Committees, Village Health Committees and similar bodies are of importance. Focus groups and individuals affected by the program should be included and the selection of respondents be gender and age sensitive.

Note on methodology: Surveys and interviews with representatives of beneficiaries in communities are expected to be indicative of the situation at grassroots levels. A high degree of statistical reliability or randomization is not required at this stage. Qualitative studies with focus groups or samples of beneficiaries that can be judged to give a reasonably sound assessment of program delivery perceptions among beneficiaries will be sufficient. The Inception Report will explore the research method in details.

5.1 Information sources for new data collection

The external evaluation team is expected to conduct interviews with all key personnel involved with the planning, implementing and monitoring & evaluation of the Project, including field work in Mangochi focusing on recipients and deliverables.

The external evaluation team is expected to review key documents: project doucment, plans and reports, and minutes of key meetings (documents provided by ICEIDA)

5.2 Methods: data collection, analysis, involvement of stakeholders

The evaluation shall be conducted in accordance with the prevailing OECD/DAC Quality Standards for Development Evaluation.

The final evaluation team shall make use of appropriate empirical methods such as interviews, focus groups, and data/literature surveys to collect data, which will be analyzed using well specified judgment criteria and suitably defined qualitative and quantitative indicators (including from the logframe) as defined and described in an Inception Report.

5.3 Results expected

The results from this process are expected to provide for a better understanding of major stakeholders in the program how is best to proceed. By reporting the findings to stakeholders the evaluators will be able to facilitate communication about the process on a neutral and level ground with fair and objective analysis of the current situation.

5.4 Involvement of key stakeholders

Involvement of key stakeholders rests primarily in granting access to information through key documents and interviews. They may also have to facilitate meetings and inform secondary informants of the evaluation and its purpose to generate smooth coordination.

6. Process and Deliverables

- The overall direction of the evaluation process is for the consultants to familiarise themselves with documentation, conduct research and in-depth analysis. They will have to give draft reports to the evaluation management of ICEIDA for feedback and eventually report to stakeholders in Malawi.

  Specific milestones in the evaluation process are the following:
  - Presentation of an Inception Report to ICEIDA HQ evaluation management before the commencement of the evaluation proper
  - Interview key informants and focus groups, including doing surveys of community representatives
  - Present initial findings to evaluation management and get feedback.
  - Do a final report to stakeholders and participate in meetings about findings and lessons.

The Project is budgeted with a maximum input from the external final evaluation team of 35 days . The Evaluation is to start before the 7th of July 2014 and the final report to be presented no later than September 12th.

The deliverables in the consultancy consist of following activities and outputs:

Activities
- ✓ Review of key documents for Inception report and development of methodology delivered to evaluation managment - 5 days
- ✓ Iceida management will have five days for feedback
- ✓ Initial data gathering and analysis as per planned method with interviews and field work focusing on recipients and deliverables (in Malawi), as per planned method. -10 days.
- ✓ Preparation of first draft report and further research, delivered to evaluation managment - 5 days.
- ✓ Iceida management will have five days for feedback
- ✓ Preparation of second draft and needed additional research, -5 days.
- ✓ Iceida management will have five days for feedback
- ✓ Preparation of final report based on feedback - 5 days.
- ✓ Final adjustments of the report and two presentations in Malawi with space for feedback and corrections and completion of a final report, five days. One presentation is to be at the Lilongwe Country Office with HQ participation through teleconfering, the other with stakeholders in Mangochi.
- ✓ See appendix for dates.

Outputs
- ✓ An Inception report (template provided) detailing the method and process of the evaluation for distribution to main partners.
- ✓ First draft report for distribution to main partners. Focus on facts and preliminary results of fieldwork and interviews.
- ✓ Second draft report (based on final report template), including an outline of how feedback was addressed (structure, facts, content, conclusion).
- ✓ Presentations with stakeholders in Lilongwe and Mangochi.
- ✓ Final report (template provided), including an outline of how feedback was addressed (structure, facts, content, conslusion).

Inception report, drafts and the final report shall be formatted according to ICEIDA templates. All presentations and reports are to be submitted in electronic format in English in accordance with the deadlines set in the work plan.

ICEIDA retains the rights with respect to all distribution, dissemination and publication of the deliverables.

7. Time schedule

The deadline for submitting a complete final report is September 12th 2014.

External evaluation time is a total of 35 days for each member.

The evaluation shall start no later than July 7th 2014.

The Inception report shall be submitted no later than 5 days after consultancy has been agreed to and include a detailed description of methodological approach.

8. Managment and Logistics

The Head of Monitoring and Evaluation of ICEIDA HQ in Reykjavik is the liaison person with the consultants to whom they report.

- Logistical issues related to staffing and working conditions:
    - The consultants are responsible for their own transportation, lodging, food, cars, laptops, tape recorders. This must be costed in the budget proposal. The procurement of items of this nature for the evaluation will not be funded by ICEIDA.
    - In Mangochi the ICEIDA office can provide access to meeting rooms and assist in planning of meetings and facilitate access to contacts.
    - ICEIDA is not responsible for health or insurance related issues of the consultants and is in no way liable for risks or hazards during the evaluation period.

9. List of key documents

- Tripartite agreement between ICEIDA, the Ministry and the District Council.
- Project documents: Master documents and three program component documents.
- Progress Reports from the program bodies and by ICEIDA to HQ.
- Budgets and Action Plans
- Various technical reports as needed.

10. List of key contacts

ICEIDA staff in Malawi can give orientation to contacts.

- ICEIDA: HQs, Country office staff in Lilongwe and Mangochi Boma
- Partner: Implementing agency, staff of District.

- Beneficiaries: Representatives of bodies in communities that are affected by the program, frontline staff.
- Respective ministry contacts.
- Others who have been involved in baseline and preparation stages.

11. Evaluation team

The external final evaluation team will be comprised of two experts, one team leader, and one expert. The external final evaluation team shall be fluent in English, and at least one team member in Chichewa

Members of the external final evaluation team are expected to have between them the relevant academic qualifications, evaluation experience, thematic expertise, and competencies.

1. Advanced university degree in a relevant discipline;
2. At least 5 years experience in development programming including evaluation experience in the sector ;
3. At least 3 years experience in the sector of the program – Integrated Rural Development, decentralization and or Disrict relations in Malawi;
4. At least one of the two consultants must possess proven capacity for financial reporting and/or analysis.
5. Competencies (facilitation skills, experience of writing reports, etc)

12. Application process

- ICEIDA will invite pre-selected consultants to submit one proposal each for a team of two and budget for all activities based on this TOR. ICEIDA reserves the right to accept a team proposal or reject all. A selection committee within ICEIDA HQ will review all proposals.

[i] In 2011 ICEIDA supported the PhD research of Ms. Florence Magadawire who did a comprehensive study of the reasons for maternal deaths in Mangochi for her thesis at Liverpool University. This was at the time considered an important baseline study for the key indicator of the Public Health program since it better captured the situation on the ground than district data. In 2014 it has been planned to enhance district data capturing in this area and the compatibility of the two data sets needs to be established through verification at the DHO.

Comprehensive study of the reasons for maternal deaths in Mangohi for her thesis at Liverpool University. This was at the time considered an important baseline study for the key indicator of the Publich Health program since it better captured the situation on the ground than district data. In 2014 it has been planned to enhance district data capturing in this area and the compatability of the two data sets need to be established through verification at the DHO.

[ii] In the water project document this specific area is considered a risk, to quote::

8.2 Implementation of the sanitation component
The implementation of the sanitation components should be regarded as carrying some risks. In the ICEIDA supported health program it has been pointed out that the role of health surveillance assistants (HSAs) is not clearly defined and currently they are overloaded with responsibilities. The HSAs play an important role, together with the WMAs in implementing the CLTS training and other sanitation related activities. Thus the implementing capabilities and coordination with these extension workers is of critical importance. It furthermore essential that WMAs and HSAs work hand in hand in the implementation of water and sanitation projects among the communities in order to ensure sufficient results. Thus monitoring of activities related to the implementation of the sanitation component is vital in order to determine if further support activities for the HSAs and WMAs need to be put in place.

The Commitment by the target group, traditional leaders and committees is also of major importance in the sanitation component. The communities have to actively participate in the committees and the implementation to ensure results. An awareness campaign including sensitization meetings will be held in the communities to mobilize people.

[iii] Program monitoring has already captured data about this aspect through surveys that can be analyzed.

Appendix 1

Timeline for Evaluation period

Estimated contract completion: Week July 1-4
Start date: No later than July 7

	Duration	Delivery date
Consultants, writing Inception Report	**5**	July 11
Management: Feedback on Inception Report	*5*	July 18
Consultants: Data gathering in field	**10**	
Research analysis and writing of first draft	**5**	August 8
Management: Analysis and feedback	*5*	August 15
Response to feedback, further research, draft 2	**5**	August 22
Management analysis and feedback	*5*	August 27
Consultants: Preparation of final report	**5**	8th Sept
Consultants, Presentations, completion,	**5**	12th Sept
Consultants	**35**	

Annex 5: Evaluation Questions

Evaluative Criteria Questions	Indicators	Source	Methodology
Relevance: How does the project relate to the main objectives of development priorities of ICEIDA and at national and implementing levels?			
Programme relevance	• Consistency with ICEIDA Country strategy • Consistency with Malawi Government sector priorities • Consistency with Mangochi District Development Plans • Consistancy and responsive to vulnerabilities at community level	• ICEIDA Country Strategy document • Malawi Growth and Development Strategy II. • Mangochi District Development Plan • Baseline Report	• Documentary review and discussions with relevant officials in ICEIDA, Ministry of Local Government and Rural Development (MOLGRD), and Mangochi District Council.
Effectiveness: To what extent have the expected outcomes and objectives of the project been achieved?			
1. Supervisory role of Ministry of Local Government and Rural Development	• Coordination/ communication mechanisms established within the tripartite agreement. • Number of consultative meetings organized and chaired by the MOLGRD at central level with ICEIDA and sector Ministries (Health, Water, Education) • Framework put in place for programme monitoring, both programs and financial • No. of progress reports received, shared with partners, reviewed, and timely feedback provided . • Recommendations actions/ decisions from tripartite review meetings implemented.	Ministry of Local Government and Rural Development Coordinating Team	Key Informant Interviews with MOLGRD. **Tool in Annex 1**

2. Role of ICEIDA – Country Office	• Compliance with disbursement schedule • Framework/system put in place for programme monitoring • Framework/system in place for financial tracking, review and feedback to Mangochi District Council and MOLGRD. • Attendance at tripratite meetings organized by MOLGRD – number of meetings attended • Procurement Guidelines in place and operationalized • Recommendations/proposals submitted through tripatite meetings on improving programme delivery based on review of progress and financial reports	ICEIDA Country Office in Lilongwe	Review disbursement records **Tool in Annex 2** Progress monitoring **Tool in Annex 2** Key Informant Interviews **Tool in Annex 3**
ICEIDA – Mangochi Sub-Office	• Number of Partneship, DEC, and management and coordination meetings attended organized by Mangochi District Council • Number of progress and financial reports received, reviewed, and feedback provided. • Financial monitoring tools and schedule in place to monitore financial transactions at the District Council. • Key observations in programme implementation submitted to Mangochi District Council and District Implementing Teams for incorporation into programme operational plans. • Participation in review of operational plans and budgets organized by the District Council. • Procurement monitoring framework in place.	ICEIDA Sub-Office in Mangochi	Key Informant interviews **Tool in Annex 4**
Role of Mangochi District Council	• Number of Partneship, DEC, and management and coordination meetings organized by Mangochi District Council • Number of progress and financial reports prepared and submitted to MOLGRD and ICEIDA in a timely manner based on the reporting schedule.	Mangochi District Council Officials: District Commissioner, Director of Planning and Development, M&E and Finance Officers, DEC	Review relevant documents Key Informant interviews with District Council staff. **Tool in Annex 5**

	• Key adjustments incorporated into work plans and budgets based on programme performance. • Separate financial system (ledgers) in place for managing programme funds. • Schedule in place for reviewing programme performance and developing work plans and budgets for the following quarter. • Compliance with funds disbursement schedule • Compliance with the schedule for programme review, development of work plans and budgets. • Number of Officers assigned to coordinate MBSP implelnetation. • % timeof assigned officers spent on MBSP per week/month. • M&E personnel skills and experience in M&E • % time of M&E officer spent on MBSP. • Interface/incorporation of Area Development Commitees (ADC), Area Executive Committee (AEC) in programming and implementation.	members, etc.	Funds disbursement schedule **Tool in Annex 5** Submission of Progress reports and Financial reports to MOLGRD and ICEIDA **Tool in Annex 5**
Role of Area Development Committee (ADC) and Area Executive Committee (AEC) in programme implementation	• Number of District level planning and review meetings attended. • Participation in developing work plans and budgets • Participation in community mobilization for health, water, and education programmes at community level	Members of ADC and AEC	Focus Group Discussions **Tool in Annex 6**
Role of District Implementing Teams – DHO, DWO, DEM	• Number of Partnership meetings attended. • Compliance with progress reporting schedule • Compliance with financial reporting requirements. • Participation in review of work plans and budgets and planning for next Quarter. • Actions/recommendations from partnership	DHO, DWO, DEM	Key Informant interviews **Tool in Annex 7** Submission of Progress Reports to mangochi

	meetings and work plans and budget review meetings implemented. • Achievement of targets based on work plans. • Institutionalization of programme activities into District operational programmes. • Programme delivery strategies e.g. utilization of communitybased groups/commiitees/ and committees		District Council **Tool in Annex 7**
Programme implementation (Outcomes will be assessed under Impact)			
A. PUBLIC HEALTH PROGRAMME			
OUTPUTs • Improved infrastructure and equipment in maternal and child health services in HCs • Improved referral services • Strengthened Community based health services • Institutional capacity strengthened at the DHO • Improved/strengthened health management information system	• Health centres (%) with electricity, improved sanitation and water • Health centres (%) with safe waste disposal • Fully equipped maternity wards (% of district target, 16) • Maternity ward at MDH constructed and equipped • Proportion of district health zone having running ambulances • Proportion of HSAs trained • Proportion of HSAs with required transport and equipment • % of health facilities receiving integrated supervision quarterly and written feedback provided • % of health facilities reporting timely • Number of health workers who had undergone certified trainings • Proportion of official villages with updated village health registers • Proportion of health zones with effective internet service	Health Management Information system (HMIS) at District level	Review HMIS and use theProgramme Implementation/Activity Tracking Tool for all activities that we have developed **Tool in Annex 8**

B. WATER AND SANITATION			
OUTPUTS • At least 150 new boreholes constructed • At least 100 protected shallow wells constructed • At least 100 defunct boreholes rehabilitated. • At least 350 water point management committees trained in community based management (operations and maintenance, sanitation and organization). • At least 80% of households construct and use improved pit latrines and hand washing facilities in TA Chimwala • District system strengthened for WASH service delivery • Management systems for operations and maintenance in place at the DWO • District Water office has increased capacity and is better equiped to performa its tasks • Environmental aspects around water points and in relation to sanitation activities have been examined and addre	• # of boreholes constructed • # of households which gain access • # of shallow wells • # of households which gain access • # of boreholes rehabilitated • # of households which gain access • # of water point committees trained (50/50 gender balance) • # of refresher courses implemented • # extension workers and VHWCs trained in CLTS • % of households with improved pit latrines and hand wash facilities • # of new improved latrines in the target area • # of villages triggered • Proportion of villages verified as ODF in target area • # of follow up visits made to each water point • # of Village Area Mechanics trained and operating • Management system for O&M in place • DCT meetings held monthly • Data management system in place • M&E system in place • Strategy for availability of spare parts in place • Proportion of functioning water points in the district • # of additional WMAs employed • DWO office and staff properly equipped • Motorcycles and vehicles in place with operational guidelines • Proposal/Assessment Implementation plan	HMIS/DWO	Review of HMIS Indicators and use the Programme Implementation/Activity Tracking Tool for all activities that we have developed **Tool in Annex 8**

C. EDUCATION PROGRAMME			
OUTPUTS • Capacity building of teachers and school managers • Teaching and learning materials provided in target schools • Community mobilised for educational support • Infrastructure rehabilitated in target schools • Strengthen the role of Mother Groups in the schools • Strengthen the status of girls in schools • Support to OVCs • Increase enrolment of special needs learners into target schools • Increased attendance and participation of learners • Improved management of target schools • Capacity building and training in education management and administration • Strengthening of DEM's office operations	• # of teachers trained • # of school managers trained on school management • # of teacher trainees graduated and hired at target schools • # of schools with Talular centres • % of teachers per school actively using the teaching and learning materials developed. • # of learners have relevant textbooks • -learner/textbook ratio • # of supplementary books available for learners and actively used • # of classes using sports equipment in PE classes. • # of notebooks received by learners • Teacher/teachers' guide ratio per learning area • # of students having taken standardised tests • Number of PTAs, SMCs and MG actively participating in school management • # of theatre for development organised • # of different people invited to give a talk • # of classrooms constructed • # of teacher's houses constructed • # of improved latrines constructed • # of water and sanitation facilities installed • # of classrooms provided with school furniture • # of classrooms provided with teacher's tables and chairs • Situational analysis conducted • # of buildings maintained • # of pushbikes provided • # of mother groups receiving support • # of active mother groups • # of trainings given to mother groups • # of mother groups having been introduced to Village Savings and Loans Scheme	DEMIS/EMIS	Review of DEMIS Indicators and use the Programme Implementation/Activity Tracking Tool for all activities that we have developed **Tool in Annex 8**

	• # of exchange visits • # of girls' clubs formed • # of girls' clubs trained • # of girls' clubs engaged in interface meetings with school authorities • # of bursaries provided • retention rate of OVCs • enrolment rate of OVCs • # of scholarships provided • # of OVCs receiving psychosocial support • # of special needs children identified and supported. • - # of materials and devices provided • # of resource centres established and rehabilitated • # of teachers trained in administering deworming tablets • # of deworming tablets procured and distributed • # of schools monitored and supervised • Data management training package developed • # PEAs trained in data management. • # of staff trained in the use of ICT • # of trained PEAs		
Efficiency: Was the project implemented efficiently, in-line with international and national norms and standards?			
Programme efficiency	• Compliance with disbursement schedule • Funds/budget utilization rate • Compliance with reporting requirements • Utilization of community-based organizations/groups/commitees for programme delivery without creating new structures in the community	ICEIDA, Mangochi D Council Mangochi District Council fi Mangochi District Council District/sector Implementing Teams	**Annex 2** **Annexes 8,** **Annex 2** **Annexes 7**

Sustainability: To what extent are there financial, institutional, social-economic, and/or environmental risks to sustaining long-term project results?			
Institutionalization of programme activities	• Incorporation of operational and overhead expenses in the recurrent budgets of respective Ministries (Health. Water development, Education). • Other systems in place or being established to ensure continuity with programme activities	Mangochi District Council DHO/DWO/DEM	Key Informant Interviews **Tool in Annex 7**
Impact: Are there indications that the project has contributed to, or enabled progress toward, reduced environmental stress and/or improved ecological status?			
A. PUBLIC HEALTH PROGRAMME			
Immediate Objective (Outcome): Increased availability, access and utilization of high impact, quality maternal and child health services in mangochi district.	• Proportion (%) pregnant women starting antenatal care in the trimester of pregnancy • Deliveries (%) attended to by skilled health workers • Proportion (%) of under five children fully immunized • Proportion (%) pregnant women tested for HIV	• HMIS and Health Centres Records • HMIS and Health Centres Records • HMIS and Health Centres Records • HMIS and Health Centres Records	• HMIS updated district indicators • MTE secondary data from supported Health Centres (**Tool in Annex 9).** • Caregivers/Mothers satisfaction with health services delivery in their area **Tool in Annex 9** • FGDs with HSAs (**Tool Annex 9**) • FGDs with VHCs (**Tool Annex 9**)

	B. WATER AND SANITATION PROGRAMME			
	Immediate objective (Outcome): **Increased and sustainable access to and use of safe water sources and improved sanitation in TA Chimwala.**	• Proportion of households with access to improved and safe water in target area • Proportion of households with access to an improved sanitation facility in target area • Proportion of villages verified as ODF in target area • Reduction in waterborne diseases in target area • Time savings for women and girls as a result of new water points	HMIS/DWO	HMIS District data • Caregivers survey in communities where boreholes and shallow wells ahave been installed **Tool in Annex 10** • FGDs with WPMCs (**Tool Annex 10**)
	C. EDUCATION PROGRAMME			
	Immediate Objective (Outcome): **Improved quality of education in target schools to reduce drop-out and repetition and promote effective learning**	• Retention rate of learners in target schools • Promotion % of learners • Pass rate, % of learners at each grade level passing/taking exams • Selection rate for secondary school (% of learners in std.8 who get selected)	DEMIS	Review of DEMIS MTE Schools Survey **Tool in Annex 11**

Annex 6: Itenerary for the MBSP Mid-Term Evaluation

Date	Activity
30 June 2014	First meeting at ICEIDA's Country Office in Lilongwe. Meeting held to assess my experience in consultancy work with regard to health and education issues. During the meeting it was also agreed that the completion date should be shifted by 4 days to allow for more analysis of collected data. The completion date was therefore set as 16 September 2014.
14 July	Travelled to Lilongwe; signed contract; held preliminary discussions with ICEIDA; arranged meetings with stakeholders in Lilongwe.
15 July	Held discussions with ICEIDA; Documentary Review.
16 July	Held discussions at the Ministry of Local Government and Rural Development; Continued with documentary review and development of tools
17 July	Made logistical arrangements – vehicle hire and photocoying arrangements Documentary review and finalization of tools.
18 July	Made final arrangements for hired vehicle; and photocopying was completed for the Mid-Term Evaluation tools. Also made arrangements with Research Assistant's travel.
19 July	Documentary review.
20 July	Travelled to Mangochi, held initial meeting with Research Assistants – preliminary introduction to the evaluation tools.
21 July	Held introductory meeting with ICEIDA, District Council, and District Implementing Teams; Oriented Research Assistants to evaluation tools; Mapped out field travel logistics with ICEIDA mangochi Office.
22 July 23 july 24 July 25 July 26 July 27 July 28 july 29 july 30 July 31 july	FIELD DATA COLLECTION IN MANGOCHI INCLUDING STAKEHOLDER DISCUSSIONS WITH THE DISTRICT COUNCIL AND DISTRICT IMPLEMENTING TEAMS Several meetings were held with District Council, DCTs, HMIS, DEMIS and DWO to get information on outputs, funds utilization, and other variables. Evenings were spent with data technician to ensure we were on the same page especially on FGDs and KIIs data entry on Excel Spreadsheets. DATA ANALYSIS
01 August	Return to Lilongwe; off-hired vehicle; travelled to Mzuzu.
02 August 03 August 04 August 05 August 06 August	DATA ANALYSIS AND PREPARATION OF DRAFT REPORT

Date	Activity
07 August	
08 August	
09 August	
10 August	
11 August	
12 August	SUBMISSION OF DRAFT 1 REPORT TO ICEIDA
17 August	PREPARATION OF DRAFT 2 REPORT
18 August	
19 August	
20 August	
21 August	SUBMISSION OF DRAFT 2 REPORT TO ICEIDA
29 August	PREPARATION OF FINAL DRAFT
30 August	
31 August	
1 September	
2 September	
3 September	
4 September	
5 september	
6 September	
7 September	SUBMISSION OF FINAL DRAFT
11/12 September	Presentation of Report in Lilongwe

Annex 7: List of People Interviewed during the Mid-Term Evaluation

NAME	**ORGANIZATION**	**POSITION**	**LOCATION**
Dr V. Wiium	ICEIDA	Country Director	Lilongwe
Dr Gudmundur Runar Arnason	ICEIDA	Programme Director	Lilongwe
Linley Magwira (Mrs)	ICEIDA	Finance & Administration Manager	Lilongwe
Levi Soko	ICEIDA	Senior Programme Officer	Mangochi
Kiswell D. Dakamau	Ministry of Local Govt & RD	Director of Local Government Services	Lilongwe
B. C Mandele	Mangochi District Council	District Commissioner	Mangochi
Ernest Kadzokoya	Mangochi District Council	Ag Director of Planning & DEV	Mangochi
Geoffrey Chilenga	Mangochi District Council	Monitoring & Evaluation Officer	Mangochi
Dave J Matola	Mangochi Diistrict Council	Ag Director of Finance	Mangochi
Cleverson K Nyando	Mangochi District Council	Chief Public Works Officer	Mangochi
Dr William Peno	Mangochi District Hospital	District health Officer	Mangochi
Steven Masiano	Mangochi District Hospital	Principal Health Services Administrator	Mangochi
J.W. Kumbukani	Manngochi District Hospital	Assistant Health Services Administrator	Mangochi
Kondwani Chilopa	Mangochi District Hospital	HMIS Officer	Mangochi
Kondwani Andrea	Mangochi District Water Dev Office	District Water Development Officer	Mangochi
Sam Kalanda	District Education Managem Office	District Education Manager	Mangochi
Joe Magombo	District Education Managem Office	Deputy District Education Manager	Mangochi
Andrew Matendeu	District Education Managem Office	District Education MIS Officer	Mangochi
Field - Health			
F. Kapinga	Monkey-Bay Community Hospital	Hospital In-charge	Monkey Bay
Zacheous Solomoni	Monkey-Bay Community Hospital	Ag Environmental Health Officer	Monkey Bay
P Ng'oma (Mrs)	Monkey-Bay Community Hospital	Health Surveillance Assistant (HSA)	Monkey Bay
F. Ganeti	Monkey-Bay Community Hospital	Health Surveillance Assistant (HSA)	Monkey Bay
M. Nanundu	Monkey-Bay Community Hospital	Health Surveillance Assistant (HSA)	Monkey Bay
M. Mbonongo	Monkey-Bay Community Hospital	Health Surveillance Assistant (HSA)	Monkey Bay
R. Wengawenga	Monkey-Bay Community Hospital	Health Surveillance Assistant (HSA)	Monkey Bay
A. Kagone	Monkey-Bay Community Hospital	Health Surveillance Assistant (HSA)	Monkey Bay
Clement Masombeta	Nankhumba Health Cetre	Medical Assistant	Nankhumba
Patrick Malita	Nankhumba Health Cetre	Health Surveillance Assistant (HSA)	Nankhumba
Martin Kawondo	Nankhumba Health Cetre	Health Surveillance Assistant (HSA)	Nankhumba
Thomsom Materechela	Nankhumba Health Cetre	Health Surveillance Assistant (HSA)	Nankhumba
Maxwell Manda	Nankhumba Health Cetre	Health Surveillance Assistant (HSA)	Nankhumba
Jonathan Tsukambale	Nangalamu Health Centre	Nurse	Nangalamu
Elise Dongwe	Nangalamu Health Centre	Nurse	Nangalamu
Chikhulupililo Kachingwe	Nangalamu Health Centre	Medical Assistant	Nangalamu
Steven Abillu	Nangalamu Health Centre	Health Surveillance Assistant (HSA)	Nangalamu
Willard Makiyi	Nangalamu Health Centre	Health Surveillance Assistant (HSA)	Nangalamu
Priscilla Nkhomanya	Nangalamu Health Centre	Health Surveillance Assistant (HSA)	Nangalamu
Afiya Yambani	Nangalamu Health Centre	Health Surveillance Assistant (HSA)	Nangalamu
Ellias Gondwe	Chilipa Health Centre	Medical Assistant	Chilipa
Anne Kambuku	Chilipa Health Centre	Nurse	Chilipa
Gladys Kazombe	Chilipa Health Centre	Health Surveillance Assistant (HSA)	Chilipa
Hadjison Kasimu	Chilipa Health Centre	Health Surveillance Assistant (HSA)	Chilipa
Agness Chinkondenji	Chilipa Health Centre	Health Surveillance Assistant (HSA)	Chilipa
Chrispin Kapu	Nancholi Health Centre	Medical Assistant	Nancholi
Anthoby Khauke	Nancholi Health Centre	Health Surveillance Assistant (HSA)	Nancholi
Rose Moffat Mogoya	Nancholi Health Centre	Health Surveillance Assistant (HSA)	Nancholi
Iman hilarly	Nancholi Health Centre	Health Surveillance Assistant (HSA)	Nancholi
Robert Akim	Nancholi Health Centre	Health Surveillance Assistant (HSA)	Nancholi
Gift Jalasi Chanasi	Nancholi Health Centre	Health Surveillance Assistant (HSA)	Nancholi
Tumpale Ghambi	Nancholi Health Centre	Health Surveillance Assistant (HSA)	Nancholi

NAME	**ORGANIZATION**	**POSITION**	**LOCATION**
George Stenala	Mtimabi Health Centre	Medical Assistant	Mtimabi
Adamson Anubi	Mtimabi Health Centre	Nurse	Mtimabi
Peterson Chinyama	Mtimabi Health Centre	Health Surveillance Assistant (HSA)	Mtimabi
Peter Buledi	Mtimabi Health Centre	Health Surveillance Assistant (HSA)	Mtimabi
F. Manyungwa	Namwera Health Centre	Nurse Midwife Technician	Namwera
V. Kumbuyo	Namwera Health Centre	Nurse Midwife Technician	Namwera
Luckia Gonani	Namwera Health Centre	Health Surveillance Assistant (HSA)	Namwera
Stella Shauli	Namwera Health Centre	Health Surveillance Assistant (HSA)	Namwera
Mike Matewere	Namwera Health Centre	Health Surveillance Assistant (HSA)	Namwera
Cecilia Chilumpha	Namwera Health Centre	Health Surveillance Assistant (HSA)	Namwera
Grace Simwaka	Namwera Health Centre	Health Surveillance Assistant (HSA)	Namwera
Jenala Mobe	Katuli Health Centre	Medical Assistant	Katuli
Innocent Pagonegone	Katuli Health Centre	Nurse	Katuli
Afera Samson	Katuli Health Centre	Health Surveillance Assistant (HSA)	Katuli
Joyce Willy	Katuli Health Centre	Health Surveillance Assistant (HSA)	Katuli
Omar Fazili	Katuli Health Centre	Health Surveillance Assistant (HSA)	Katuli
Feston Sinosi	Katuli Health Centre	Health Surveillance Assistant (HSA)	Katuli
Paul Chinguwo	Jalasi Health Centre	Medical Assistant	Jalasi
Lynole Mphwatika	Jalasi Health Centre	Nurse Midwife Technician	Jalasi
Ellen Mwaseteza	Jalasi Health Centre	Nurse Midwife Technician	Jalasi
E. White (Mrs)	Jalasi Health Centre	Health Surveillance Assistant (HSA)	Jalasi
T. Phiri	Jalasi Health Centre	Health Surveillance Assistant (HSA)	Jalasi
Asnet Chikwete	Chikole Health Centre	In-Charge	Chikole
Charles Saiwala	Chikole Health Centre	Nurse	Chikole
Elizabeth Jumbe	Chikole Health Centre	Health Surveillance Assistant (HSA)	Chikole
Millis Pikison	Chikole Health Centre	Health Surveillance Assistant (HSA)	Chikole
Maggie Naphambo	Chikole Health Centre	Health Surveillance Assistant (HSA)	Chikole
Joyce Chakhaza	Chikole Health Centre	Health Surveillance Assistant (HSA)	Chikole
Innocencia Jobe	Malombe Health Centre	Medical Assistant	Malombe
Biswick Chipokosa	Malombe Health Centre	Health Surveillance Assistant (HSA)	Malombe
Eveness omar	Malombe Health Centre	Health Surveillance Assistant (HSA)	Malomba
Sapulayi Gomani	Kukalanga Health Centre	Health Surveillance Assistant (HSA)	Kukalanga
Dorothy Chimphambe	Kukalanga Health Centre	Health Surveillance Assistant (HSA)	Kukalanga
Ronex Gama	Kukalanga Health Centre	Health Surveillance Assistant (HSA)	Kukalanga
Brenda Nkhupu	Kukalanga Health Centre	Health Surveillance Assistant (HSA)	Kukalanga
Water and Sanitation			
Emi Duwa	District Water Development Office	Water Monitoring Assistant (WMA)	Stephen Village
Mabvuto M'mamga	District Water Development Office	Water Monitoring Assistant (WMA)	Changali Village
Agness Kotima	District Water Development Office	Water Monitoring Assistant (WMA)	Mtimabi
Brian Kawerenga	District Health Office	Health Surveillance Assistant (HSA)	Changali Village
Vincent Dumba	District Health Office	Health Surveillance Assistant (HSA)	Mawanga Village
Supply Gomani	District Health Office	Health Surveillance Assistant (HSA)	Mwalija village
Stella Mazengela	District Health Office	Health Surveillance Assistant (HSA)	Ndsege village
Dorica Simati	District Health Office	Health Surveillance Assistant (HSA)	Changamire Village
Lilian M'mera	District Health Office	Health Surveillance Assistant (HSA)	Mwachikumbata vge
Emmanuel Tembo	District Health Office	Health Surveillance Assistant (HSA)	Mpembena Village
Peterson Chinyama	District Health Office	Health Surveillance Assistant (HSA)	Kuhotelo Village
Peter Buledi	District Health Office	Health Surveillance Assistant (HSA)	Kuhotelo Village
Education – Teachers Programme Schools			
Fostino Kabango	Chikomwe School	Headmaster	Chikomwe
Chikondi Mapanga	Chikomwe School	Teacher	Chikomwe
Cassim Idrissa	Chikomwe School	Teacher	Chikomwe

NAME	**ORGANIZATION**	**POSITION**	**LOCATION**
Ruth Maulidi	Chikomwe School	Teacher	Chikomwe
Eneless Nahano	Chikomwe School	Teacher	Chikomwe
Khadija Chisisi	Chikomwe School	Teacher	Chikomwe
Madam Sungapako	Chikomwe School	Teacher	Chikomwe
Madam Joyce Chingwalu	Chikomwe School	Teacher	Chikomwe
Anthony Sikawa	Mtengeza School	Head Teacher	Chikomwe
Alex Godffrey	Mtengeza School	Deputy Head Teacher	Chikomwe
Harrison Mannuel	Mtengeza School	Teacher	Chikomwe
Richard Pamanda	Mtengeza School	Teacher	Chikomwe
Jackson Gumbala	Chimbende School	Head Teacher	Chimbende
Agness Mkali	Chimbende School	Deputy Head teacher	Chimbende
Frank Malowa	Chimbende School	Section Head	Chimbende
Lovemore Phiri	Chimbende School	Section Head	Chimbende
John Phiri	St Joseph School	Head Teacher	St Joseph
Anthony Mpwasiwa	St Joseph School	Deputy Head Teacher	St Joseph
D. Mkwala	St Joseph School	Teacher	St Joseph
J. Matewere	St Joseph School	Teacher	St Joseph
K. Marko	St Joseph School	Teacher	St Joseph
W. Mndala	St Joseph School	Teacher	St Joseph
A. binoni	St Joseph School	Teacher	St Joseph
Charles Mkunga	Milimbo School	Head Teacher	Milimbo
Chiyankhulitso L. Banda	Milimbo School	Deputy Head Teacher	Milimbo
Maymouna Hussein	Milimbo School	Second Deputy Head Teacher	Milimbo
Laws Nalikata Mbewe	Milimbo School	Teacher	Milimbo
Steve Magetsi	Milimbo School	Teacher	Milimbo
Kettie Mwitha	Milimbo School	Teacher	Milimbo
Ronald Tsine	Milimbo School	Teacher	Milimbo
Thomas Awazi	Milimbo School	Teacher	Milimbo
Douglas Masimbe	Lupetele School	Head Teacher	Lupetele
Monica Allie	Lupetele School	Deputy Head Teacher	Lupetele
Meya Amadu	Lupetele School	Section Head	Lupetele
Saimon Kadyampakeni	Lupetele School	Teacher	Lupetele
Andrew Mbewe	Lupetele School	Teacher	Lupetele
M. Mhango	Lupetele School	Teacher	Lupetele
Iva Galilea	Lupetele School	Teacher	Lupetele
Veregina Mbando	Lupetele School	Teacher	Lupetele
Symon Mateme	Koche Model School	Head Teacher	Koche
Ronald Mkwichi	Koche Model School	Deputy Head Teacher	Koche
Mr Wizilamu	Koche Model School	Teacher	Koche
Mr Thewe	Koche Model School	Teacher	Koche
Mr S. Mbalu	Koche Model School	Teacher	Koche
Mrs Kumilambe Nyasulu	Koche Model School	Teacher	Koche
Mrs M. Butao	Koche Model School	Teacher	Koche
Mrs Magombo Salanje	Koche Model School	Teacher	Koche
Peter Kawaga	Lwanga School	Head Teacher	Lwanga
Ludzu Numori	Lwanga School	Deputy Head Teacher	Lwanga
Lennex Zuze	Lwanga School	Teacher	Lwanga
J. B. Nyaluwa	Lwanga School	Teacher	Lwanga
Chrissie Mzumara	Lwanga School	Teacher	Lwanga
Neliana Bwanali	Lwanga School	Teacher	Lwanga
George Kumbama	Lwanga School	Teacher	Lwanga
Mathias Kamwendo	Lwanga School	Teacher	Lwanga
C A Banda	Lwanga School	Teacher	Lwanga
Prisca Kumwanje	Lwanga School	Teacher	Lwanga
Rosemary Mulenga	Makawa School	Head teacher	Makawa
Faiti Mbwana	Makawa School	Deputy Head Teacher	Makawa

NAME	**ORGANIZATION**	**POSITION**	**LOCATION**
Mzuzu Magombo	Makawa School	Second Deputy Head Teacher	Makawa
James Banda	Chimwala School	Deputy Head Teacher	Chimwala
Cecilia Chigumula	Chimwala School	Section Head	Chimwala
Edward Mbewe	Chimwala School	Section Head	Chimwala
Edina Kambwewa	Chimwala School	Section Head	Chimwala
Isaac Chaziko	Chimwala School	Teacher	Chimwala
Laston Kholowa	Chimwala School	Teacher	Chimwala
Kondwani Chikwembani	Chimwala School	Teacher	Chimwala
Mary Machemba	Chimwala School	Teacher	Chimwala
Stein Nthanda	Chimwala School	Teacher	Chimwala
Calorine Mponda	Chimwala School	Teacher	Chimwala
Stella Ngomanya	Chimwala School	Teacher	Chimwala
Alexandra Khonje	Chimwala School	Teacher	Chimwala
Edina Audi	Changamire School	Head Teacher	Changamire
Mervis Sando	Changamire School	Deputy Head Teacher	Changamire
J Mtifikanji	Changamire School	Teacher	Changamire
J Madiwati	Changamire School	Teacher	Changamire
D Chiwalo	Changamire School	Teacher	Changamire
K Linje	Changamire School	Teacher	Changamire
M Kanthalo	Changamire School	Teacher	Changamire
G Mtambalika	Changamire School	Teacher	Changamire
R ndovie	Changamire School	Teacher	Changamire
Edson Mwanyausi	Changali School	Head Teacher	Changali
P H J Magola	Changali School	Teacher	Changali
C Chisale	Changali School	Teacher	Changali
E Kanama	Changali School	Teacher	Changali
B J Makungwa	Changali School	Teacher	Changali
Teachers : Non-Programme Schools (Control)			
C Msonkho (Mrs)	Mtonda school	Head Teacher	Mtonda
M. Nankhumba	Mtonda School	Deputy head Teacher	Mtonda
Joseph Chipanga	Nasenga School	Head Teacher	Nasenga
Kenneth Magasa	Nasenga School	Deputy Head Teacher	Nasenga
Matsimbe Alubi	Ulande School	Head Teacher	Ulande
Tiger Nopson	Ulande School	Deputy Head Teacher	Ulande
Maston Mathewe	Mikombe School	Head Teacher	Mikombe
Samson Deverson	Mikombe School	Deputy Head Teacher	Mikombe
William Mputa	Miwawe School	Head Teacher	Miwawa
Alayika Phiri	Miwawe school	Deputy Head Teacher	Miwawa
Collings Masauko	Makumba School	Head Teacher	Makumba
Gloria Ndiwaliwa	Makumba School	Deputy Head Teacher	Makumba
Victoria Ngunga	Makumba School	Second Deputy head Teacher	Makumba
Mary Kachoka	Kausi School	Head Teacher	Kausi
Geoffrey Njelule	Kausi School	Deputy Head Teacher	Kausi
Moon Kandiero	Nasite School	Head Teacher	Nasite
Patricia Kasambala	Nasite School	Deputy Head Teacher	Nasite

Annex 8: List of People that were present during Draft 3 Presentation on 17 September 2014 at ICEIDA Country Office in Lilongwe

NAME	**ORGANIZATION**	**POSITION**
Dr Gudmundur Runar Arnason	ICEIDA	Programme Director
Linley Magwira (Mrs)	ICEIDA	Finance & Administration Manager
Levi Soko	ICEIDA	Senior Programme Officer
S'dey Hsgeiksdoltir	ICEIDA	Intern
Harnet Gondwe	ICEIDA	Accountant
Mphatso Sokosa	ICEIDA	M&E Officer
Kondwani Andreah	Mangochi District Council	District Water Development Officer
Ernest Kadzokoya	Mangochi District Council	Director of Planning and Development
Sam Kalanda	Mangochi District Council	District Education Manager
Geoffrey Chilenga	Mangochi District Council	M&E Officer
Davison Matola	Mangochi District Council	Ag Director of Finance

Annex 9: List of Documents Reviewed

1. ICEIDA - Mangochi Basic Services Programme – Master Document (2012 -2016).
2. ICEIDA – Partnership Agreement (2012-2016)
3. ICEIDA - Mangochi Basic Services Programme – Health Design Document (2012 – 2016)
4. ICEIDA - Mangochi Basic Services Programme – Water and Sanitation Design Document (2012 – 2016).
5. ICEIDA - Mangochi Basic Services Programme – Education Design Document (2012 – 2016).
6. Mangochi District Council - Mangochi District Development Plan (2012 – 2016)
7. Mangochi District Council - Mangochi Socio-Economic Profile (Draft)
8. National Statistical Office - Malawi Demographic and Health Survey (MDHS) 2010
9. National Statistical Office - Integrated Household Survey 3 (2010 – 2011)
10. National Statistical Office - Education Management Information System (EMIS) – 2010
11. Mangochi District Hospital – HMIS
12. District Education Manager's Office – DEMIS

Annex 10: Bibliography

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2. Ministry of Health Canada: *Guide to Project Evaluation, A Participatory Approach*, August 1996.
3. Olive Publications: *Planning for Monitoring and Evaluation*, South Africa, April 2002.