Mangochi Basic Services Programme

comprising

i. Partnership in Water and Sanitation

ii. Partnership in Public Health

iii. Partnership in Education

FINAL REPORT

[V2]

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Executive Summary

The MBSP was relevant when it was designed and remained so at the time of the evaluation. The three component projects responded to critical aspects of the DDP, the overarching Vision 20/2020 and the Malawi Growth and Development Strategy II. The programme and its component parts were in line with the ICEIDA – GOM Country Strategy Paper, 2012 – 16 and with Iceland's Strategy for Development Cooperation, 2011 – 14 as well as being designed in accordance with Iceland's international commitments. The three project logframes are individually logically coherent, generally have SMART indicators and also have the potential to be utilitarian project management tools.

The mid-term review (MTR) concluded that the projects were generally efficient and reflected a utilitarian flow of funds. The final evaluation broadly concurs with this view. While there have clearly been hiccups in respect of both the education and health projects, the resources have been utilised in accordance with plans and the infrastructure, albeit some of questionable quality, delivered.

ICEIDA pursued an unusual budgetary approach, establishing totals in accordance with emergent needs in the light of Malawi's economic crisis, exacerbated post-Cashgate. At the very least, the experiment in flexible budgeting proved costly with overruns in excess of the initial estimates.

The evaluation concurs with the MTR's conclusion that the MBSP has been effective. While there have been challenges, the overall picture presented through field work and documentary review is the (over)achievement of most targets and the delivery of the identified outputs. These outputs have proved a substantial contribution to the achievement of the MBSP outcomes. All three sets of gains are clear evidence of effectiveness.

If the three projects fell short in any regard in terms of contributing to MBSP outcomes, it was in respect to the reality that the provision of staff housing was inadequate to respond to both existing and future demand.

Overall, the evaluation is of the opinion that there is clear indication that the MBSP has contributed to achieving impact. Data clearly shows increased enrolment and declining drop out in the targeted schools. More expectant mothers are attending ANCs and delivering their babies at health centres. This has contributed to a decline in maternal mortality and increased access to emergency obstetric care. While the number of still births has remained roughly constant over the project's life, this is probably due to better recording of still births. Lastly, the increased access to and utilisation of potable water has seen water borne diseases no longer perceived as a major cause of morbidity in the district. Clearly, the additional (new and rehabilitated) boreholes and protected shallow wells has been a contributory factor in this regard.

In the evaluation's view, sustainability is possible but it is dependent on there being the political will to ensure that maintenance and additional salaries are prioritised so as to achieve it. Furthermore, community partnership has to be a priority in the way the Council carries out its responsibilities, building and deepening existing partnerships.

Lessons Learned

Four key lessons emerge from the foregoing review. First, despite the clear attempt to avoid this (limiting the sub-sector scope of the health project and the number of schools in the education one), as it turned out both were spread too thin. Second, greater concentration potentially would have resulted in greater benefits, albeit possible for a fewer number of immediate beneficiaries. Third, it is clearly desirable to ensure coherence between all aspects of an intervention. Finally, it is apparent that infrastructure and training is inadequate to achieve the education outcome.

Spread too thin

In both the education and health sectors, the MBSP sought to provide infrastructure. In neither case was the infrastructure delivered sufficient to ensure that

a) all learners were taught in classrooms (in most at least two classes were either taught outside or under open-sided shelters);

b) sufficient maternity and delivery beds were available to meet existing need; or

c) housing was adequate to meet existing, not to say desirable, staffing levels in either education or health sectors.

Greater Concentration

The foregoing strongly suggests even greater concentration than that attempted under the MBSP. Concentration is always a trade-off between total numbers and short- and medium term impact. The evaluation believes that the MBSP experience underl1ines the need to revisit this on a regular basis.

Coherence

The core message of the sanitation sub-project, including its associated ODF effort, was the central importance of sanitary practices at home, in school and in the wider community. This message needs to be reinforced at every opportunity and continuously, if it is to become embedded in everyday life. The absence of hand-washing facilities, particularly in government institutions, especially health centres, undermines the message for the users of these institutions.

Attitudinal Change Paramount

It is critical to tailor the intervention to the root causes of the challenge. The education intervention sought to improve education participation through improved infrastructure and teacher performance, leading to improved learner educational outturn. These are important influences on the expected result; but they fail to really address the root cause of the challenge: parental disinterest in their children's education.

Such attitudes need addressing if the education outcome is to be successfully and sustainably addressed. DoE acknowledges it has a problem mobilising communities in support of education. Given the deep-rooted social attitude in favour of income generation and lack of visible evidence of the success potential of education, there is a need for an increased number of (Muslim) role models in this regard.

Recommendations

1) Require the contracted consultants to make good the necessary repairs and/or repair the identified defaults identified in the technical audit.
2) Conduct a technical audit of all new and rehabilitated boreholes to identify any shortcomings; require the consultants to make necessary repairs.
3) Prepare and maintain a reliable map referencing all safe water points in the district.
4) If not already done, absorb onto the government payroll all teachers, WMAs and other staff recruited through the programme.
5) If not already done, absorb onto the district council budget all maintenance and travel costs in respect of vehicles procured through the project.
6) Establish a list of unsatisfactory contractors based on objective measures of performance and ethical behaviour.
7) Measures need to be taken to address any technical competence issues in the Public Works Department and the Clerk of Works office, in particular, commencing with a thorough needs assessment of the Clerk of Works office and, should it be necessary, competent technical support to ensure necessary, but absent, technical skills are developed.
8) Develop means to address the community's negative/disinterested attitudes to education, including identifying suitable role models of value-added through education.
9) Consider mechanisms to address gaps, particularly in class room and staff housing provision, identified in the course of the MBSP.
10) Develop a decentralised pilot fund to support minor maintenance at health centres based on the principals established through the School Fund.

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Notwithstanding the support received, the consultants are responsible for any misunderstandings or misinterpretations that may be present within the report.

Acronyms

ADC	Area Development Committee
AEC	Area Executive Committee
ARI	Acute Respiratory Infections
c.	circa
CD	Country Director
CHAM	Christian Health Association of Malawi
CLTS	Community Led Total Sanitation
CSO	Civil Society Organisation
CSP	Country Strategy Plan
DC	District Commissioner
DDF	District Development Fund
DDP	District Development Plan
DDP	District Development Plan
DEM	District Education Manager
DEMIS	District Education Management Information System
DHO	District Health Officer/Office
DHS	Demographic and Household Survey
DIP	District Implementation Plan
DoA	Director of Administration
DoE	Director of Education
DoF	Director of Finance
DPD	Director of Planning & Development
DWDO / DWO	District Water Development Office/Officer
EMIS	Education Management Information System
EP	Extended Programme for Immunization
GoM	Government of Malawi
HAC	Health Centre Advisory Committee
HC	Health Centre
HHs	Households
HIS	Integrated Household Survey
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
IPC	Internal Procurement Committee
M&E	Monitoring and Evaluation
MBSP	Mangochi Basic Services Programme
MGDS	Malawi Growth and Development Strategy
MHDC	Mangochi District Council
MKW	Malawi-Kwacha
MoEST	Ministry of Education Science and Technology
MoF	Ministry of Finance
MoH	Ministry of Health
MoLGRD	Ministry of Local Government and Rural Development
MTE	Mid-Term Evaluation
MTR	Mid-term review
NGO	Non-Governmental Organization
ODPP	Office of the Director of Public Procurement
OVC	Orphans and vulnerable children
SIP	School Improvement Programme
SMC	School management committee
SPSS	Statistical Package for Social Scientists
TA	Traditional Authority
TAULAR	Teaching and Learning Using Locally Available Resources
TBA	Traditional Birth Attendants
TOR	Terms of Reference
VDC	Village Development Committee
VHC	Village Health Committee
VHR	Village Health Register
WASH	Water, Sanitation and Hygiene
WATSAN	Water and Sanitation
WMA	Water Monitoring Assistant
WPMC	Water Point Management Committee

CHAPTER 1 Introduction

1.1 Background

Malawi has been a bilateral partner country in Icelandic development cooperation since 1989. In the beginning, the focus was entirely on development in the fisheries sector but around the turn of the century ICEIDA's strategy changed in accordance with international commitments such as the UN Millennium Development Goals (MDGs) and increased emphasis was placed on providing support to the social sector. A large part of ICEIDA supported operations in Malawi have been carried out in Mangochi District, with focus on the Monkey Bay area within Nankumba Traditional Authority (TA) (see annex 2 for Mangochi Overview). ICEIDA's assistance has until now mostly been in the form of direct project support in cooperation with various line ministries. In general the support has included provision of funds as well as technical assistance. Project management and disbursement of funds to activities were principally in the hands of ICEIDA. In 2011, three ICEIDA supported projects in Mangochi came to an end: Adult Literacy Programme (ALP), Water and Sanitation (WATSAN), and the development of the Monkey Bay Community Hospital (MBCH) was phased out in beginning of 2012.

In 2012 a formal district cooperation programme was started in Mangochi District in Malawi, building on previous development cooperation projects, which had been implemented in the district. The chosen approach has placed MFA-ICEIDA as a key external partner to the district authority and as the single largest financier of investments in social infrastructure, such as water and sanitation, education, and maternal and child health. Financing for capacity building and administrative strengthening of the district administration has also been provided.

A Country Strategy Plan (CSP) 2012-2016 (extended to 2018) for cooperation between Iceland and Malawi was approved by the Ministry for Foreign Affairs in Iceland and Government of Malawi. The CSP is aligned with the Malawi Growth and Development Strategy 2011-2016 (MGDS II) of the Government of Malawi. Prior to MBSP, ICEIDA had been collaborating on various development projects in the Monkey Bay area of Mangochi district. The Mangochi Basic Services Programme (MBSP) was subject to 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.

1.1.1 District Characteristics

Mangochi District is situated at the southern end of Lake Malawi and is one of 13 districts in the Southern Region. It lies within a savannah woodland, with baobab trees dominating the lakeshore areas. 23% of the total land area is forested. Deforestation is a growing problem. The district is approximately 200 km northeast of Blantyre, a major commercial and industrial city in the country. Mangochi has a total land area of 6,273 km2 and covers approximately 6.7% of the country's land area. The district is divided into nine so called Traditional Authorities (TA) or parishes. Yao are the predominant ethnic group, concentrated in TA Makanjira, Jalasi, Katuli, Chowe, Chimwala, Mponda and Nankumba. The Nyanja or Chewa have a significant presence in TA Nankumba. The Ngoni, Tonga, Lomwe and Tum-

buka are also found in the District. Yao is the main language spoken, although most people in Mangochi understand Chichewa and over 50 % of the population speak Chichewa. The predominant faiths in the District are Islam (71%) and Christianity (28%). Traditional religions and practices are also evident especially during times of stress such as during drought and flooding. Religion plays important role in the daily life of people.

The 2011 population of Mangochi was about 800.000 (mid-2015: 1 017 070) and ranks among the poorest in Malawi (60.7%, 2015). The dependency age group of younger than 17 years is 57% of the total population while that over 65 years comprises 4%. Nearly one-third of households (mean 4/HH) are female headed. Literacy rate for age group 18 years and over is 49%. Although the age group of 3-29 years has a total of 493,000 potential students, only 150,730 (44%) of this population attend school. Thus only 31% of the total number of school-aged boys and 29% of the total number of school-aged girls attend school. There has been an increase in HIV infected persons accessing anti- retro-viral treatment from 3% in 2000 to 65% in 2011. The Health Sector Strategic Plan 2011-2016 ranked Mangochi fourth lowest among Malawi's 28 districts as regards access to health services.

Agriculture and natural resources, including fishing, are the main sources of income and employment for 85% of the people in the district. Approximately 16,000 people are directly employed in the fishing industry while over 40,000 indirectly benefit through fish trading, boat building, fish gear construction and other related activities. Other sources of employment are commerce, manufacturing and the service sector including the tourism industry. This includes petty traders and hand crafters making cane chairs and mats. The authorities believe that the tourism industry can be strengthened in the future. The District is one of the primary tourist destinations in the country. Lake Malawi is the major tourist attraction, but problems like high incidence of malaria in the district and parasites (bilharzia) in the lake discourage tourism.

1.1.2 Mangochi Basic Services Programme, 2012 - 16

Under MBSP, ICEIDA provided programme based assistance to the District Council of Mangochi to achieve the goals of its development strategy in areas of social services, which included, water and sanitation, education and public health. The Programme has included capacity building at district level which was incorporated into all relevant areas of support.

The overall objective of the MBSP 2012-2016 was to assist the Malawian Government and the Mangochi District Council to improve living standards in the rural communities in Mangochi District. This was expected to result in a more resilient population in adversity and a more resourceful one for self-sufficiency.

In water and sanitation the main objectives were to increase access of the population to potable water and improving hygiene practices with the use of adequate sanitation facilities to reduce waterborne diseases and to promote better health and well-being. The immediate objective of the water and sanitation programme was: Increased and sustainable access to and use of improved safe water sources and improved sanitation practices in Traditional Authority (TA) area of Chimwala.

In public health the main goal was to reduce maternal and neonatal mortality through increased availability, access and utilization of improved maternal and neonatal healthcare services. The immediate objective of the Public Health Programme was: Increased availability, access and utilisation of high impact, quality maternal and child health services in Mangochi.

In education the programme objective was to provide more equitable access to education, to improve the quality of education facilities and to increase the pass rate in primary schools by means of improving school facilities and training of staff. The immediate objective of the Education Programme is: Improve quality of education in target schools to reduce drop-out and repetition and promote effective learning.

Capacity building to strengthen the ability of Mangochi District Council to deliver quality services and ensure successful implementation of the MBSP. It is important to note that this component was never separately budgeted, capacity building activities being subsumed through the individual projects.

Throughout the MBSP, two cross-cutting issues, gender and environment, were to be systematically considered and indicators developed to measure progress towards gender equality.

For monitoring and reporting purposes the MBSP has followed the district monitoring and reporting system. Furthermore a specific M&E plan was developed for the programme and extensive monitoring data are available for the programmes, which shall be incorporated in the evaluation. A mid-term review (MTR) was conducted of MBSP in 2014[1].

In 2016, the MBSP and its three component projects were extended for a period of one year, and in 2017 a new programme was designed and approved, implementation of which commenced from late 2017.

1.1.3 Stakeholders and target groups / beneficiaries

Annexes 2 and 6 provide details of the stakeholders and direct beneficiaries with whom the evaluation engaged. In broad terms, they comprised national Ministries, District administrative departments and officials, health workers and teachers, and community-based management structures and individual community members.

1.2 Methodological Approach

In pursuit of the terms of reference, the consultant has applied a mix of methodological approaches. These include

- Stakeholder interviews (See Annex 2)
- Documentary review (See Annex 3)
- Project sampling and field visits (See Annex 6)
- Debriefing (See Annex 7)

Wherever possible, and this was constrained by the tight timeframe, the consultants employed participatory methodologies and discussed possible means of achieving project and programme goals more efficiently and effectively with beneficiaries and interlocutors.

[1] http://www.iceida.is/media/pdf/MBSP_Mid-Term_Evaluation_Final.pdf

1.3 Structure of the Report

The report is structured in accordance with standard OECD DAC criteria. In Section 2, it discusses the programme's design and relevance including an assessment of the logframe. This is followed in Section 3 by a discussion of Efficiency and, in Section 4, of Effectiveness. Section 5 makes a preliminary assessment of Impact, followed by consideration of programme Sustainability in Section 6. Section 7 comments on the cross-cutting issues of gender and environment. Finally, section 8 outlines the consultant's recommendations arising from the foregoing.

CHAPTER 2 Design and Relevance

2.1 Introduction

In 2014, ICEIDA commissioned a mid-term review of the MBSP. The MTR concluded 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."

This section reassesses this conclusion in the light of the subsequent passage of time to reach a judgement as to whether it remained valid at the time of the final evaluation.

The DAC defines Relevance as the

"…extent to which the aid activity is suited to the priorities and policies of the target group, recipient and donor, including consideration of the following questions:

- *To what extent were the objectives of the programme still valid at the conclusion of the MBSP?*
- *Were the activities and outputs of the programme consistent with the overall goal and the attainment of its objectives?*
- *Were the activities and outputs of the programme consistent with the intended impacts and effects?"*

In seeking to address these questions, the evaluation engaged district and state policies, as well as those of ICEIDA.

2.2 Government of Malawi

Malawi's development policy framework is framed in the overarching Vision 20/2020 and actualised in Malawi's national framework for guiding the country's development (2011 to 2016) set out in the Malawi Growth and Development Strategy II (MGDS II), which succeeded the first MGDS (2006-2011). The overall objective of the MGDS II is continued poverty reduction through sustainable economic growth and infrastructure development. This guided the production of the Mangochi District Development Plan (DDP), which identified 14 priority areas for the district. The MBSP responds directly to the priorities of both the national and three of the 14 district ones through seeking to address

- Low access to potable water;
- High morbidity and mortality rate (infant & maternal mortality); and
- Low access to quality education, and high illiteracy rate.

A fourth area of MBSP support, Capacity Building, aimed to provide institutional support to the District Office to assist it in building a capable workforce to successfully implement development projects.

A number of points are appropriate:

a. Malawi's national development strategy, the MGDS II, places great emphasis on these issues and they are also prioritized in Mangochi's District Development Plan.
b. Stakeholders' consultations and baseline surveys clearly demonstrate the need for continued assistance in support for access to potable water and improved sanitation.
c. The need for additional education support was confirmed by the District Authorities and through stakeholders' consultations. Infrastructure, school furniture, teaching materials, teachers' houses and sanitation facilities in schools are all in short supply.
d. The MBSP sought to alleviate the acute need for improved health services in the District, particularly in regard to addressing maternal health and neonatal mortality.

Overall, therefore, it is clear that the MBSP was and remains relevant to the needs of the Mangochi district population, the DDP's priorities and those of the national Government and its overarching Vision 20/2020 for the country as a whole.

2.3 ICEIDA Policy and Strategy

ICEIDA's policy and strategy are set out in the Country Strategy Paper, 2012 – 16, agreed with the Government in 2012. This states that Iceland will support Malawi in its efforts to improve the living conditions of the poor population and to support the authorities in achieving the Millennium Development Goals (MDGs) by focusing on development issues prioritised by and agreed with the Malawian Government.

The CSP strategic approach focuses on Mangochi District with the intention that social infrastructure shall be better equipped to serve the population. The MBSP seeks to achieve this global goal through support to

- Improving the capacity of the Mangochi District Council to address the water and sanitation, health (in particular maternal and infant), and education concerns identified in the DDP;
- Increase access to potable water and sanitation;
- Reduce maternal and infant mortality and morbidity through improving access to health services; and
- Address education issues, in particular non-attendance, repetition, and pupils, particularly girls', drop-out.

All respond to the priorities identified in the CSP and to the experience gained and lessons learned since the development partnership with Mangochi district commenced. As such, the MBSP was and remained, at the time of the final evaluation, relevant to the CSP's identified priorities and the development needs of the district and country.

2.4 A Programme Strategy

The Strategy for Iceland's Development Cooperation 2011-2014, was approved by the Icelandic Parliament in 2011. ICEIDA aligned its development efforts with international agreements and declarations and incorporated the principles of these (Paris, Accra, Busan) into its operational procedures in Malawi.

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) supported and followed the overall development strategy of the District Council. This meant that:

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

ICEIDA, in its plans, followed the budget cycle of Malawi from 1 July each year to 30 June the following year. Funds for the MBSP were 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.

2.5 The Logframe

No log or results framework was prepared for the MBSP as a whole. However, as stated in the programme document, its overall objective is to assist the Malawian Government and the Mangochi District Council to improve living standards in the rural communities in Mangochi District. This would result in a more resilient population in adversity and a more resourceful one for self- sufficiency. This was to be achieved through three projects (Improved Water Supply and Sanitation, Public Health, with a particular focus on Maternal and Infant/Child Health, and Improved Education, particularly increased retention of girls and reduced repetition), each of which had a logframe.

The immediate objective of the Education Project is: Improve quality of education in target schools to reduce drop-out and repetition and promote effective learning.

Main outputs:

1. Infrastructure and capacity strengthening in target schools
2. Enhanced equity and improved retention of girls and orphans and vulnerable children (OVC) in target schools
3. Improved management of target schools

The Education Project logframe is a coherent narrative from outputs through outcome to overall objective. At closer reading, some of the activities (e.g. the provision of pushbikes for Mothers' Groups, or their introduction to Savings and Loans Groups) may appear somewhat delinked from the overall output, but there are underlying links that can justify the activity. The indicators, especially in respect to infrastructure and procurement, are clearly spelt out and if, on occasion, are too focused on the activity (e.g. # of Mothers' Groups' exchange visits, # teachers or school man-

agement committees trained) as opposed to the result of the activity (e.g. # Girls clubs engaged in interface meetings with schools), this is often overcome by additional proxy indicators (e.g. in respect of the efficacy of teacher training, the school results, reduced repetition, etc.). Overall, therefore, the logframe is well structured and had the potential to be a useful project management tool

The immediate objective of the Public Health Project is: Increased availability, access and utilisation of high impact, quality maternal and child health services in Mangochi.

Main outputs:

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 Improved Public Health Project logframe narrative summary is a coherent description of the proposed intervention and logically demonstrates how the planned activities contribute to the achievement of the expected outputs and outcomes. As with most infrastructure- and procurement-based programmes, the stipulated indicators clear and measure the achievement of the expected deliverable and its contribution to output and outcome. The logframe represents a utilitarian project management tool.

The immediate objective of the improved water supply and sanitation project is: Increased and sustainable access to and use of improved safe water sources and improved sanitation practices in TA Chimwala.

Main outputs:

- At least 150 new boreholes constructed in target area
- At least 100 protected shallow wells constructed in target area
- At least 100 defunct boreholes rehabilitated in target area
- At least 350 water point management committees trained in community based management (operations and maintenance, sanitation and organization) in target area
- At least 80% of households construct and use improved pit latrines and hand wash facilities in target area
- District system strengthened for WASH service delivery
- Environmental aspects around water points and in relation to sanitation activities have been examined and addressed

The WATSAN Project's logframe represents a logical sequence of events from activities through outputs, outcomes and their collective contribution to the achievement of the overall goal. Equally, in respect of the infrastructure aspects of the project, the indicators are SMART and provide clear indications of project progress and ultimate success. There is less clarity around the indicators that measure the efficacy of the training, albeit this can be implied

through proxies: the continuation of the management committees and the continued functionality of the water points, sanitation facilities, reduction in water-borne disease and the sustainability of ODF status. In this respect, the increased capacity of the District Water Office is critical and the indicators in this respect are appropriate and provide the information required for an accurate assessment. Overall, the project logframe represents a functional project management tool.

2.6 Conclusion

The MBSP was relevant when it was designed and remained so at the time of the evaluation. The three component projects responded to critical aspects of the DDP, which was itself developed in accordance with national priorities, the overarching Vision 20/2020 and the Malawi Growth and Development Strategy II. The overall programme and its component parts were in line with the ICEIDA – GOM Country Strategy Paper, 2012 – 16 and with Iceland's Strategy for Development Cooperation, 2011 – 14. Furthermore, the MBSP was designed in accordance with Iceland's international commitments, in particular the Paris Agreement, the Accra Accord and Busan Partnership Agreement.

While not all encompassing MBSP log or results framework exists, the three individual component projects (Education, Health and Water and Sanitation) all have logframes; they are individually logically coherent, generally have SMART indicators and have the potential to be utilitarian project management tools. If a gap exists, it is in respect of the fourth Capacity Building component, this being subsumed within the individual sector projects. This may have represented a missed opportunity for a more effective means of addressing capacity shortfalls within the district council and consideration to addressing this explicitly should be considered in future partnerships.

CHAPTER 3 Efficiency

3.1 Introduction

The MTR concluded in September 2014 that there was

"….ICEIDA [complied well] 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 had been no disruption to the programme implementation process. There was 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."

The following discussion of Efficiency considers to what extent these still remained valid.

Efficiency measures the outputs -- qualitative and quantitative -- in relation to the inputs. It signifies that the aid uses the least costly resources possible in order to achieve the desired results[2], taking into account the following:

- Were activities cost-efficient?
- Were objectives achieved on time?
- Was the programme implemented in the most efficient way compared to alternatives?

[2] This generally requires comparing alternative approaches to achieving the same outputs, to see whether the most efficient process has been adopted. In the UNDAF context, this is problematic given the paucity of data and the need to adapt what data is available in order to present as coherent a picture as possible.

3.2 Investment Budget

At the time of programme design, economic uncertainty made costing extremely challenging. As a result, the programme documents note that actual investment budgets would be worked out annually in line with the District Implementation Plan (DIP) and presented for approval at the March biannual Partnership Committee meeting. Tables 1 – 3 outline the indicative sector investment proposals for Education, Health and Water and Sanitation.

Financial Year	US $
2012/3	161 700
2013/4	1 378 850
2014/5	898 350
2015/6	1 030 700
Total	3 469 600

Table 3-1 Indicative Education Investment

Source: Project document, Section 5, P 29

Financial Year	US $
2012/3	1 215 000
2013/4	2 293 000
2014/5	1 318 000
2015/6	1 092 000
Total	5 918 000

Table 3-2 Indicative Health Investment

Source: Project Document, Annex 2

Financial Year	US $
2012/3	352 000
2013/4	514 000
2014/5	705 000
2015/6	792 000
Total	2 363 000

Table 3-3 Indicative Water and Sanitation Investment

Source: Project Document, Section 5, P 23

As noted, the project documents all note that the actual investment budget would be determined on an annual basis in line with the District Implementation Plan. According to the former ICEIDA Country Director: 'The budget and work-plans discussion was good, because this was really the only time of the year when all the managers from the district met with us as a group. Of course, the budgets and work-plans had been thoroughly planned and debated well ahead of the meetings, so normally, we didn't see any significant changes following the bi-annual meetings[3] . Table 3-4 provides an overview of the actual investments made in the period 2012 - 17.

	US $
Partnership Agreement Budget	13 000 000
Extension Agreement Budget	1 670 000
TOTAL	14 670 000

Table 3-4 Ultimate Investment Budget[4]

Source: ICEIDA Communication

The indicative total in the three project documents was US $11 750 600. In total, ICEIDA allocated just under US $14.7 million to the three component projects of the MBSP. Initially, the US $13 million was in respect of the period to 2016; subsequently an extension to end 2017 was agreed and an addition US $1.67 million allocated. In total, the actual turn-out represented a 24.8% increase over the indicative amounts in the three project documents; the eventual total partnership agreement budget (i.e. before the extension agreement) was 10.6% larger than the indicative total.

In the evaluators' experience, such increases are extremely unusual. ICEIDA is to be congratulated for its demonstrable flexibility in the light of the self-inflicted Malawian economic crisis; the evaluation has reservations whether it was an appropriate response, in particular to the 2013 Cashgate scandal.

Having noted this, the evaluation observes that the MBSP represents a very interesting combination of project and budget support modalities. The requirement for monthly/quarterly accounting for resources utilised is a project modality approach, while direct payments into the district council's budget is a form of budget support. Based on its observations, the evaluation concludes that this combination has proved successful, not least in underlining the importance of transparency and accountability and supporting the district council's institutional development, and might usefully be explored by other donors in other district councils.

[3] Direct Communication, 3 May 2018.

[4] Excluding Capacity Building Support for District Council (see Table 3-5).

3.3 Resource Utilisation

ICEIDA provided details of expenditure by individual project and in total. Table 3-5 provides a summary overview. The detailed report by expenditure category is appended at Annex 5.

Year	District Council	Education	Health	WASH	Total
2012	0	0	0	411,108	413,120
2013	133,222	1,330,400	2,052,682	641,721	4,160,038
2014	81,168	1,374,112	1,725,697	744,220	3,927,211
2015	14,061	1,095,517	938,109	765,627	2,815,329
2016	8,872	1,090,573	1,335,724	663,234	3,100,419
2017	15,543	274,231	271,891	131,565	695,247
Total	252,866	5,164,833	6,324,103	3,357,475	15,111,364

Table 3-5 Total Expenditure by Project 2012 - 17

Source: ICEIDA communication

ICEIDA confirmed the overspend (US $146 4110 had been retroactively approved. Figure 3- 1 shows that resource utilisation rose steeply from 2012 to 2013 (as Education and Health spending commenced – see Figures 3-2 and 3-4) and peaked in 2013; subsequently it declined falling quite sharply in 2015 and 2016, before substantially falling away in 2017.

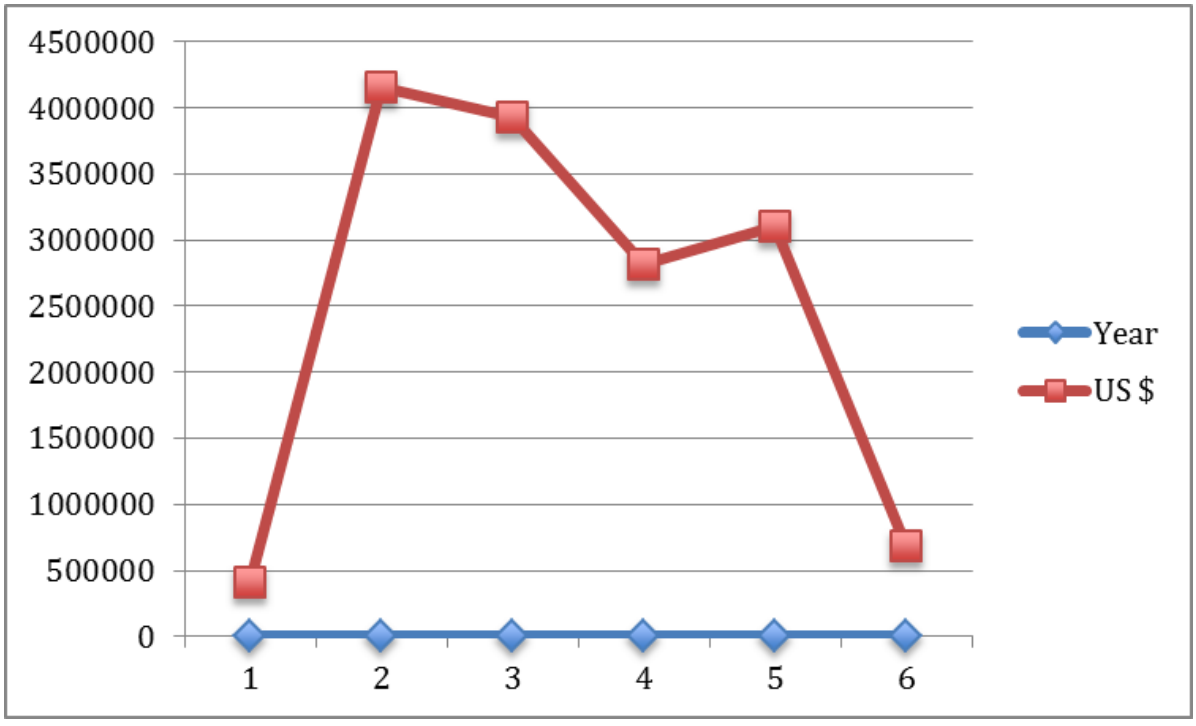


Figure 3-1 Total Expenditure by Year, 2012 - 17

Source: Calculated from ICEIDA data

The evaluation notes that the graph reflects expectations for the first and final years, as well as for the second year (2013); however, the fall off in Years 3 – 5 (2014 – 16) is unusual since that is when spending tends to be steady with implementation fully engaged (see Figure 3-6 in comparison). The procurement challenges experienced in 2013 and 2014 do not fully provide a reason, as one would have expected to see a spike in spending once approvals were received and contracts approved. It is more likely that the graph reflects the capacity challenges that the Education and Health departments experienced (see Quarterly Output Based Budget Reports for corroboration) in driving the contractors forward to deliver quality infrastructure products and successfully procuring the necessary medical and school equipment. This would represent a constraint on overall efficiency, which the capacity building component was expected to address.

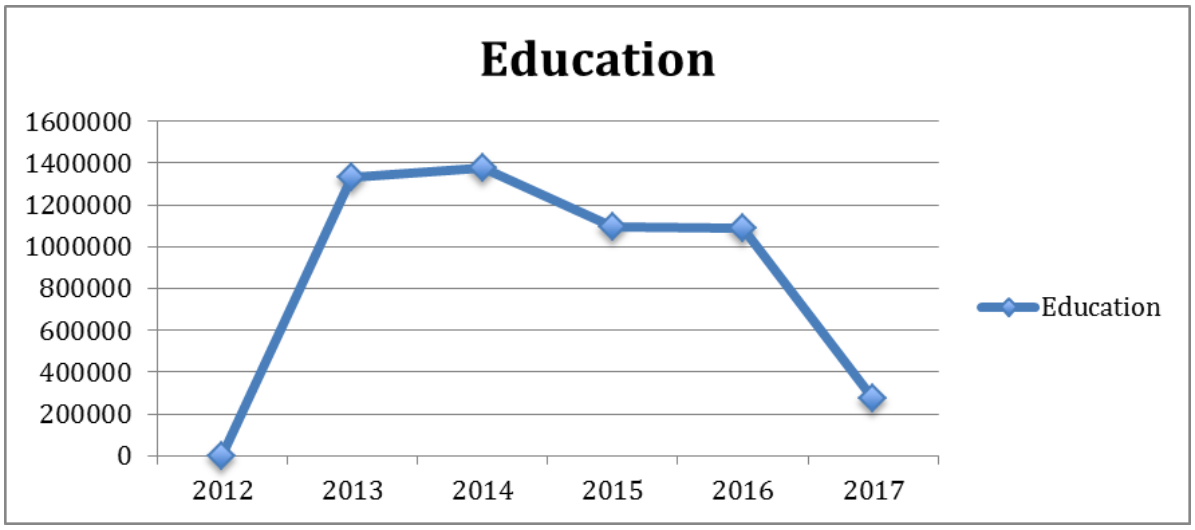


Figure 3-2 Total Expenditure: Education, 2012 - 17

Source: ibid

Figure 3-2 underlines the general conclusion above. Expenditure was significantly below the 2013/4 peak, when attention focussed on delivering the training components of the project, not least because the procurement processes were stalled. Infrastructure started being delivered in 2015/6, which maintained expenditure levels, albeit at earlier much higher levels.

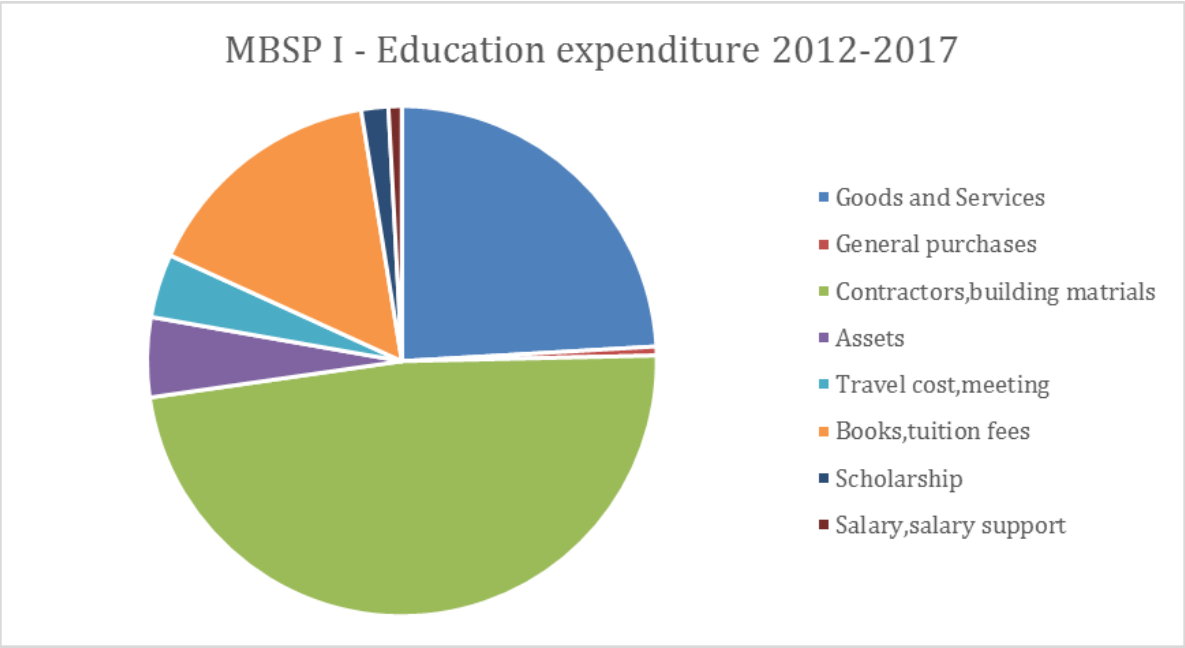


Figure 3-3 Expenditure by Category (Education)

Source: ICEIDA data

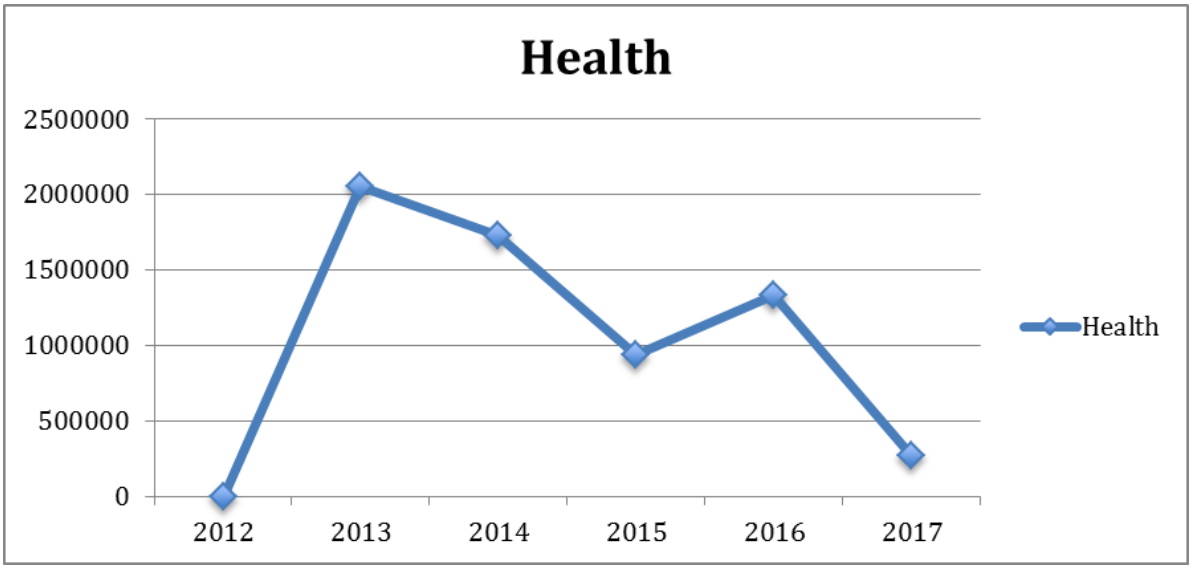


Figure 3-4 Total Expenditure: Health, 2012 - 17

Source: op cit

Figure 3-4 presentation shows greater efficiency challenges, possibly reflecting the greater percentage of procurement-based activities. In addition, some procurement (e.g. hospital and health centre equipment and furnishing) was dependent on the completion of other procured (infrastructure) activities. The effective freeze on procurement approvals at the start of the project, therefore, impacted negatively on its efficiency, although it is important to note that this was outside of the project implementers' control.

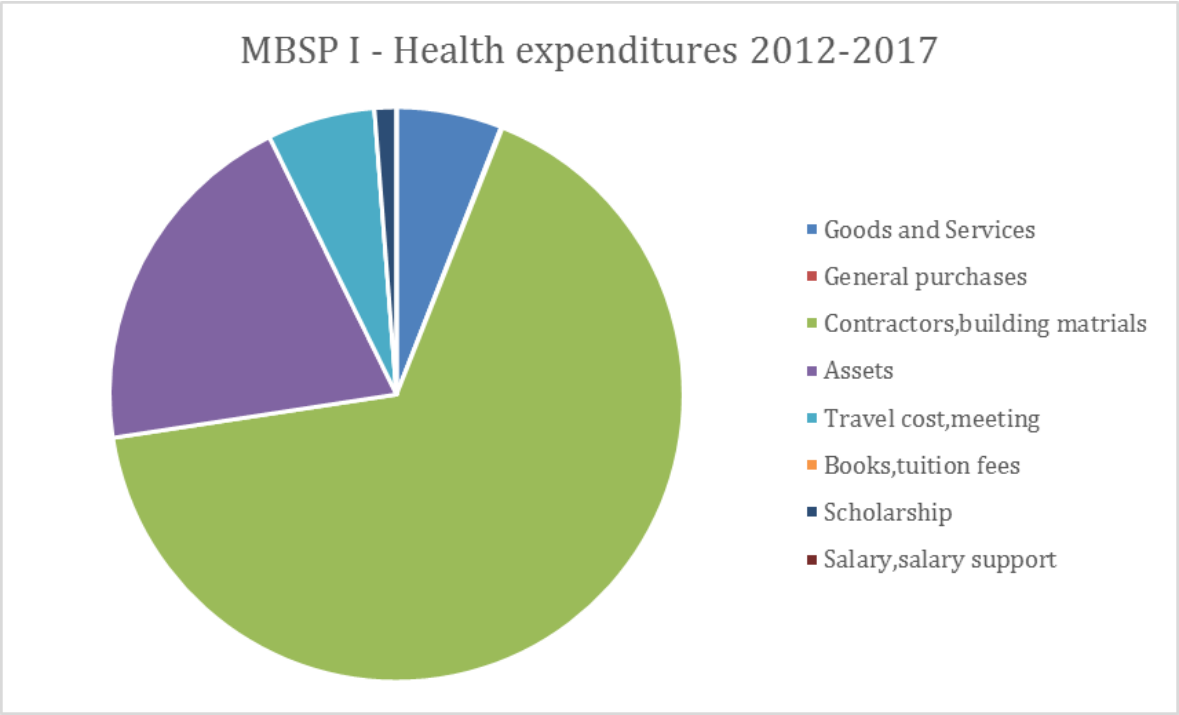


Figure 3-5 Expenditure by Category (Health)

Source: ICEIDA data

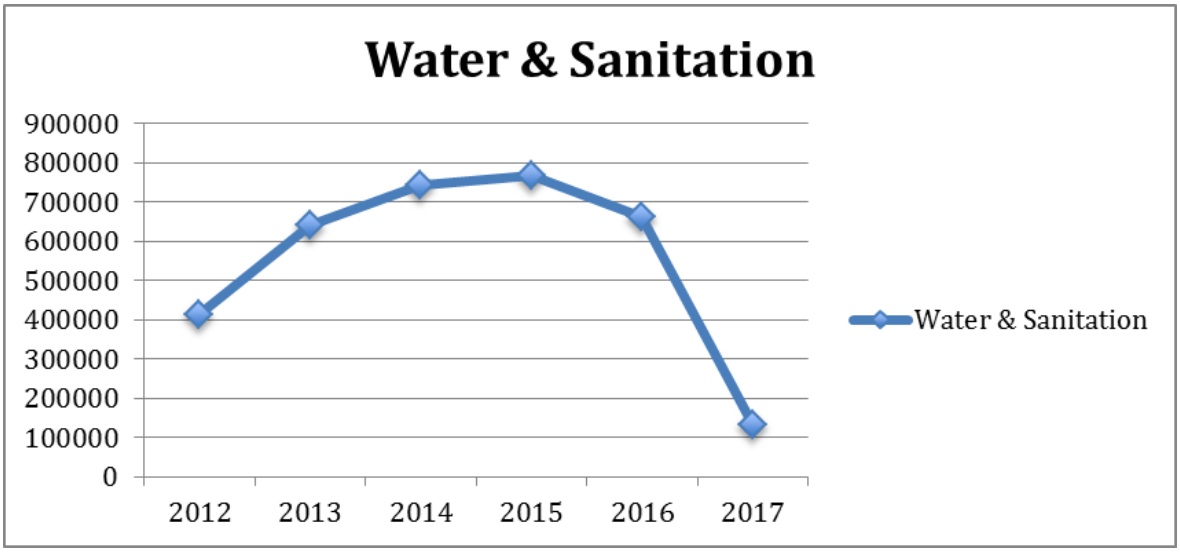


Figure 3-6 Total Expenditure: Water and Sanitation, 2012 - 17

Source: op cit

Figure 3-6 reflects the expected expenditure cycle: a quick build-up, followed by sustained spending (2013 – 16 all between US $600 000 and US $800 000) followed by a steep fall in the final year. The graph underlines the evidence of efficiency contained in the quarterly Output Based Budget Reports on the sector activities.

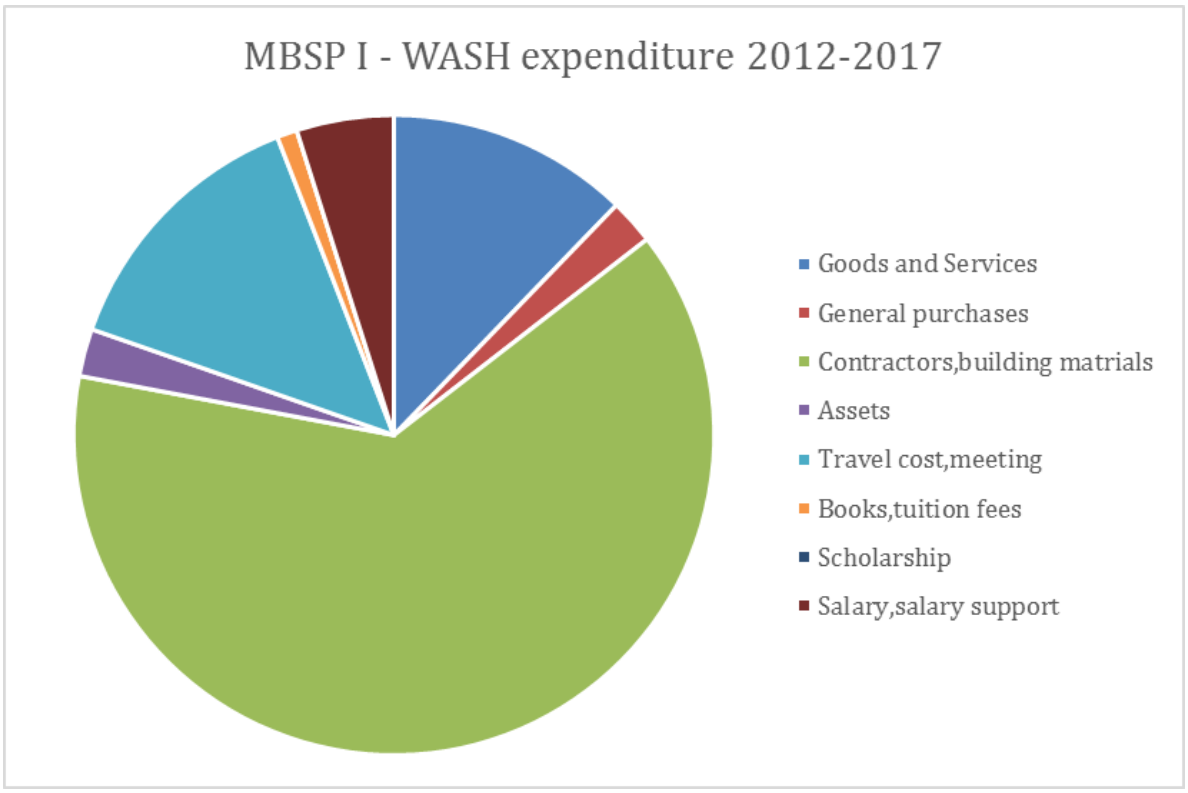


Figure 3-7 Expenditure by Category (Water and Sanitation)

Source: op cit

What is noteworthy is that none of the categories address Component 4, Capacity Building, of the MBSP.

3.4 Capacity Development

Initially the MBSP proposed capacity development as a fourth component. In the event, this was never developed as a specific approved component/cost centre. However, several activities were carried out in a form of institutional support to the District Council office to assist it in building a capable workforce, which would successfully implement development projects and deliver quality services. Outputs related to this component included; training of the District Council personnel and local community development committees such as Area Development Committees (ADCs) and Village Development Committees (VDCs)[5], infrastructure development and provision of office supplies and equipment. According to the ICEIDA Mangochi Programme Manager, support included:

- Procurement of 2 motorcycles
- Maintenance of office building and fitting new air conditioners
- Architectural fee for development of building plan for chamber Building, (MKW 20 million)

[5] ADCs and VDCs training data was unavailable. However, based on the sample of those met in the course of field work, most members were male in ADCs with a small majority of women in VDCs. Overall, therefore, it is likely that more women than men received training although this was a 'one-off' event and subsequent changes in membership was not followe3d up with more training.

- Provision of scholarships to 9 staff members (seven for Masters degree (of whom one remains on the Council's complement) programmes and two for Bachelors degree courses)
- Procurement of office equipment including: Computer sets (UPS, monitors and printers) and 3 laptops
- Photocopying machine
- Office furniture

The total disbursed for these activities over the programme period was US $252 866. Figure 3-8 illustrates the expenditure by year.

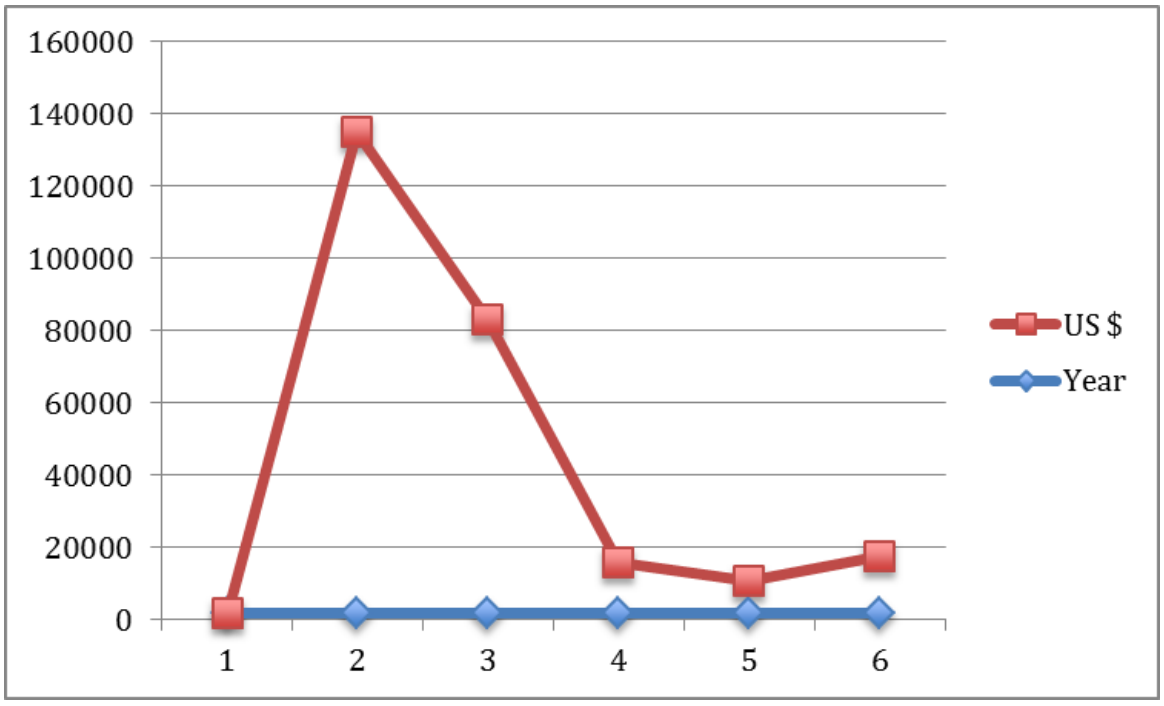


Figure 3-8 District Council Capacity Building, 2012 - 17

Source: ICEIDA Communication

3.5 Conclusion

The MTR concluded that the projects were generally efficient and reflected a utilitarian flow of funds. In broad terms, the final evaluation concurs with this view. While there have clearly been hiccups in respect of both the education and health projects, in the main the resources have been utilised in accordance with plans and the infrastructure, albeit some of questionable quality, delivered.

In general, the flow of funds has been timely, the exception being when the implementers failed to report in a timely and comprehensive manner. The main exception to this general experience occurred with the decision to extend the projects by another year; the inevitable delays associated with this decision, resulted in funds being released at the beginning of the rainy season, which impacted negatively on infrastructure (both buildings and protected shallow wells) development because both require commencement during the dry season.

Resource utilisation differed considerably between Water and Sanitation projects and those in Education and Health. The water and sanitation resource utilisation (Figure 3-6) is an almost picture perfect representation over the life of a project. By contrast, both the education and health disbursement patterns are lumpier, reflecting the procurement challenges experienced at the projects' start and the need to sequence procurements. Having noted this, however, resources across all three projects were utilised in accordance with plans and only one expenditure line had to be cancelled because of inadequate resources.

In part this might reflect the unusual budgetary approach ICEIDA pursued, establishing budgetary totals not on an existing budget but in accordance with emergent needs in the light of Malawi's economic crisis, exacerbated post-Cashgate. This resulted in initial disbursements 10.6% over the indicative budget in the project documents and the MBSP Programme Document and an eventual outturn 24.8% greater than initially planned. Furthermore, a US $146 411 overspend took place, which had to be subsequently authorised. At the very least, the experiment in flexible budgeting proved costly.

CHAPTER 4 Effectiveness

4.1 Introduction

The MTR concluded that, as of September 2014,

"….the MBSP was making good progress towards the achievement of immediate objectives mid-way in the implementation cycle; there is also progress towards the programme goal. While there were slippages in the achievement of a number of programme outputs (civil works being the most visible component in Health and Education Programmes), this was largely because some activities were dependent on the completion of civil works. Output to Outcome analysis showed that there was good progress towards achievement of programme outcomes by 2016 [provided] the infrastructure and other remaining outputs were accomplished as planned."

The discussion of Effectiveness reviews the validity of this conclusion at the time of the final evaluation. It also provides an overview of the technical quality of the infrastructure provided as well as that of the services delivered.

According to the DAC, effectiveness is a

"….measure of the extent to which an aid activity attains its objectives, considering, inter alia, the following:

- *To what extent were the objectives achieved / likely to be achieved?*
- *What were the major factors influencing the achievement or non-achievement of the objectives?"*

Consideration of Effectiveness necessitates a review of the programme management structures, the implementation of programmatic activities intended to achieve Outputs and Outcomes, and a review of the M&E approach. The following sections address each.

4.2 Programme Management

The MTR does not consider programme management. The Programme management structure established was fairly traditionally structured in an effort to maximise ownership of the MBSP, one of the lessons learned in the review of preceding partnerships in Mangochi District. Essentially, it established a partnership committee, comprising substantial GoM representation in its membership and headed by the most senior administrative representative in the district. According to the former ICEIDA Country Director,

"Central government, in general, was not interested in these meetings and hardly participated, apart from MoLGRD. And even they were not always very keen. Normally, representatives from MoLGRD did not prepare well for the meetings - they for the most parts did not keep much track of the programme, and it showed in the meeting[6] ."

[6] Op cit.

Notwithstanding, the former Country Director found

"....the bi-annual meetings quite useful. In particular, there was usually quite a thorough discussion on progress and problematic issues. But, following these meetings, all the important people knew where we were heading for the coming year[7]."

Policy oversight, at district level, was the responsibility of the District Council (in accordance with the national decentralisation policy), supplemented with technical expertise from the relevant district structures and participation from ICEIDA's district representatives. The former Country Director notes that 'The ownership of the programme was first and foremost at the district level. As far as I could see, the District Council had never been given similar responsibility as they were given under this programme. It was very gratifying for me to see how the staff of the District grew in confidence as the programme progressed in time[8]. Figure 4-1 provides an overview of the MBSP management structure.

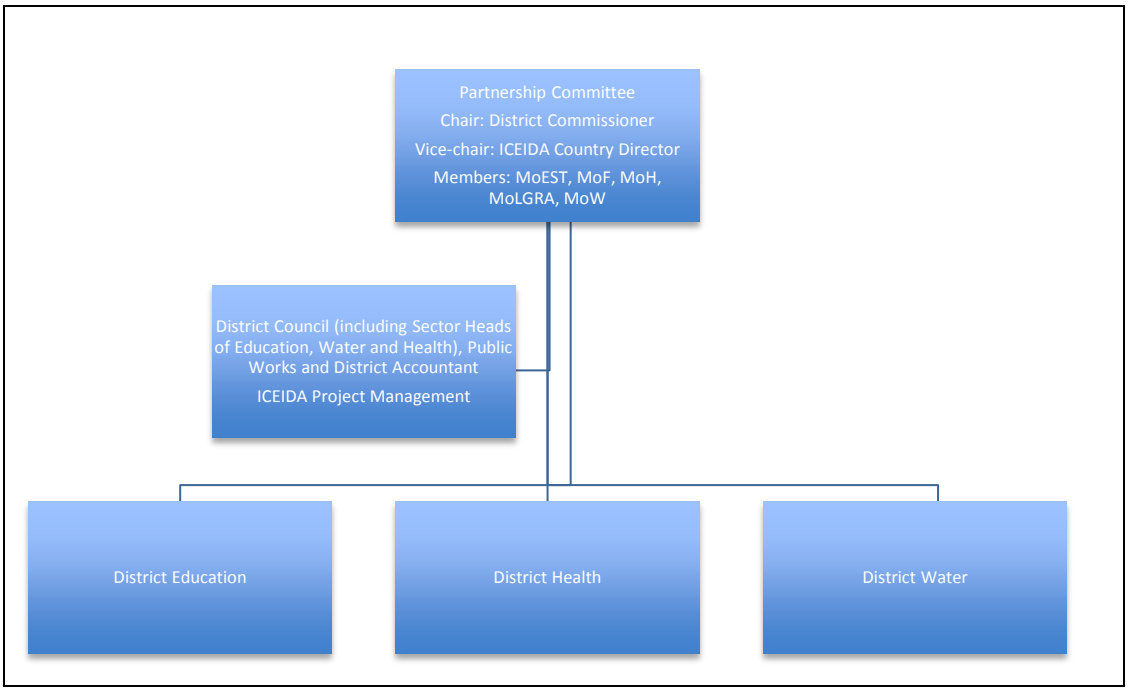


Figure 4-1 MBSP Management

Source: Adapted from Programme Document

[7] Op cit.

[8] Op cit.

In parallel to the District Council MBSP management, ICEIDA established its internal management structure. Figure 4-2 outlines this.

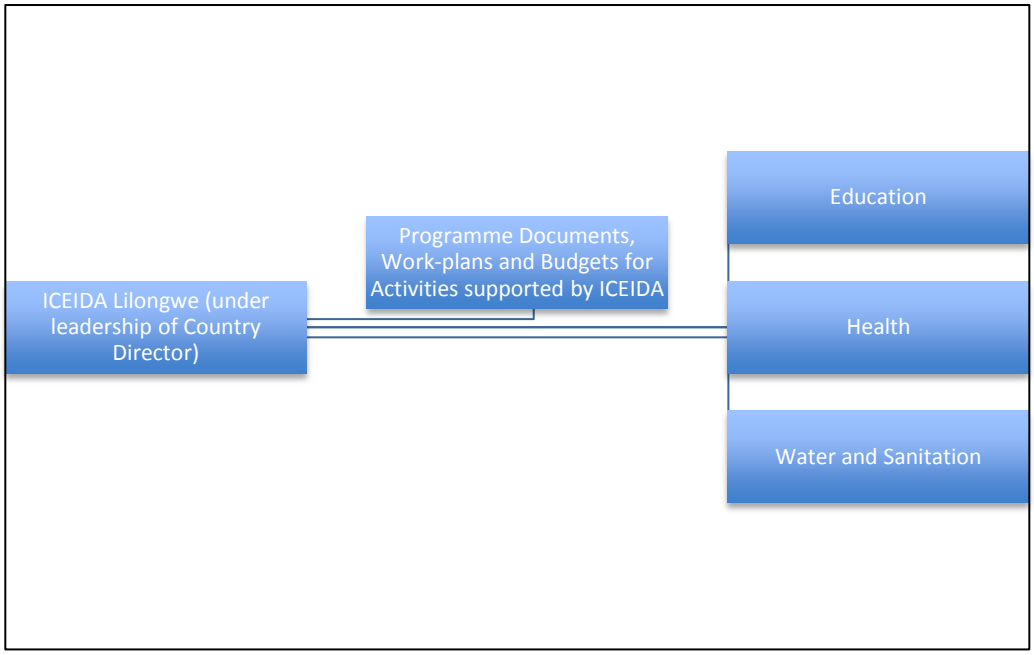


Figure 4-2 ICEIDA Internal Management

Source: Adapted from Programme Document (Note, the Capacity Development Component is not included; it is on the same plane as the three other components.)

Notwithstanding this structure, it is evident that both individual project and overall programme management were beset by challenges. For example, despite the substantial central Government presence in the Partnership Committee[9], the newly provided health infrastructure remained dysfunctional at the time of the final evaluation because the freeze on public sector recruitment meant that health staff could not be recruited in a timely fashion to ensure that

[9] Possibly reflecting the apparent lack of interest, demonstrated by non-participation in the Partnership Committee, in the project by Central Government, with the exception of the MoLGRD.

they were operational as and when the infrastructure was functional[10].Similarly, it is equally questionable that ICEIDA financed the recruitment of 18 teachers and 16 WMAs[11]; this is a public (GoM) or private sector responsibility.

If the 'ownership' function of the Partnership Committee failed[12], the District Council's management role, for a significant part of the time, was, bluntly, absent. The Quarterly Output Reports, prepared by the Council's M&E Officer throughout the 2013-14 and 2014-15 fiscal years recommend

"There is need to intensify District Coordinating Committee meetings so that there is regular review of progress and joint planning."

and noting that

"….the District Coordinating Committee did not meet to discuss the implementation progress of the activities[13]."

The reports do not explain either but there is an implicit link to delays in successfully acquiring procurement approvals from the ODPP. However well founded[14], it appears at least possible that the delays served as an ownership disincentive at District Council level regardless of subsequent statements of appreciation of support:

"The support that the Council is receiving from ICEIDA is going a long way in helping the council achieve its development mission, without which Mangochi communities would have been deprived of a lot of services."

It is worth noting that such recognitions of the value-added provided through ICEIDA support followed the arrival of a new DC.

The financial management arrangements may have been a contributory factor to dysfunctionality. According to the programme document, the implementing body (the District Council) was to report on the utilisation of disbursed monthly before the next tranche would be released. This never took place; instead the emphasis shifted to quarterly financial reporting, which, in itself, was (and remains) a challenge for capacity-challenged local authorities.

It could also be seen to go against the spirit, if not the letter, of Paris, Accra and Busan, in particular that financial commitments were linked to the District Council result framework and budget cycle. Explicitly making the release of new financial tranches dependent on accounting for the utilisation of the past disbursements, while prudent, does not respond to the undertaking to use national systems, in terms of which financial accountability is annual.

[10] The evaluation acknowledges that the district administration was addressing this, agreement having been secured for the MoH to recruit (and train) nursing staff. The point the evaluation wishes to underline is that the presence of MoH representatives in the bi-annual Partnership Committee meant that empty facilities could (and should) have been avoided and a seamless recruitment and training process was achievable.

[11] Although this recruitment to the 12 target schools was an intrinsic part of the project document, as was the recruitment of the 16 WMAs. The issue is the sustainability of such recruitment although, at least in the case of the WMAs, this appears to have been addressed as it was reported to the evaluation that the WMA recruits were being absorbed into the Department's payroll.

[12] The evaluation was informed that key line Ministries asserted that they were unaware of the MBSP and the concomitant budgetary implications down the line.

[13] Quarterly reports, various quarters.

[14] The evaluation was informed that Mangochi Council procurement approvals were put on hold pending the outcome of investigations into allegations of corruption in the award of tenders.

4.3 Project Outputs

The three projects aimed to achieve outputs that would

- Improve education, reduce absenteeism (especially amongst OVCs) and repetition, and reduce drop-out (particularly amongst girls (particularly from Form 6 up to Form 8) through a combination of infrastructure provision, teacher and school management training, and increased community participation.
- Improve maternal and child health through increasing access to health care services through a combination of equipped infrastructure provision, better and more efficient referral systems and training.
- Increase access to community managed and sustained potable water through drilling new and refurbishing defunct boreholes and providing protected shallow wells.

Annex 6 provides a detailed overview of the activities undertaken and the progress to Outputs achieved in the course of the three projects' life.

4.3.1 Project Effectiveness

Effectiveness reviews the contribution of individual projects to the achievement of the result areas and project outcome. Comments in terms of the individual projects contribution to their own and the MBSP outcome will be made under each project.

4.3.1.1 Education

The project included a strong focus on developing soft skills and access to the materials to make suck skills efficacious. Figure 4-3, below, demonstrates the successful achievement of targets in respect of ensuring teachers in the 12 target skills both had the necessary skills to teach effectively and additional teachers with such skills were recruited.

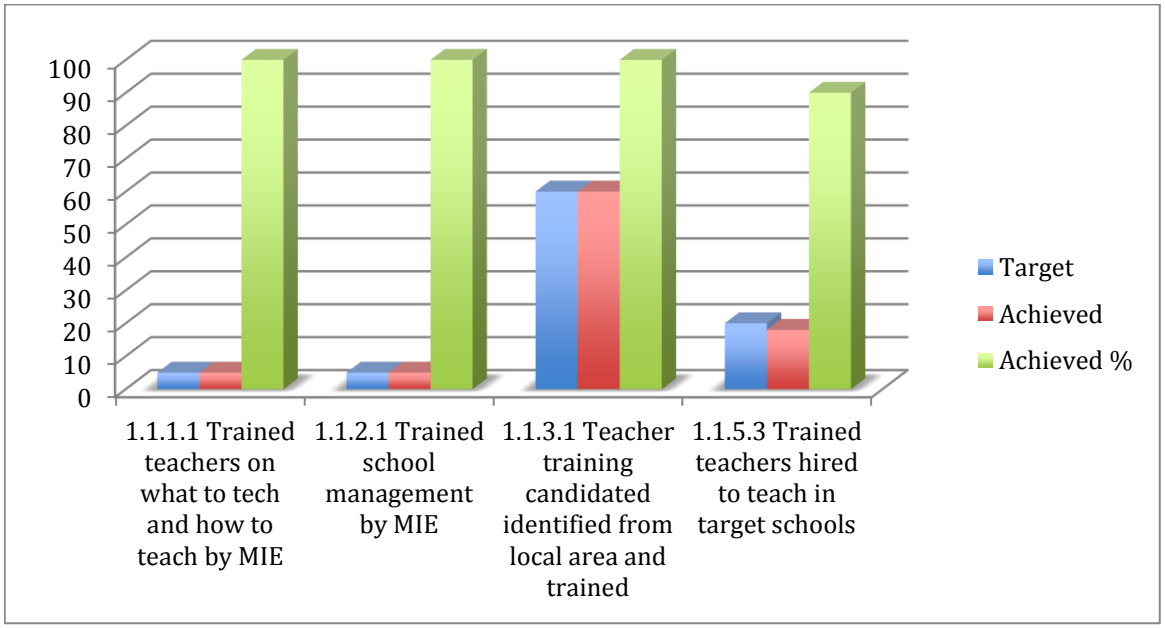


Figure 4-3 Improved Capacity and Support to Learners in Target Schools

Source: Analysis of Annex 6 Data

The Education Department reports that the training received has resulted in visible differences in teaching quality and learners performance between the target schools and others not benefitting from the programme. This is best illustrated by reports that the target schools are increasingly over-subscribed as parents seek to transfer their children from neighbouring schools to them. The training provided was expected to be supported by ensuring that the necessary materials were available to teachers and learners in the schools.

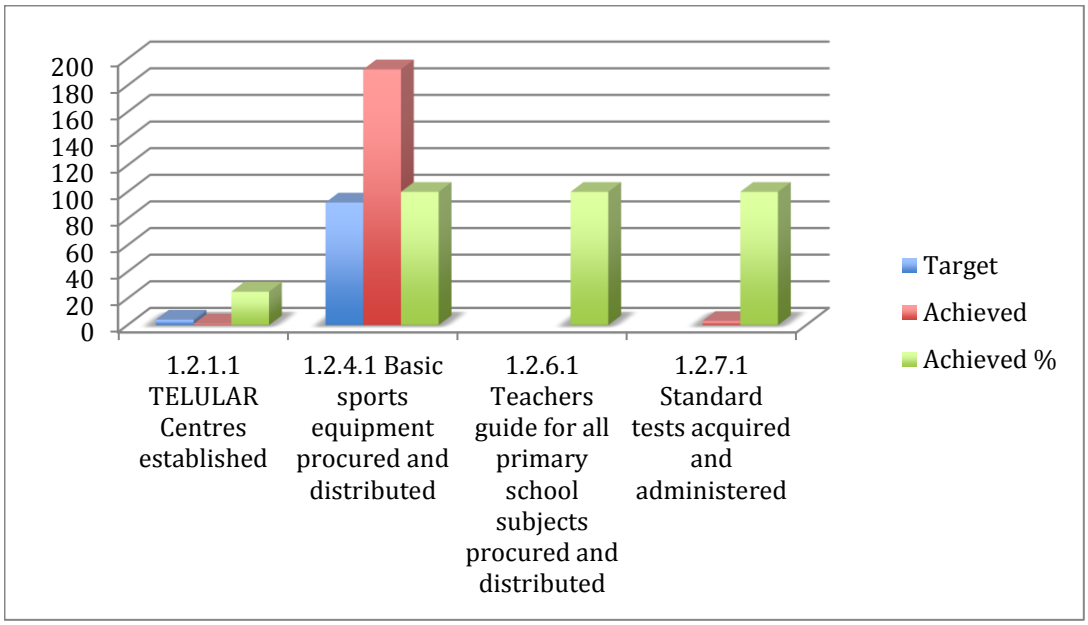


Figure 4-4 Teaching and Learning Materials Provision

Source: ibid

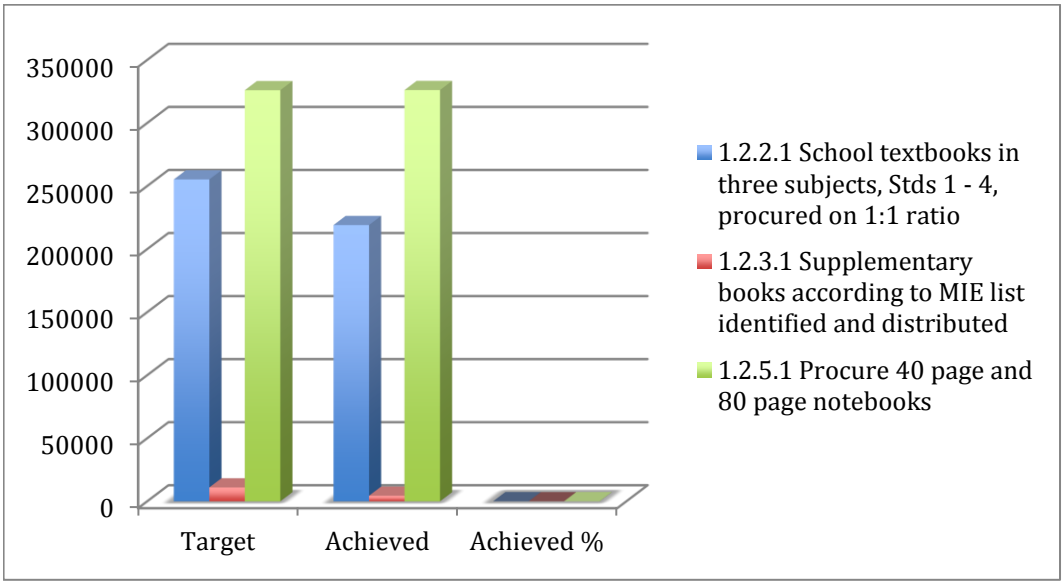


Figure 4-5 Teaching and Learning Materials Provision

Source: ibid

Figures 4-4 and 4-5 reveal that this was less successful although substantial numbers of textbooks and notebooks were procured and distributed.

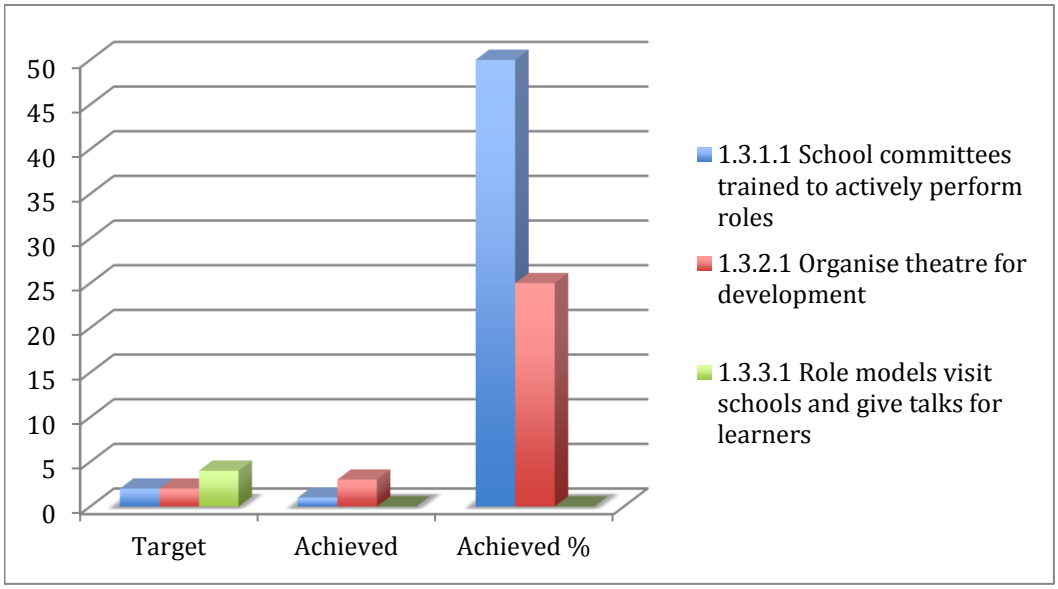
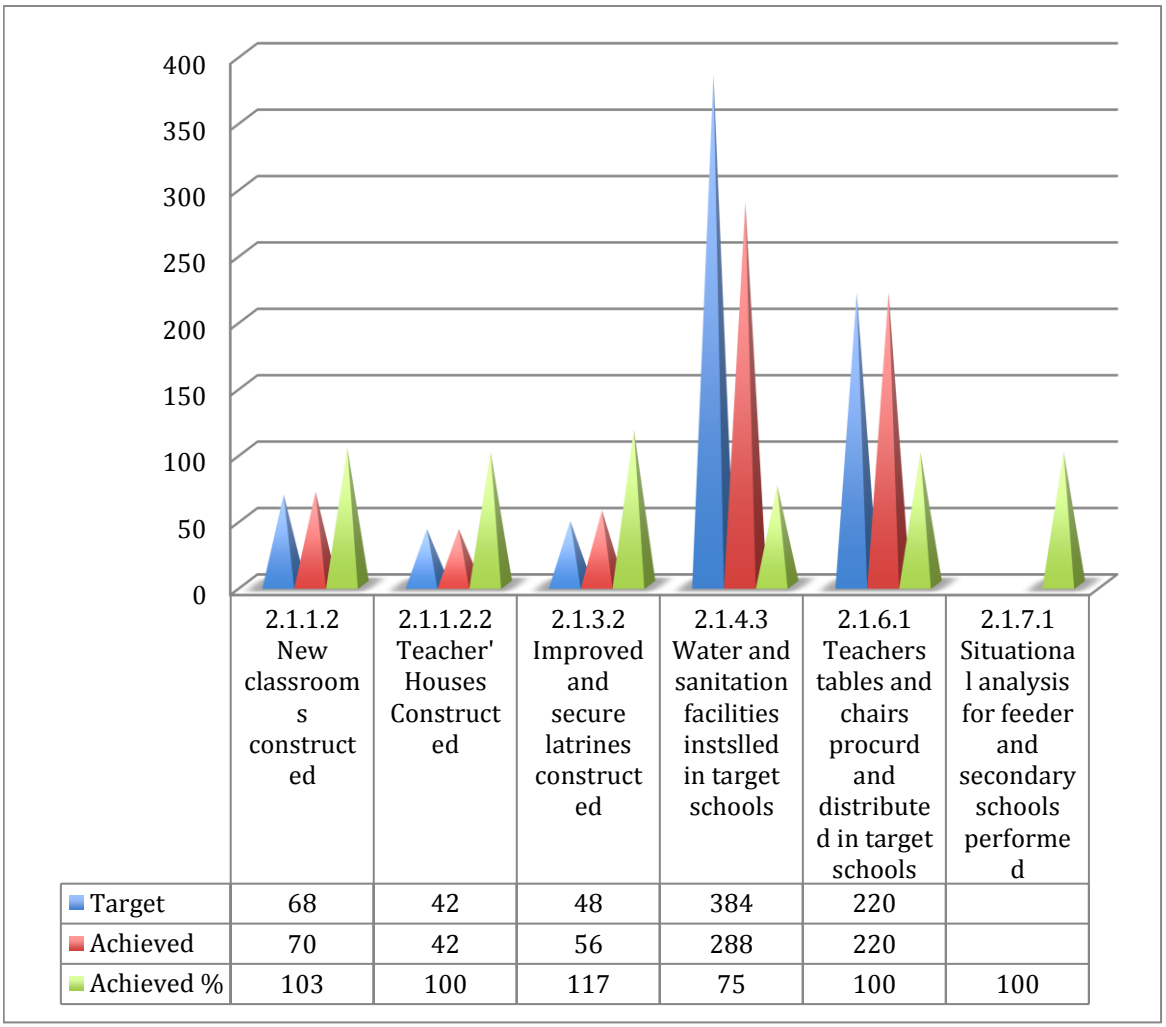


Figure 4-6 Community Mobilisation in Support of Improved Education

Source: ibid

The Education department notes that it experiences challenges in mobilising communities in support of education goals. It reports that it was only very recently made aware that the training received by the identified teacher trainees included aspects such as community mobilisation and entrepreneurship, which are not included in the standard teacher training courses. At the time of the evaluation such skills had been underutilised and the Department had plans to put these skills to use in enhancing community mobilisation in support of education aims and empowering OVCs and their care givers.



	2.1.1.2 New classrooms constructed	2.1.1.2.2 Teacher' Houses Constructed	2.1.3.2 Improved and secure latrines constructed	2.1.4.3 Water and sanitation facilities instslled in target schools	2.1.6.1 Teachers tables and chairs procurd and distributed in target schools	2.1.7.1 Situational analysis for feeder and secondary schools performed
Target	68	42	48	384	220	
Achieved	70	42	56	288	220	
Achieved %	103	100	117	75	100	100

Figure 4-7 Improved Teaching and Learning Environment

Source: ibid

In total, the education project supported the construction/refurbishment of 41 classroom blocks and 42 teachers' houses in the 12 target schools in the district. In addition, it supported the professional development of teachers (in terms of what they should be teaching and how it should be taught) and increased community engagement in the schools' life. Support to Mothers' Groups and the provision of sanitary and water facilities was intended to discourage girls'[15] and boys' drop-out, in addition to having a positive health impact.

[15] Especially for older girls (Figure 4 – 7), the absence of sanitation and washing facilities serves as an important disincentive to attend school when they have their periods.

A technical audit of the quality of the infrastructure work was conducted in early 2018. The auditors determined that the quality of work carried out was unsatisfactory in a significant number of cases. Table 4-1 details the auditors' conclusions in respect of both classroom blocks and school houses.

	Unsatisfactory - %
Classroom Blocks	27
Teachers' Houses	< 50

Table 4-1 Percentage of Unsatisfactory Construction

Source: Technical Audit, Draft Report, March 2018

A number of reasons were advanced for this state of affairs but the most critical one would appear to be the auditors' determination that

"The council has literally no capacity to handle projects of this nature. Even if measures are taken to build capacity within the council, it will take time before benefits could be realised. The lack of supervision leads to contractors taking matters in their hands."

As a result,

"The processing of claims from contractors is done without verifying whether or not the work done is acceptable or not. If only an acceptable quality of works was paid for, contractors would pay attention to detail and work diligently to achieve the best results."

It is important to contextualise the monitoring and inspection process. The Education Department readily admits that it does not possess the technical skills to monitor technical progress of the works undertaken. Their monitoring simply confirms that work is ongoing. Technical monitoring is the responsibility of the Public Works Department; education officials expect that public works inspectors would visit sites on at least four occasions: when the slab is cast (first payment trigger), once the structure has reached beam height (second payment trigger), once roofing is complete (third payment trigger) and once the work is completed (final payment minus the retention, trigger). They report that they have no actual knowledge of whether these site visits took place but base their expectation on the contractual arrangements for release of finds on receipt of Public Works approval of the progress achieved.

Furthermore, and this casts into question, the Education department's statement that they monitor that work is ongoing,

"Regular progress meetings hardly take place. It was noted that in some sites contractor commence and complete works without the council visiting the site; one such site being Chikomwe Primary School, as reported by the head teacher. During the regular meetings the quality of work would be checked and that would make the contractor comply with requirements."

In its turn, this leads to

"Some of the contractors' have become negligent in the way they carry out operations on site over the year knowing that the council does not have capacity to oversee the projects. In some cases, contractors leave the projects incom-

plete, but they still get paid. Council has to insist that staff mentioned in the qualification information at the time of tender should be the ones to be on site."

The auditors conclude that

"The physical condition of most of the infrastructure developed does not satisfy the normal standard specifications/guidelines because poor quality materials have been incorporated into the structures. The other factor is that the contractors do not use normal standard practices applicable."

Poor quality education infrastructure is a disincentive to both teachers and learners. As such, the 27% of unsatisfactorily completed infrastructure does not contribute to achieving the output and, as such, damages effectiveness. This is further damaged as the auditors noted that

"….most of these facilities are not looked after; route maintenance hardly take place and this has resulted in the deterioration of the facilities."

Overall, therefore, the evaluation is of the view that the inadequate standard of over one-quarter of the education infrastructure developed has limited its effectiveness.

Notwithstanding the infrastructure challenges experienced, Figure 4-07 shows that the project met an important necessary condition for an improved learning environment. Even high quality infrastructure is dysfunctional as an improved learning environment if necessary school furniture and equipment is not available to teachers and learners. Figure 4-8 clearly shows that 83% of the target for the procurement and distribution for 200 classrooms was achieved.

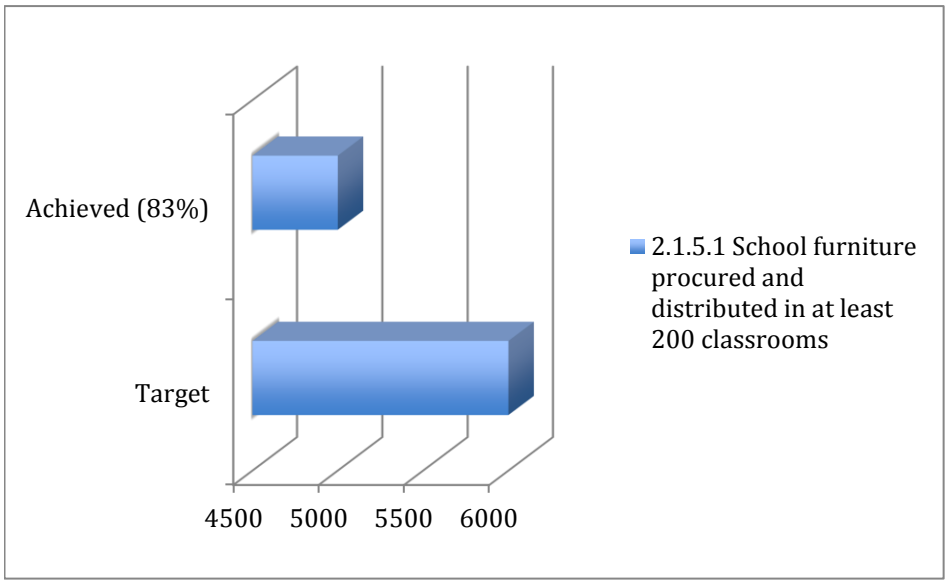


Figure 4-8 Improved Teaching and Learning Environment (School Furniture)

Source: ibid

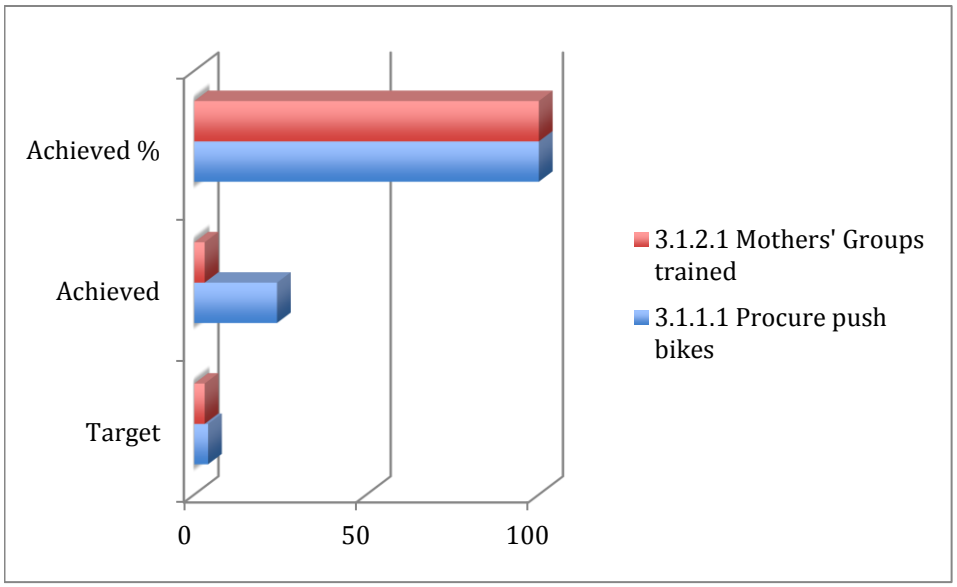


Figure 4-9 Mothers' Groups Supported

Source: ibid

The Education department reports that the training support to school management bodies and Mothers' Groups has been followed by a visible improvement in terms of both retention of learners (lower drop-out) and reduced repetition.

The Education Department received support intended to increase its school management capacity. Figures 4-10 and 4-11 detail the support areas and the percentage achievement of the target.

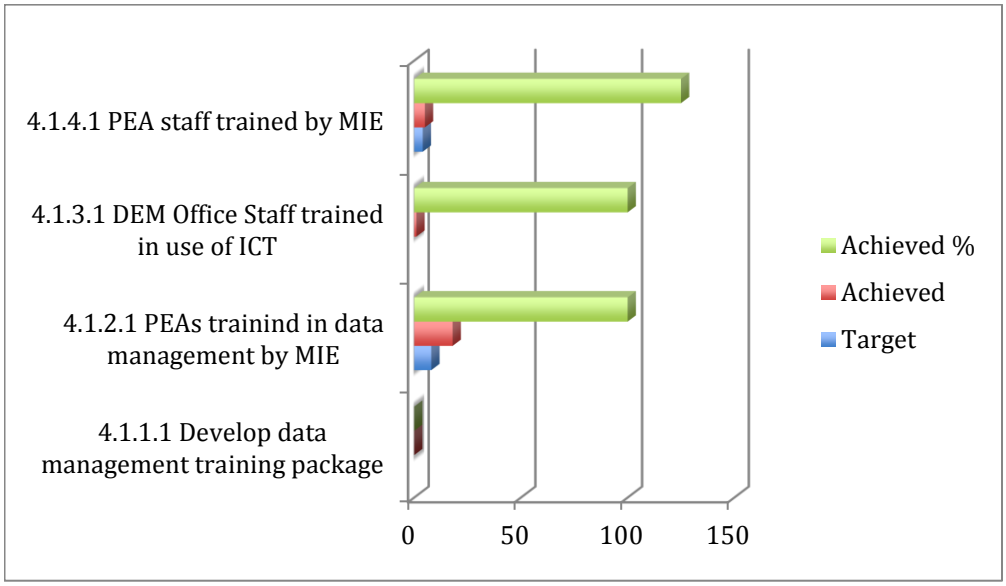


Figure 4-10 Improved Management of Target Schools

Source: ibid

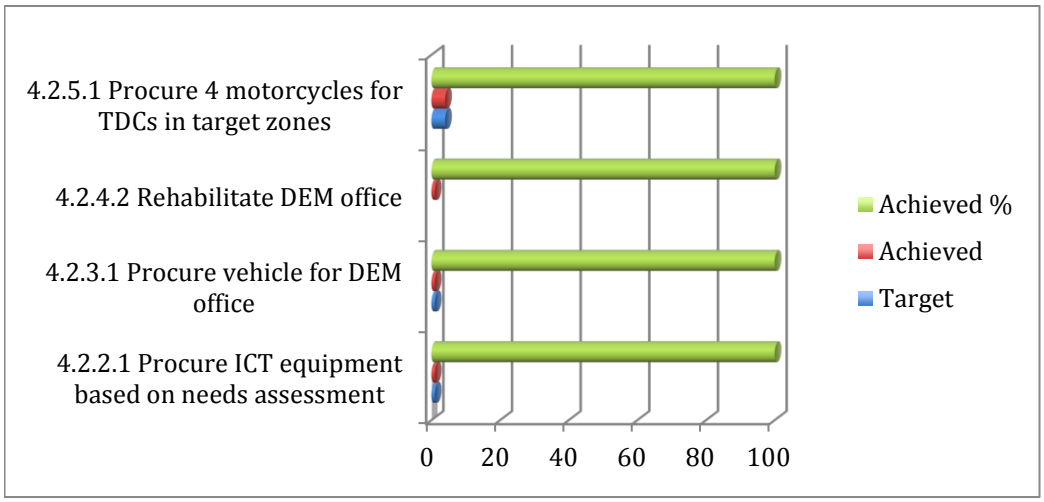


Figure 4-11 Improved Management of Target Schools

Source: ibid

In the Education Department's view, the project has been a very worthwhile contribution to efforts to improve the quality of education in Mangochi.

4.3.1.2 Health

The project supported the construction of a maternity wing, maternity units, waiting homes, health posts and staff housing. Table 4-2 identifies the number and percentage achieved.

	#	%
Maternity Block	9	100
Waiting Homes	13	100
Health Posts	10	100
Staff Houses	10	100

Table 4-2 Health Infrastructure Supported

All health infrastructure facilities were visited by the technical audit team at the start of 2018. Table 4-3 summarises the audit's findings.

	Unsatisfactory %	Moderately Satis-factory %	Reasonably Satis-factory %	Average %
Maternity Blocks	56			44
Health Posts	40	50		10
Waiting Homes			77	23
Staff Houses	60		40	

Table 4-3 Technical Audit Findings on Health Infrastructure

Source: Op cit

Of particular concern are the findings in respect of the Maternity Blocks, Health Posts and Staff Housing. Unsatisfactory construction outcomes of this size undermine effectiveness and are a strong negative influence on achieving both output and outcome. The technical audit's reasons for this finding are the same as those for the inadequate quality of some of the education infrastructure (see above). However, the technical audit also notes that

"Not all completed infrastructure is functional. The reasons vary from lack of staff, late completion of the project by the contractors to management issues where staff at the health centre are waiting for the facility to be officially opened."

The evaluation was informed that the absence of staff stemmed from the public sector hiring freeze imposed in 2012[16]; the district had successfully sought approval for the recruitment of additional nurses at the start of 2018 but, because of training requirements, the additional recruits would only become available in the second half of the year. More positively, the technical audit determined that

"Those [facilities] that are functional are used for intended purpose except for those odd cases. At one Health Centre, one room of the waiting home was used as maternity because the newly constructed maternity is not functional. In other instances, space at the waiting home is used as storage. There are also instances where the facilities are underutilised."

The project also sought to equip the new facilities and ensure that they were either connected to the grid, which has its own challenges[17], or had solar power. In addition to the load shedding, a further challenge is the cost of electricity for the grid-connected health centres and maternity units, whose connections (at 133%) well exceeded the target.

[16] The Nation Online, 28 December 2014.

[17] The Escom Malawi grid experiences considerable challenges, which the supplier meets through load shedding (Mangochi town and the surrounding areas, for example, are denied Escom electricity for an average 18+ hours every week (Thursday). See: http://www.escom.mw/load-shedding-alerts.php

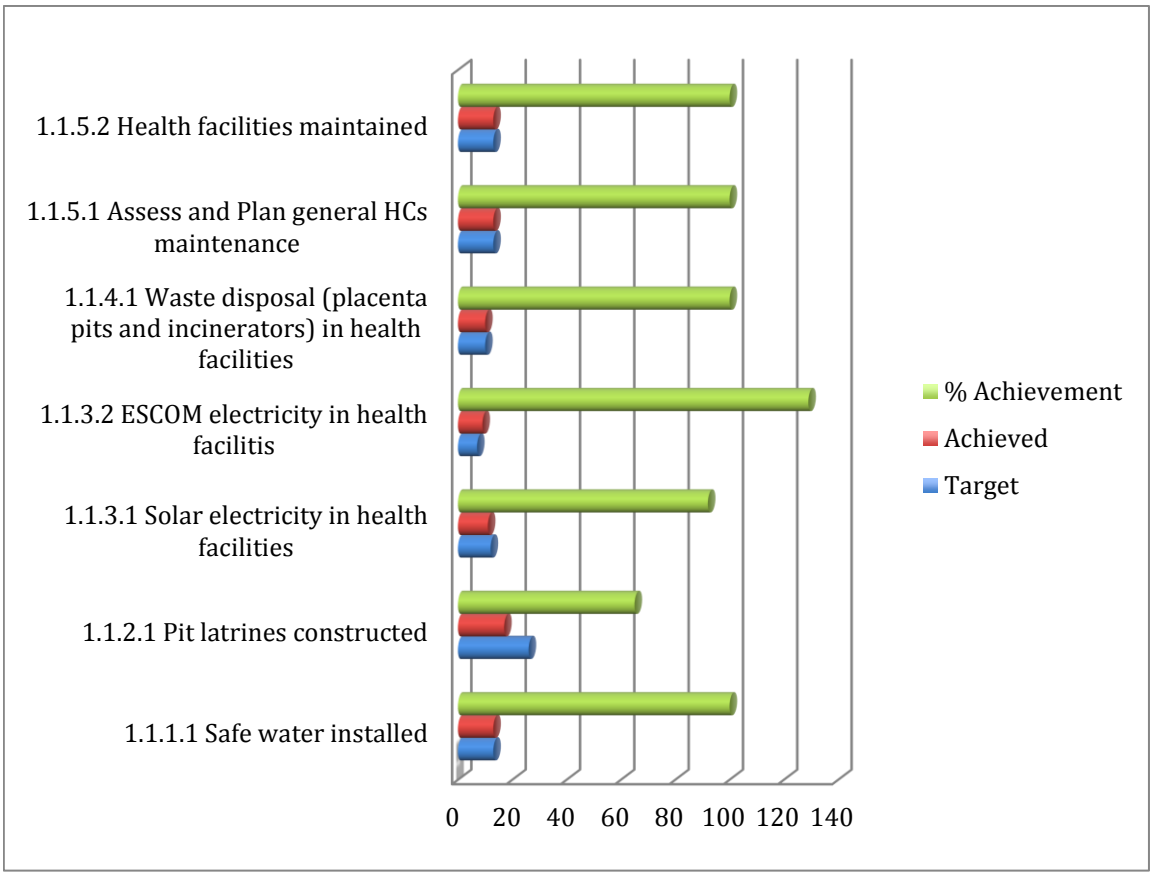
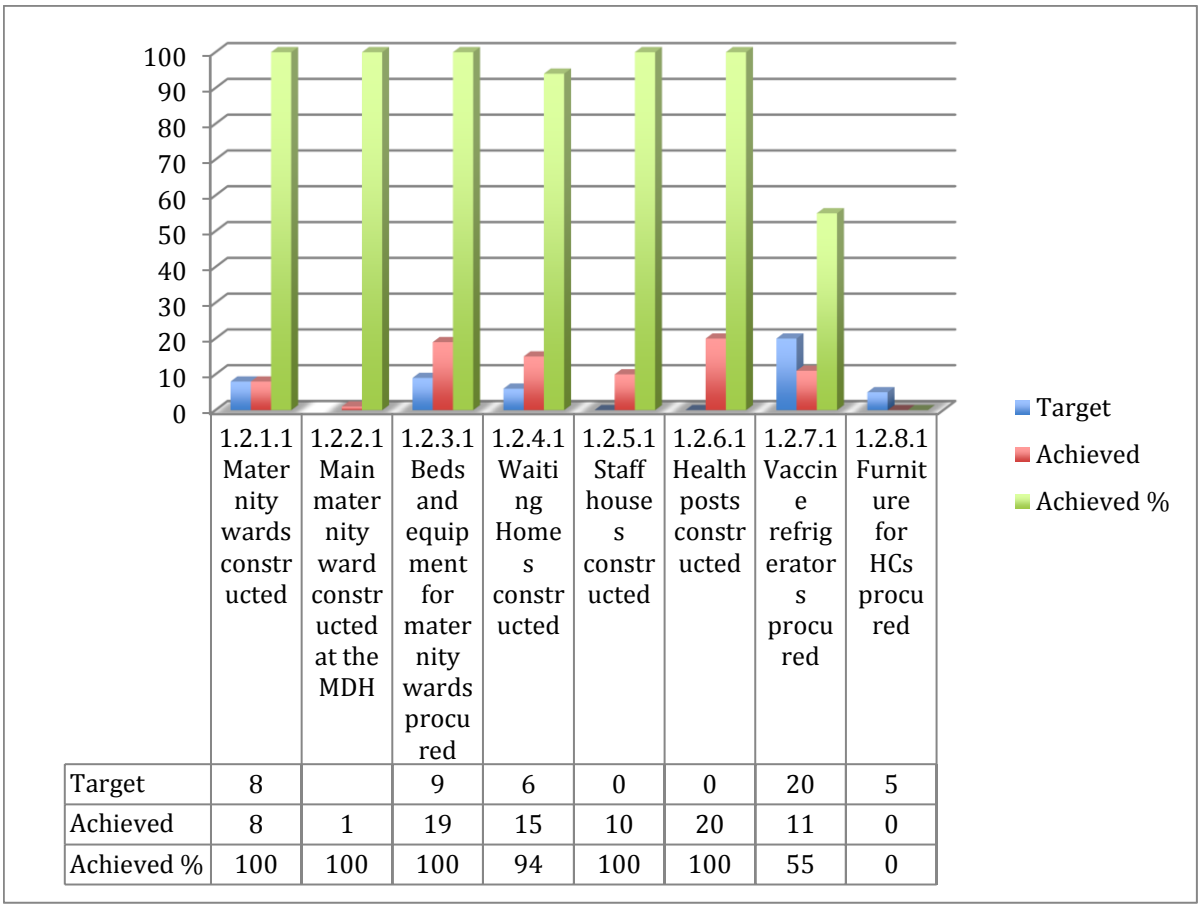


Figure 4-12 Improved Health Services Infrastructure

Source: ibid



	1.2.1.1 Maternity wards constructed	1.2.2.1 Main maternity ward constructed at the MDH	1.2.3.1 Beds and equipment for maternity wards procured	1.2.4.1 Waiting Homes constructed	1.2.5.1 Staff houses constructed	1.2.6.1 Health posts constructed	1.2.7.1 Vaccine refrigerators procured	1.2.8.1 Furniture for HCs procured
Target	8		9	6	0	0	20	5
Achieved	8	1	19	15	10	20	11	0
Achieved %	100	100	100	94	100	100	55	0

Figure 4-13 Improved Infrastructure and Equipment in Maternity and Child Health

Source: ibid

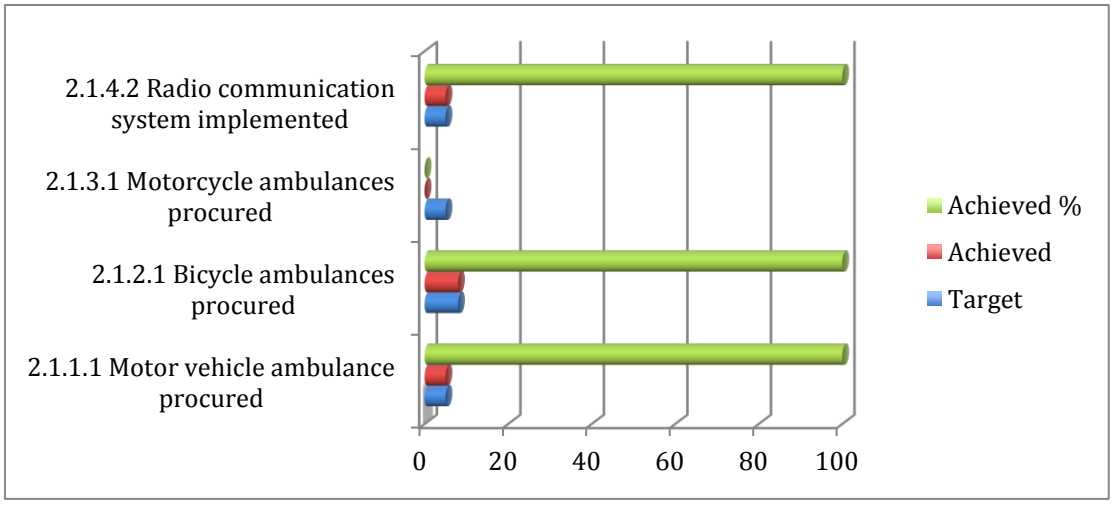
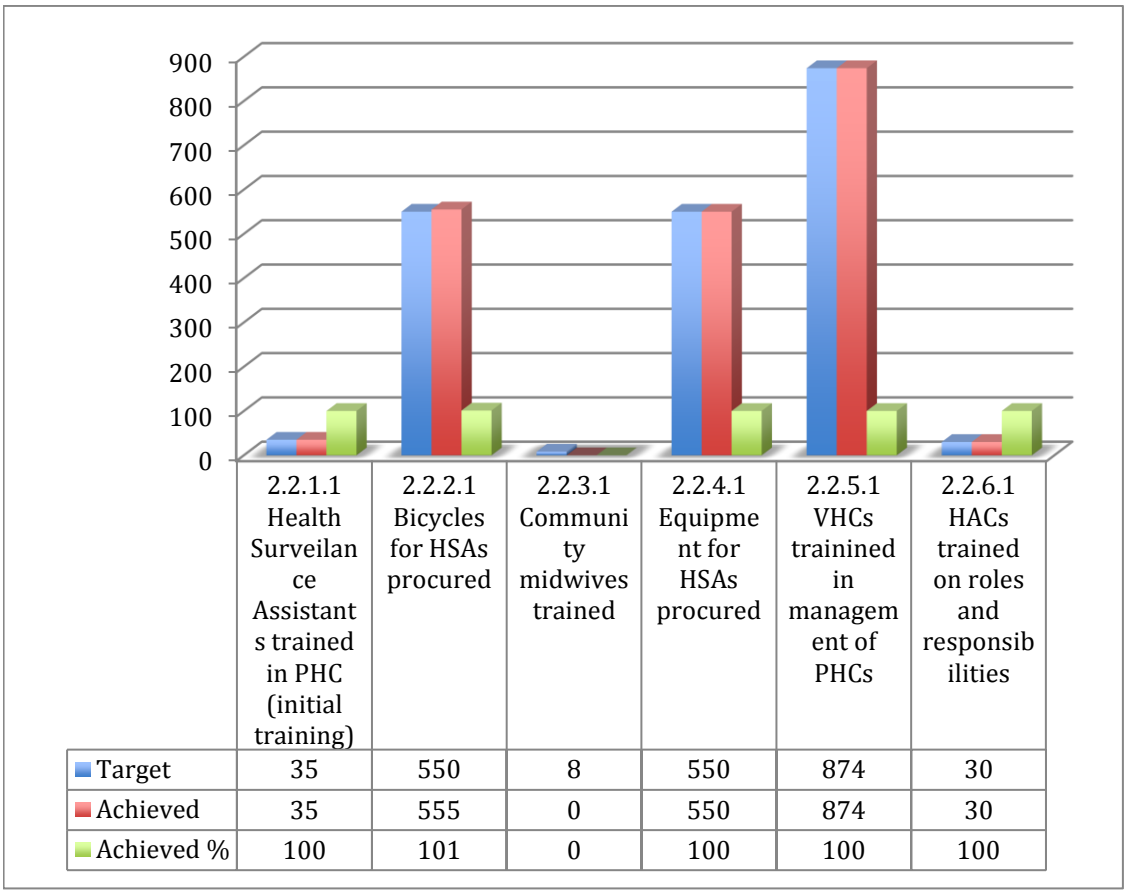


Figure 4-14 Improved Referral System

Source: ibid



	2.2.1.1 Health Surveilance Assistants trained in PHC (initial training)	2.2.2.1 Bicycles for HSAs procured	2.2.3.1 Community midwives trained	2.2.4.1 Equipment for HSAs procured	2.2.5.1 VHCs trainined in management of PHCs	2.2.6.1 HACs trained on roles and responsibilities
Target	35	550	8	550	874	30
Achieved	35	555	0	550	874	30
Achieved %	100	101	0	100	100	100

Figure 4-15 Strengthened Community-based Health Services

Source: ibid

4.3.1.3 Water and Sanitation

Figure 4-15 details the success of the project in providing access to potable water. The project supported 208 new boreholes and refurbished 112; both these achieved the targets set for the entire project period. 124 protected shallow wells were constructed; this was 11% below the all inclusive target set. The missed target reflects the timing when the funds became available (September/October[18]); work to construct shallow wells has to start in the dry season or the well is muddy because of rainwater runoff. The funds were only released at the start of the summer rainy season, making the construction of shallow wells unsuitable.

[18] This information was confirmed separately by the Education Department, which reported it impacted negatively in infrastructure development.

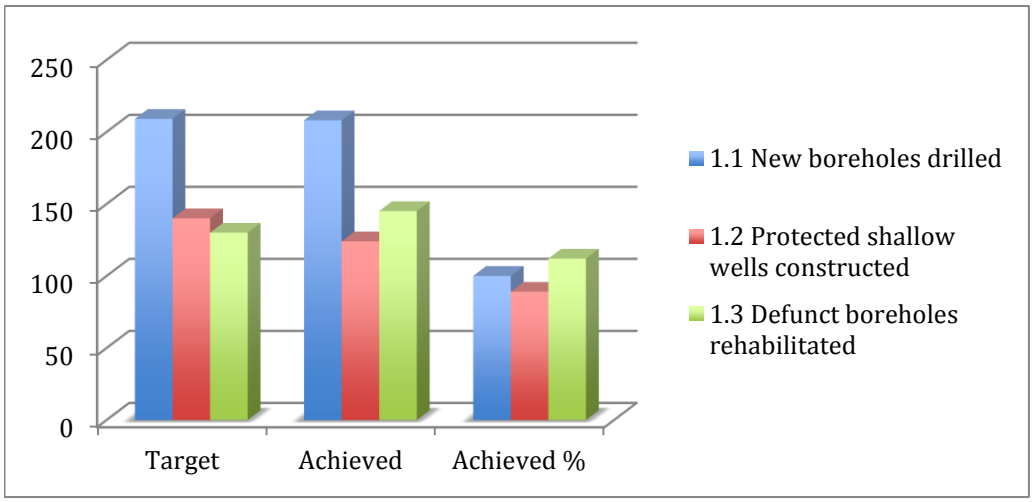


Figure 4-16 Increased Sustainable Access to and Use of Potable Water

Source: ibid

The technical audit investigated the sources of water utilised by the district's population. Their findings are summarised in Table 4-4.

Source	%
Borehole	67
Protected Shallow Well	31
Direct from lake, rivers, streams	2
	100

Table 4-4 Sources of Drinking Water

Source: Op cit

The evaluation, therefore, concurs with the conclusion of the technical audit that 'the project has improved the general wellbeing of people in the district by increasing access to safe and clean water. From the sampled areas, the percentage of people accessing water from unsafe sources such as rivers, streams and directly from the lake is very small' [Op cit].

The technical team visited 41% of the improved water sources. Table 4-5 summarises its findings.

	Non-Functional %	Very Unsatisfactory %	Satisfactory %
Boreholes	4	9	88

Table 4-5 Technical Audit Conclusions on Improved Water Sources[19]

Source: Op cit

It is important to note that the 88% satisfactory rating is an important achievement, exceeding both education and health infrastructure provision ratings. It appears likely that an important contributory factor in this regard is the

[19] Totals may exceed 100% due to rounding.

presence of skilled WMA personnel on site during drilling and installation. Furthermore, only once a headquarters-based technical team had signed off the quality of the work carried out was the contractor paid. This mitigated the poor record in the water sector identified in the University of Strathclyde's research[20], which found that many bore-holes are dysfunctional because of poor drilling and installation, significantly reducing the AfriDev pump's projected life[21]. Nonetheless, the fact that 13% of the significant 41% sample visited were found to be either non-functional or very unsatisfactory is a matter for concern.

The medium- to long-term sustainable of the improved water sources depends on the community management structures being both enthused about their roles and possessing the necessary technical expertise to enable them to fulfil their expected functions. Figure 4-16 outlines the project's achievements in this respect.

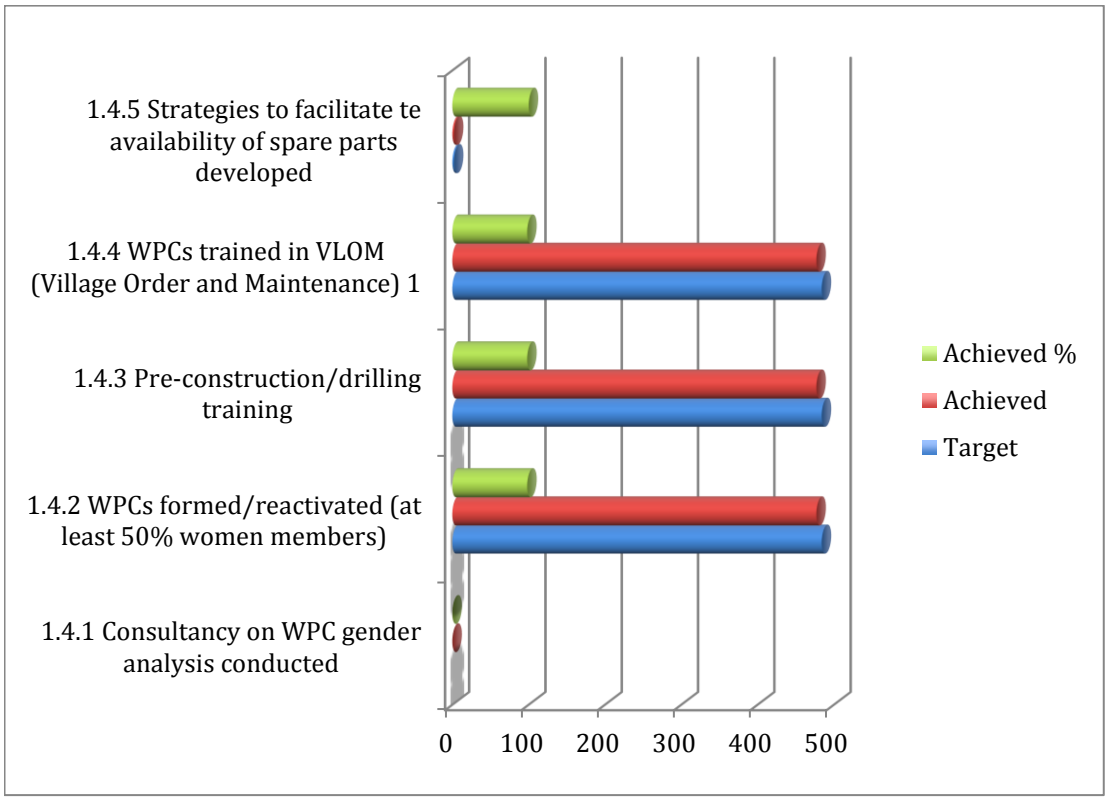


Figure 4-17 Community Management and Technical Skills Strengthened

Source: ibid

A key aspect in this regard is the local availability of spare parts and the ability to make necessary repairs. The project fully achieved its target in identifying strategies, including water user charges for this purpose, to address this need and mobilising communities behind these.

[20] https://www.strath.ac.uk/research/subjects/civilenvironmentalengineering/environment/water/

[21] The DWDO reports that three – four years ago, the Department found that some AfriDev brands have been found to be of a lower quality than others. As a result, their procurement focused in securing the best quality and most reliable brand.

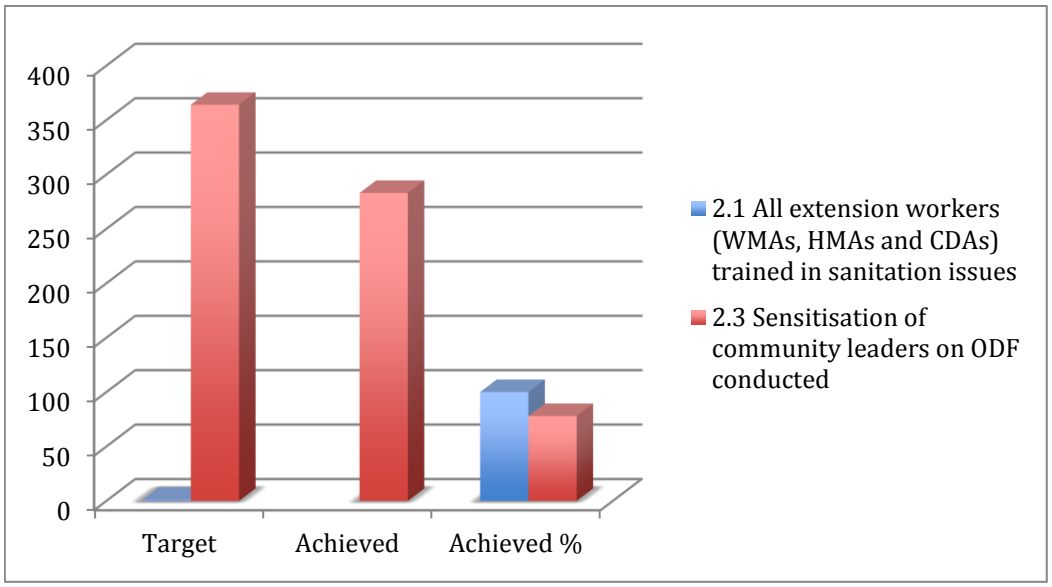


Figure 4-18 Access and Use of Sanitary Facilities Improved

Source: ibid

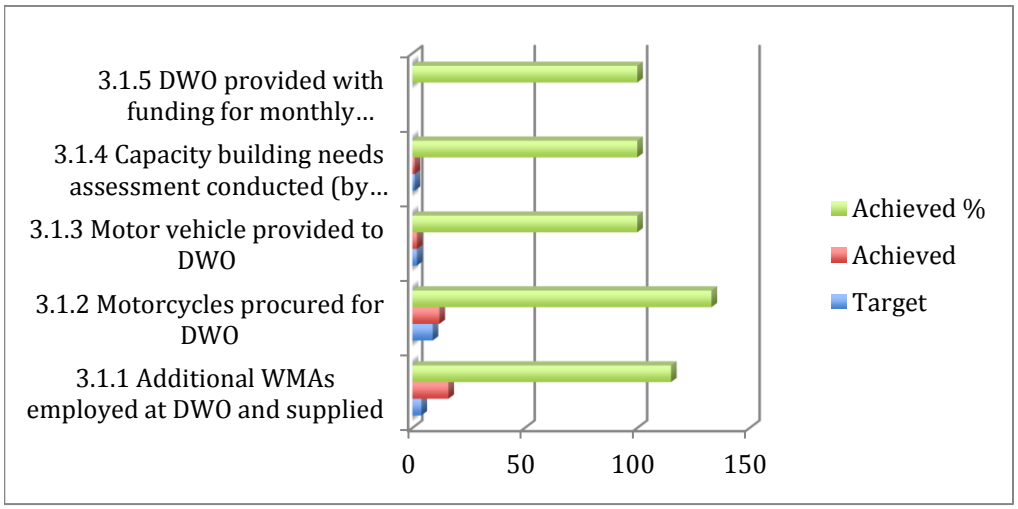
Figure 4-16 clearly shows the achievement of the training and ODF sensitisation conducted (78% of target achieved). In total 48 villages in (former) Chimwala TA had been certified ODF as of the end of 2017. (See Bamusi Village ODF Case Study at Annex 8.)

The evaluation visited a number of the installed sanitary facilities. In almost every instance of a domestic toilet, they are best described as a modification of a traditional pit latrine. The structures are all temporary and the surroundings are reed and grass. In no cases, were concrete slabs noted. In a number of cases, the toilet had collapsed in during the recently concluded rainy season and had had to be reconstructed. While it is true that some had lids, the majority did not. In addition, the surrounds were temporary – slight poles and thatch.

By no stretch of the imagination can these toilets be described as improved; for this to be the case, at the very least the slab has to be concrete and the hole covered. The definitive improved toilet is a VIP, which includes a permanent surround and a covered vent pipe, which traps the flies inside.

Furthermore, only a limited number of toilets had adjacent hand washing facilities. In many under-privileged communities such facilities are adapted from available materials: typically 'tippy taps' are plastic water or soft drink bottles filled with water and hung next to the latrine's door with soap or ash conveniently placed. Of considerable concern, was the absence of even basic hand-washing facilities at health centres (e.g. Chikole HC), where water was neither available next to the latrines, nor in the clinicians rooms. There are clear hygiene issues; but, the absence undermines the CLTS/ODF message.

The key area of capacity development support to the DWDO lay in the recruitment of 16 additional WMAs, bringing the total number in the department to 19; this is close to the expected complement of 20. This, together with the procurement of motorcycles, meant that the department's ability to fulfil its responsibilities was massively expanded. Together with the financial support for administrative and operational use, this enabled the department to be more effective in fulfilling its mandate.



[22]

Figure 4-19 Capacity of DWDO Increased

Source: ibid

4.3.2 Contribution to MBSP Outcome

The overall objective of the MBSP was to assist the Malawian Government and the Mangochi District Council to improve living standards in the rural communities in Mangochi District. This will result in a more resilient population in adversity and a more resourceful one for self- sufficiency. It sought to achieve this by targeting three sectors:

a) Improve quality of education in target schools to reduce drop-out and repetition and promote effective learning;

b) Increased availability, access and utilisation of high impact, quality maternal and child health services in Mangochi; and

c) Increased and sustainable access to and use of improved safe water sources and improved sanitation practices in TA Chimwala.

The contribution to MBSP outcome, therefore, depends on the extent to which the individual projects have achieved the above three outcomes and the degree to which the whole exceeds the sum of its parts.

4.3.2.1 Education Project

There is considerable appreciation of ICEIDA education investment in the district. Although not all the initial pre-ICEIDA challenges have been resolved, the investment contributed to improving both the teaching and learning environment in the target schools. Examples of such gains include:

a) Classroom blocks that have provided incremental learning space with the backdrop that a number of classes were conducted in open air or under trees before the MBSP;

b) the construction of additional teachers' houses has resulted into an increased in the number of teachers accommodated on compass which is also a motivation for teachers; and

[22] 3.1.1. Additional WMAs employed at the DWO and supplied with supporting; 3.1.4. Capacity building needs assessment workshop conducted (by EWB); 3.1.5. DWO provided with funding for monthly administrative and operational use

c) the improved toilets have also contributed to improving the learning environment, especially for girls who require privacy to take care of their menstrual needs.

ICEIDA's introduction of standardized tests was highly rated because it has helped learners to acclimatise to a real examination environment, a departure from the past where tests were written in exercise books. The standardized exams have high regard because all twelve schools compete and this helps motivate learners to work hard and score highly. Although the tests have been discontinued in upper primary classes (Standards 5 - 8) they have subsequently been introduced in lower classes (Standard 3 – 4), laying the groundwork for examination acclimatisation earlier. Some schools have sought successfully to maintain the upper primary exams by seeking contributions from parents/guardians to cover printing and photocopying costs.

The introduction of the quiz amongst programme schools is another ICEIDA innovation that has encouraged both teachers and learners to prepare well. In the process it has encouraged learners to read widely in preparation. The quiz has also motivated teachers to prepare their learners for a competitive experience. Skills development empowered teachers to be more assertive and confident in teaching topics, usually skipped before participation in training. Despite the fact that not all teachers were trained, all project schools acquired necessary skills with potential for productive utilisation.

Key risks arising from such capacitation appear to be:

a) Project schools may lose skilled teachers due to transfers as the schools have no control over the matter; and

b) Some teachers' skills largely remain unexploited due to lack of teaching materials such as graph paper for mathematics and materials for expressive arts (e.g. materials for weaving, knitting, etc.). Although expressive art is in the primary school curriculum, the Ministry of Education Science and Technology (MoEST) does not provide for such materials in its budget and parents/guardians are also unable to acquire the materials. Hence expressive art may gradually vanish if strategies for supplying materials for practical activities to schools are not established.

A number of challenges persist. The number of learners, who drop out of school remains high in terms of absolute numbers, despite substantial enrolment increases. The main issue appears to be the disinterest of parents/guardians to ensure that their children remain and perform well in school. Cases of pregnancies and early marriages, migrating to South Africa as young as 13/4 years[23], and engaging in fishing while in school are matters of real concern. Distance to school also affects learners, resulting in mismatch between age and class. There also seems to be no effective support from community leaders to work jointly with teachers and school governance committees to confront the school dropout issue. The male role models are school dropouts, who either go and work in South Africa or turn into fishermen in their teens and acquire 'wealth' despite low academic credentials[24].

It was evident from focus group discussions with school governance committees that some of the committees remain weak, have little understanding of their roles and responsibilities, and are not innovative/empowered to initiate change. This particularly affects school management committees (SMCs) and Parent Teacher Association. [By

[23] It is important to emphasise that such migration is essentially child trafficking. Under age children (i.e. under 18 years) require the sworn written consent of parents, a passport and a full birth certificate to enter SA legally. In effect, therefore, such child migrants are entering SA illegally and, in all likelihood, are employed at virtual slave wages in the SA agricultural sector.

[24] It is worth noting that, despite an increasing number of TAs introducing bye-laws outlawing early marriage, parents encourage girls to leave home and marry school dropouts who are seen to have assets either through migrant labour or fishing.

contrast, Mothers Groups appear to have a clear understanding of their roles and modus operandi and are very active in supporting girl children and addressing early marriage, especially in those TAs where local bye-laws have outlawed the practice.] There have recently been elections where some entire committees have been dropped with some retaining a few existing members. As a result, there is need for capacity enhancement to enable new committee members understand their functions and deliver effectively. Providing refresher trainings to ensure that all members remain abreast with new school management approaches are also desirable.

4.3.2.2 Health Project

There is good progress in safe motherhood in that, increasingly, most deliveries are done at a health facility attended by a qualified health worker. For example, Traditional Birth Attendants (TBAs) have been eliminated in Katuli HC catchment area. Maternal and new borne deaths are increasingly rare, based on the discussions at Katuli (between 150 – 200 ANC attendees/month), Namwere (up to 20 deliveries/day) and Jalasi (on average 100 deliveries/month) HCs. The overall picture is reinforced by reports from the Kwitunji VHC, which reported the only maternal death in the Katuli HC catchment area; the deceased, who attended the ANCs like most pregnant women in the village, was advised to remain at the HC but opted instead to return home to collect some belongings and then return. Unfortunately, delivery started at home and complications set in.

The establishment of HAC at the health centres is a positive implementation of national policy; it has also proved to be a sound idea in terms of patient and health centre staff conflict/dispute management and ensures that both parties' rights are respected. HAC has scheduled quarterly meetings, monitors the receipt and utilisation of drugs by the HC, and plans/develops a work plan for its activities. However, despite early training on responsibilities, current HACs have not been oriented to their responsibilities, which impact their effectiveness in improving services delivery. As an important institution whose members are periodically elected, it needs training and/or orientation. The direct involvement of the TA leadership and representatives of political parties as HAC participants reflects political will to advance the objectives of HAC, emphasising the importance of the committee's regular capacity enhancement.

No VHC has received any training in the members' functions or even the uses of the basic drugs and equipment with which they are provided. In Kwitunji village (some 10 km from Katuli), the VHC, despite lack of training, appears abreast with the health issues that affect its community. The VHC also expressed considerable concern over the experience of women of the attitude of HC maternity staff, which was described as unfriendly to expectant mothers especially at night. Hygiene conditions at the HC were also perceived to be a deterrent to expectant mothers to move into the facility early, while awaiting delivery. As a result, it was reported that expectant mothers wait frequently until the last moment to move to the HC, some mothers delivering en route.

There emerged in the course of field visits the existence of under-utilised infrastructure. For example, the Under-5 growth monitoring facility in Kwitunji village is only used once a month; the facility has solar power and furniture and potentially provides a base for other health-related provision, including as a site for ANCs. Constraints of more efficient utilisation include: there is no Health Surveillance Assistant (HAS) in the area, Katuli HC has limited ANC portable equipment, only one vehicle (an ambulance) is available, and has few nursing staff that is responsible for ANC. All form barriers to the efficient utilisation of the Under-5 facility infrastructure. It is important for HCs in consultation with the DHO to explore ways of utilising such facilities more productively.

Construction of maternity unit and waiting homes at HCs in the district have been completed relatively recently. Most of these facilities remain to be commissioned for operation. All are larger and more spacious facility; in Katuli, for example, the new unit has 8 beds (a 267% increase) compared the current ward. Other HCs have also seen increases, a doubling of delivery beds at Jalasi, an additional full scale maternity ward at the district hospital, and so on. However, based on reports, there is often a need for improved nursing staff attitudes vis a vis patients, as well as improvements in hygiene standards. Both should be a priority.

4.3.2.3 Water and sanitation project

It is without question that the installation of water facilities has improved the lives of families in the project focal area. More people have access to clean and safe water, congestion has been reduced, cholera has been eradicated, and other water borne diseases have also been considerably reduced[25]. Women and girls no longer travel long distance to collect water, most spending less than 10 minutes to access safe water, a sharp drop from 30 plus minutes walking time to a water facility before ICEIDA's support.

Nearly all Water Point Management Committees (WPMCs) have been trained in water point management including technical aspects, in particular opening, inspecting and replacing worn out parts of borehole pumps. The training also included local leaders in order for them to garner support for community mobilization and contribution to the water point maintenance fund. Local mechanics have also been trained and equipped with basic tools for maintenance.

However, challenges remain: some communities have at the water point maintenance fund but some users are unwilling to contribute stemming from mistrust between community members and WPMCs, principally around the latter transparency and accountability of the maintenance fund's management.

[25] Only Namwere HC reported water borne diseases, especially diarrhoea as amongst the top three causes of morbidity.

No feedback mechanisms, which would facilitate the interface between the WPMCs and the community (e.g. through village meetings to explain how much was raised, utilized, and the balance) exist. An improvement would be:

a) to involve local leaders in the communities where they are not actively involved;

b) schedule monthly meetings for the WPMCs to interact and share information on the status of the fund and get community feedback; and

c) introduce a simple cash book system whereby all transactions are recorded for water users to inspect.

This could probably restore confidence in community members and motivate non-compliant water users to start contributing to the fund. Of greater long-term concern, there were no viable sustainability plans for the water facilities with community contributions remaining the major source of necessary funds.

There are also hygiene and environmental in the immediate surround of the water facilities. Where committees are weak or in conflict with community members, the hygienic standards are low: community members fail to clean the area, leaving the responsibility to the WPMCs. Typically, waste pits/tanks/soak-aways in most of the water facilities were observed to be overflowing, a reflection of silting or blockage of the waste disposal channels, resulting in both hygiene and waste water problems. To some extent this is a design problem, which needs to be corrected. In some boreholes/shallow wells the waste tanks are emptied and cleaned at least twice a week, which is not in accordance with design specifications. The alternative would be to re-construct the soak ways but funding might be a constraining factor.

Most households have latrines, which are also utilized. A majority of those observed are temporary structures constructed from poles, grass thatch and mud floors; only a few that have concrete floors, a minimum requirement for an improved latrine. Some structures are semi-permanent[26], walls being constructed with burnt bricks, grass thatched, but with a mud floor. These structures have proved vulnerable to adverse weather conditions (i.e. the rainy season) as a good proportion collapsed during the just-ended rainy season. Renovations are underway and sharing of latrines is currently a common phenomenon. Without infrastructural support especially for the concrete floors, the ODF status in some communities appears threatened due to the latrines vulnerability to weather conditions and annual replacements, which is likely to be expensive.

[26] The former ICEIDA Country Director noted in an email to the evaluation: When the water and sanitation project was being prepared there was considerable emphasis from our part (ICEIDA) that all latrines should have a concrete slab. We therefore wanted to find ways to provide slabs to each family that would build a latrine. If you like, some sort of a prize for having done the hard work. We knew, and still know, that most of the families in the target areas can ill afford a slab, or the cement if they were to make their own. However, the Ministry dealing with sanitation was vehemently opposed to this because the government had a zero subsidy policy relating to sanitation. We were therefore not allowed to provide any such support in the sanitation project. We tried hard to find ways around this; we suggested to set up a fund that would allow local artisans to be trained in making the slabs and that the slabs made during training would go to the project. This would have two benefits: (i) training people in a craft that would give rise to income opportunities, and (ii) providing the slabs for the project. The answer was no. We suggested that we could do a pilot - providing some with slabs, others not, and at the end of the project compare the two groups in terms of quality of the latrines etc. The answer was no.
At the end of the day, we decided to continue with the project without the slabs. After all, the sanitation part costs very little in the big picture and we felt that any progress was better than no progress. We were nonetheless very unhappy with the stringent line taken by government in this matter.

The foregoing sections have demonstrated that

1. According to the education department, there is clear evidence of reduced repetition and drop-out in the 12 target schools. Furthermore, based on the evidence of growing over-subscription of the target schools (parents voting with their children's feet), the quality of education and the management of the schools has also improved. Given the unique relationship between the project and the 12 target schools, it is perhaps easiest to attribute the project supported interventions to the evidence of positive changes in those schools. More widely, the project is expected to contribute to an overall improvement in the quality of education in the district as parental pressure rises for other schools to emulate the achievements of the targeted twelve.
2. The potential exists for improved access to and quality of maternal and child health services. While there are remaining challenges (the need for infrastructure repairs, increasing the functionality of the infrastructure through appropriate staffing levels, etc.), there is evident potential and, by all accounts, clear political and administrative commitment to ensure that the potential is met. While there are clearly challenges surrounding attribution, it is safe to say that the project has made a contribution to the achievement of this outcome.
3. Similarly, there is clear evidence that there has been a decline in the utilisation of unsafe water sources (> 2% according to the technical team's survey). And, there has also been an improvement in sanitation, 48 villages having been verified as ODF in (former) Chimwala TA. It is possibly too early to see visible improvements in water-borne disease morbidity levels but, if safe water use is sustained, such gains in proxy indicators will be visible in the short-term.

Across all three sectors, the sustainability of the gains achieved will determine the continued contribution to the MBSP's stated desired outcome: to contribute to people's improved living standards in the district.

4.4 Community perspective

Antenatal care (ANC) is defined as health care (medical and support services) of the pregnant woman and her foetus from conception to the onset of labour[27]. ANC helps to ensure that the expectant mother and her foetus survive pregnancy and child birth in good health. ANC is also important for early detection and treatment of problems and complications, prevention of complications and diseases, birth preparedness, complication readiness, and promotion of good health.

The HH Survey results show that of the 149 mothers interviewed 100% attended antenatal care, 97.3% delivered at a health facility, 94.7% were assisted by skilled health personnel during delivery, and 100% were tested for HIV during antennal visits. These results reflect good progress in safe motherhood.

[27] Ministry of Health (March 2009): Manual for Integrated Maternal and Neonatal Care.

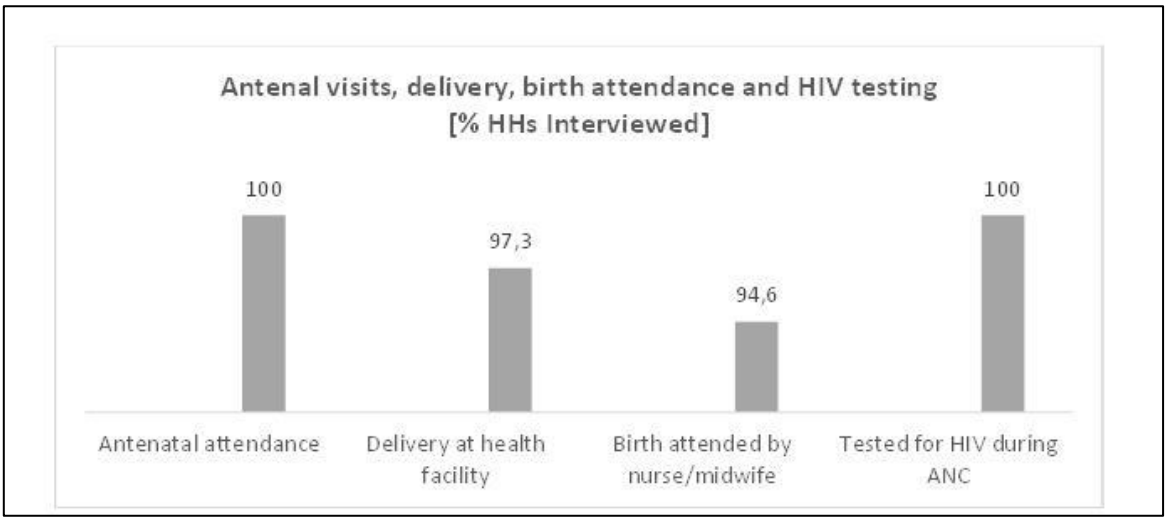
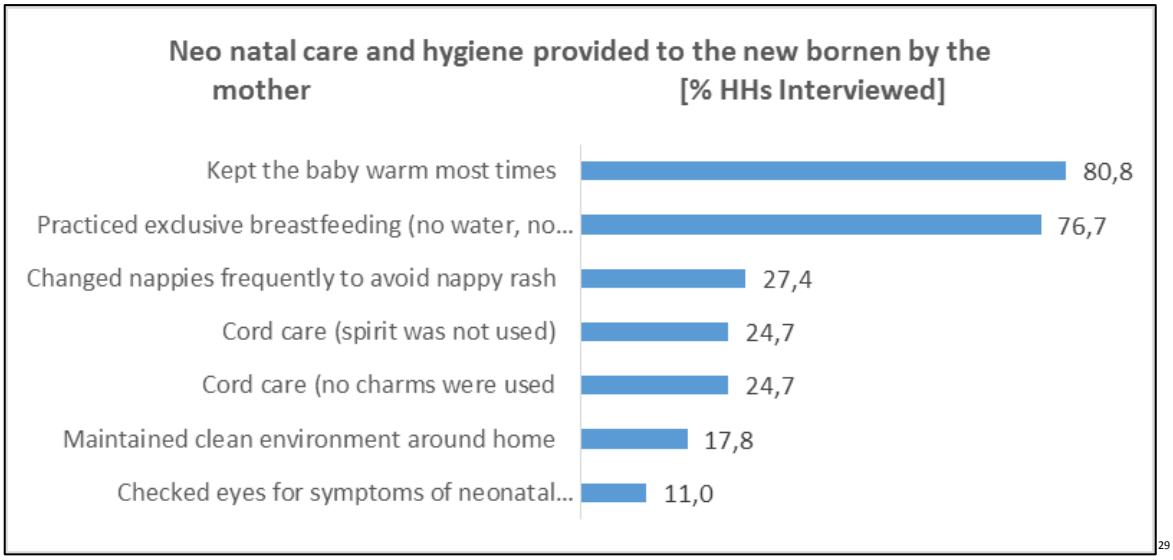


Figure 4-20 Antenatal care

Source: Household survey in Annex 9

Improved neonatal care

According to WHO[28] a new born or infant is a child under 28 days of age. During the first 28 days of life, the child is at the highest risk of dying and therefore appropriate feeding and care should be provided during this period to improve the child's chances of survival. HH Survey results indicate that only two recommended neonatal care practices were highly adopted: keeping the baby warm all the time to avoid pneumonia attack (80.8% of the mothers interviewed), and exclusive breastfeeding (76.7% vs. 68.8% DHS 2015). All the other practices had low adoption, an indication that extensive health education delivery is required.



[29]

Figure 4-21 Neo natal care

Source: ibid

[28] WHO www.euro.who.int/en/health

[29] Checked eyes for symptoms of neonatal conjunctivitis

Improved health seeking behaviours

The HH Survey assessed the incidence of diarrhoea, ARI, and malaria amongst 2-year old children and the practices mothers and caregivers provided regarding prompt treatment. The results show ARI was reported by 44.9% (vs. 63.5% DHS 2015) of the mothers interviewed and 96.8% (vs. 63.5% DHS 2015) of mothers sought treatment from a health facility; 39.6% (vs. 54.2% DHS 2015) of mothers reported malarial infection and 96.2% (vs. 54.2% DHS 2015) sought assistance from a health facility; and 18.9% (VS 38.8% DHS 2015) of the mothers reported incidence of diarrhoea and 89.7% (vs. 46.8% DHS 2015) having sought assistance from a health facility. Overall, the results show that mothers prioritized assistance from health facilities to save their children's lives. This behaviour culminates from the health education delivered with MBSP support .

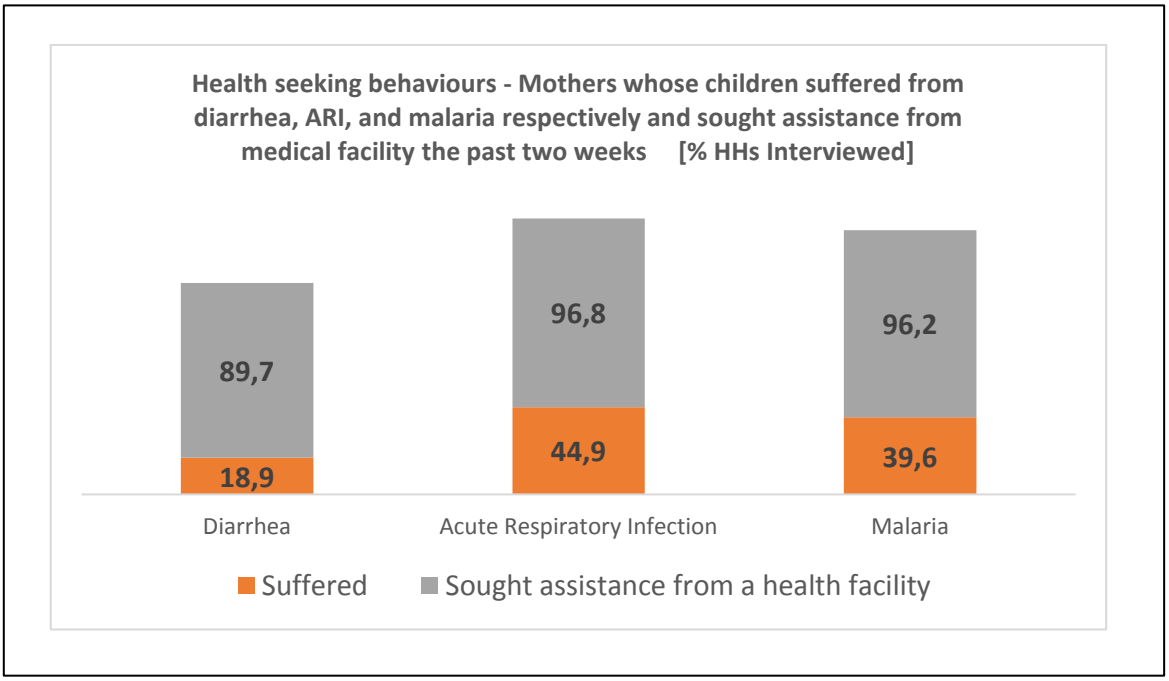


Figure 4-22 Health seeking behaviours

Source: ibid

Access to and use of mosquito nets to prevent malaria

Access to and use of mosquito nets for malaria prevention in mothers and children was good but not high enough. 79.2% of the HHs interviewed had mosquito nets (vs. 60.7% DHS 2015) and 77.9% of HHs had children sleeping under mosquito nets every night.

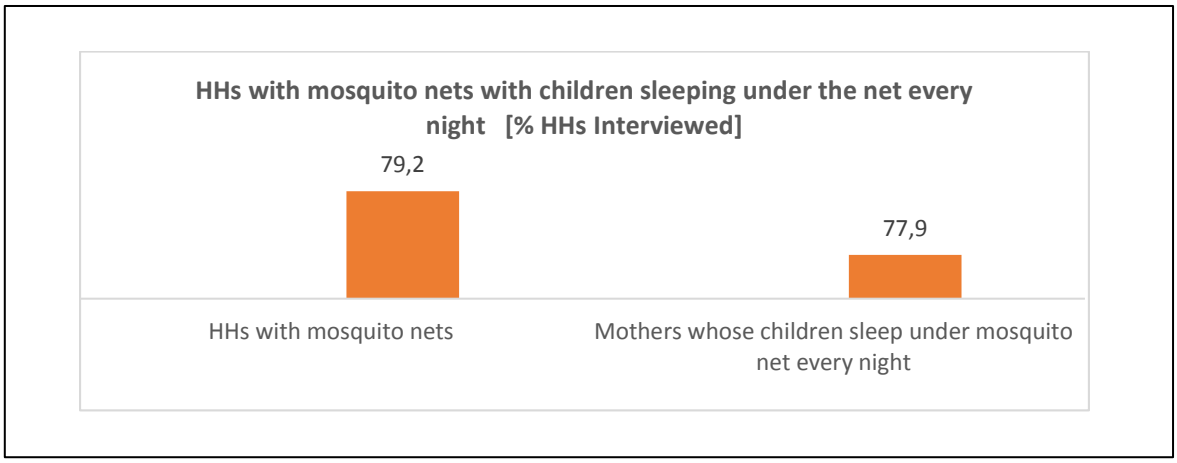


Figure 4-23 Access to and use of mosquito nets

Source: ibid

Increased child immunization

The HH Survey results show a very high immunization rate almost 100% except for Measles and Vitamin A. This is a result of the health education being delivered in Health Centres, HSAs and the VHCs.

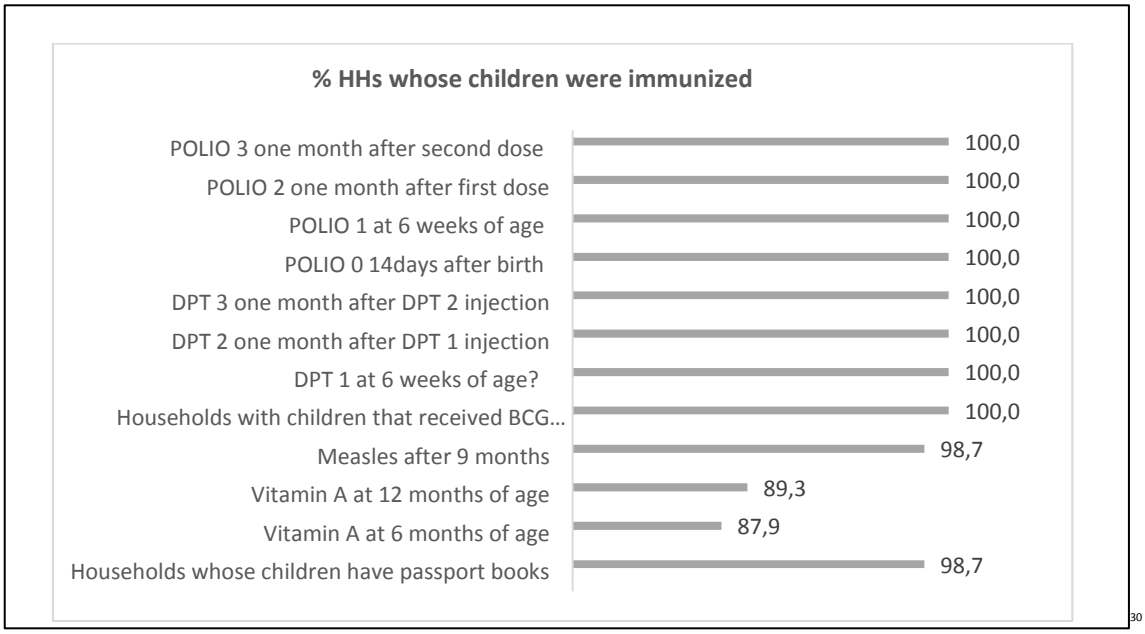


Figure 4-24 Child immunisation

Source: ibid

[30] Households with children that received BCG vaccination at birth

Education Programme

Improved performance of school governance committees with MBSP support

The HH Survey results indicate improved performance of school governance committees particularly Mother Support Groups reported by 89.6% of the HHs interviewed; Parent Teacher Association (79.3%); and School management Committees (77.9%).

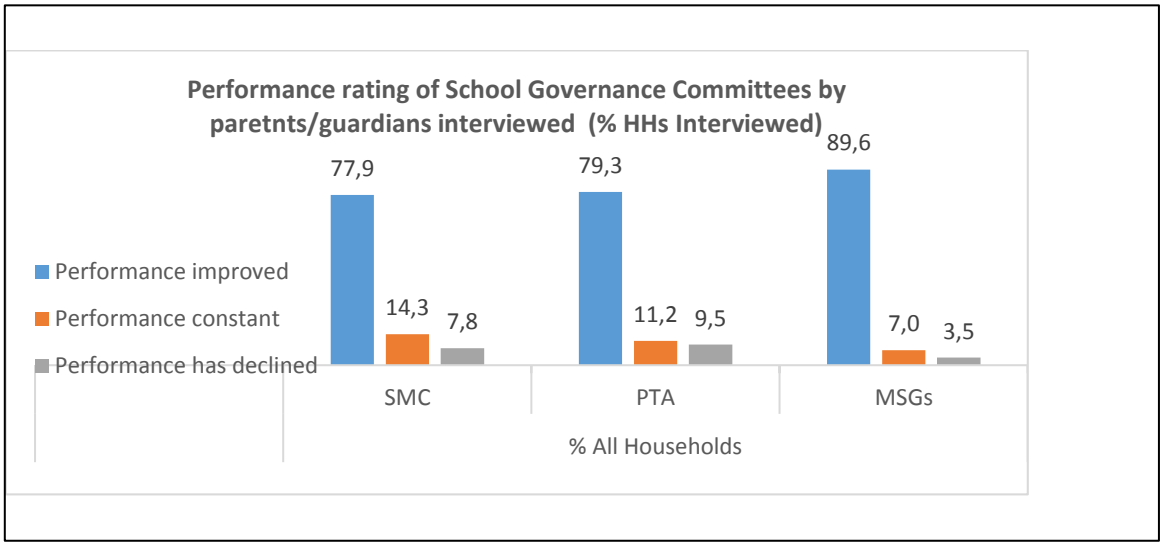


Figure 4-25 Performance of school governance committees

Source: ibid

Improved teachers' attitude towards learners

The results reflect a consensus that teachers attitude towards learners has improved due to teachers' attendance in short courses facilitated by the Malawi Institute of Education (MIE) where various skills were acquired including leadership. 84.9% of the parents/guardians reported positive change in teachers' attitude towards learners. The MBSP also sponsored training for school governance committees in order for them to recognize their core roles and to deliver effectively. The combination of teachers' and SGCs training has contributed towards improved teachers' attitude and performance.

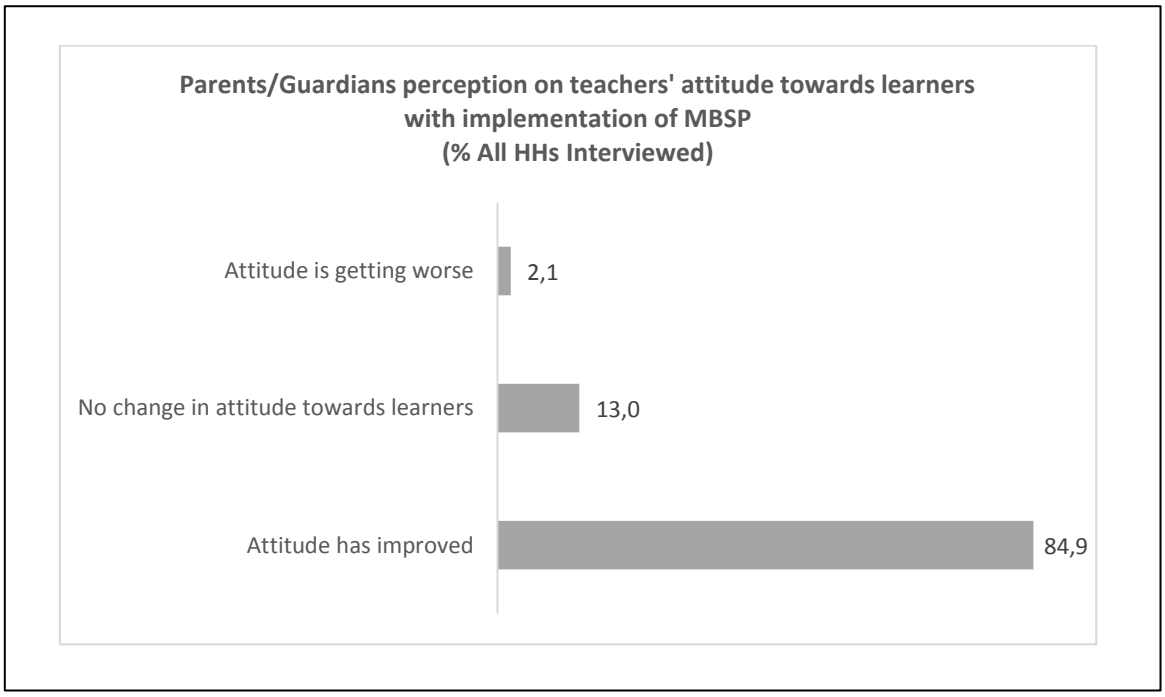


Figure 4-26 Teachers' attitude towards learners

Source: ibid

Water Programme

Improved access to clean and safe water

With the implementation of the MBSP, 98.4% of sampled households reported improved access to clean and safe water compared to 58.7% before the installation of the water facilities by the MBSP. ICEIDA's investment in the water programme has been the most successful of the three programmes according to WPMCs.

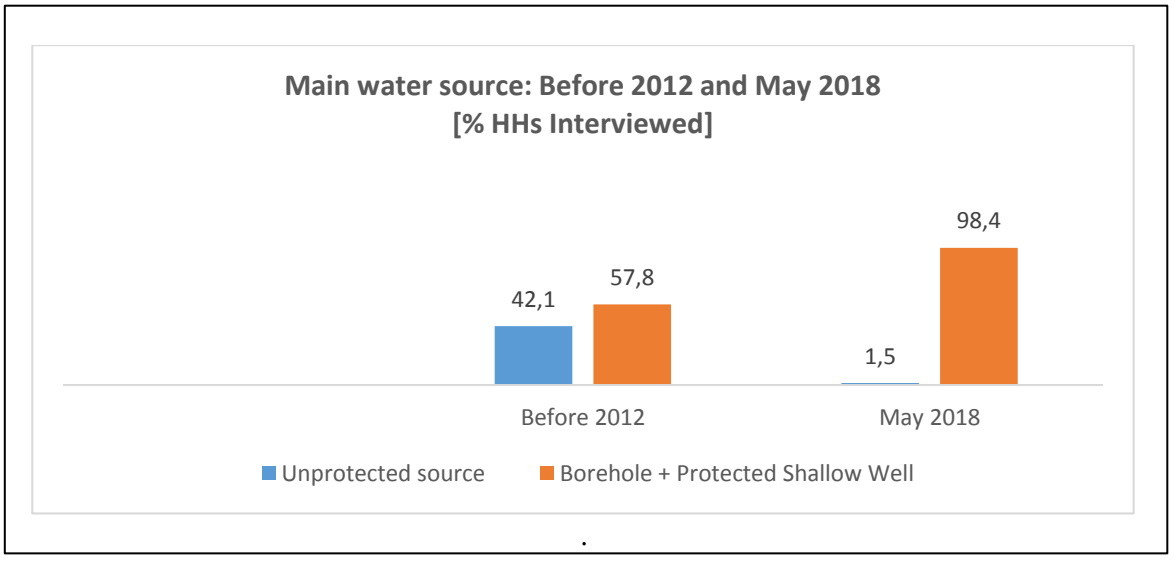


Figure 4-27 Access to clean and safe water

Source: ibid

Reduced average walking time to and from a water facility

The HH Survey results indicate that the mean walking time to a water source has drastically been reduced from 42.9 minutes before the installation of water facilities to 9.8 minutes with the installation and/or rehabilitation of water facilities in the target area. The saved walking time is being utilized by households in various domestic and economic activities.

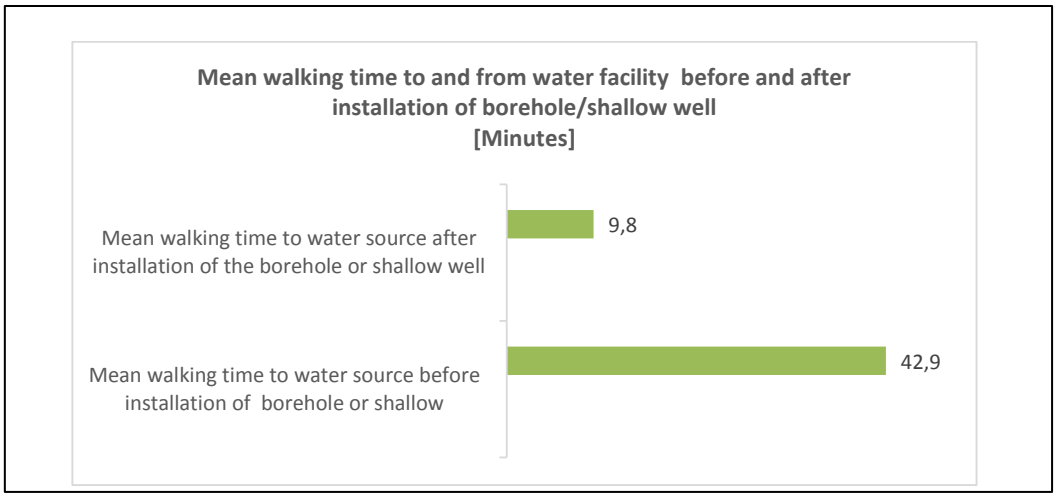


Figure 4-28 Mean walking time to and from water facility

Source: ibid

Reduced incidence of water borne diseases with the installation of water facilities

Before the installation of water facilities by the MBSP, 49.7% of the sampled households reported incidence of water borne diseases mainly diarrhoea (68.4% of HHs); dysentery (20.4%); and cholera (8.2%) With the installation of water facilities, the communities have not experienced water borne diseases in the target area.

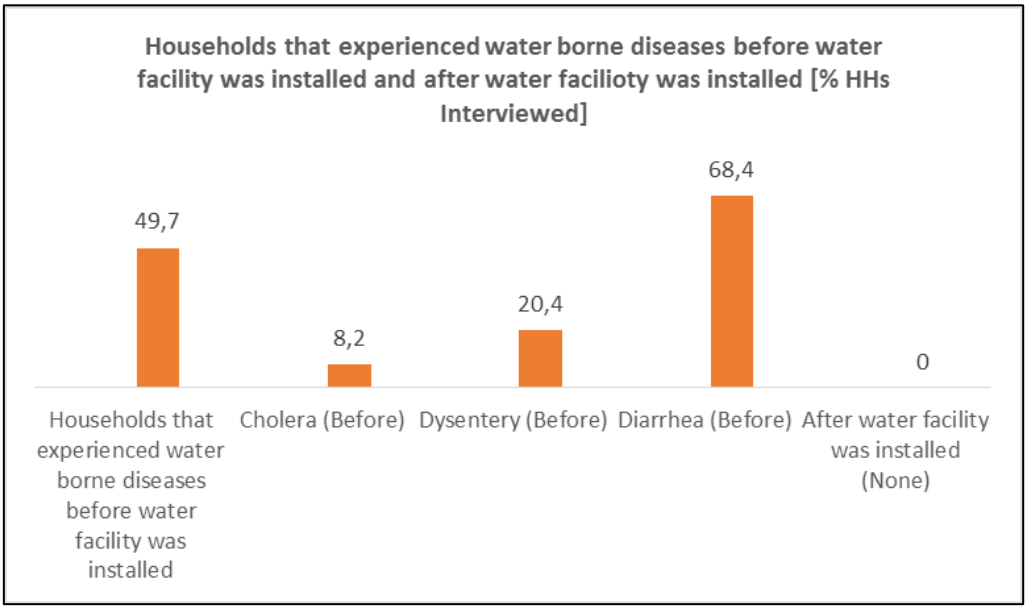


Figure 4-29 Incidents of water borne diseases

Source: ibid

Improved access to good quality water

Water quality from the installed water facilities was reported to be of good quality by 89.8% of the sampled households.

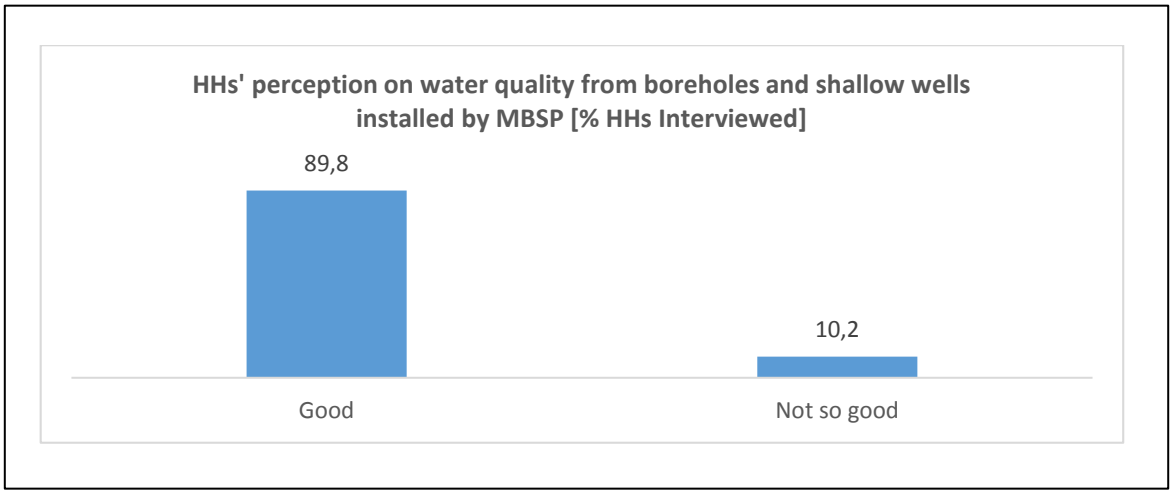


Figure 4-30 Access to good quality water

Source: ibid

Improved skills for servicing/maintenance of water facilities

One positive aspect of the MBSP's capacity building interventions at community level was to equip the communities with knowledge and technical skills in water facility maintenance. The MBSP has trained a number of village mechanics who are responsible for maintaining the water facilities. Some 99.1% of the sampled households reported that the maintenance is currently done by village water mechanics trained by the MBSP. This is an appropriate and sustainable way of ensuring community access to clean and safe water.

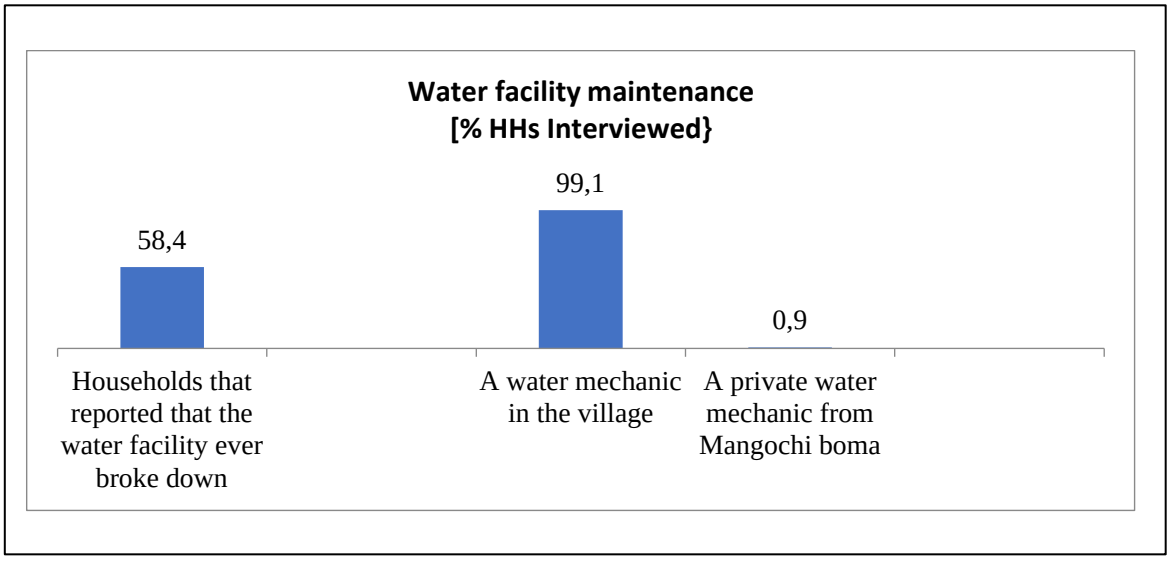


Figure 4-31 Water facility maintenance

Source: ibid

Project effectiveness has also been assessed from a community perspective in terms of results that can be attributable to MBSP implementation. The analysis is based on HH Survey Results (ANNEX 9), Key Informant Interviews (KII) with frontline staff, and FGDs with community-based committees linked to the three programmes. The results are as follows:-

4.5 Monitoring and Evaluation

The three project documents identified the M&E approach as being that of Mangochi District. What is plain from the outcome of the technical audit, whose conclusions are supported by observations in the course of the evaluation's site visits, is that monitoring was inadequate. The evaluation fully accepts that, the Water and Sanitation department aside[31], Education and Health officials do not possess the technical skills required to monitor the technical aspects of infrastructure development. As DoE officials noted, monitoring of the technical aspects of the infrastructure delivery is the responsibility of the Public Works Department and the Clerk of Works office, in particular.

Contractually, Public Works is required to approve the technical aspects of infrastructure on four occasions: when the slab is cast, when the building reaches beam height, when the structure is roofed and, finally, when the contractor notifies that the works have been completed. Furthermore, there is usually a 20% retention for at least an 18 - 24 month period, during which the contractor addresses any short-comings that emerge (the snag list) and makes good any identified problems.

The evaluation has been unable to determine whether the required technical site inspections took place. However, the scale of problems identified in the technical audit raises major questions as to whether they did; furthermore, if they did, there are inevitable questions surrounding either the technical competence of the Clerk of Works office personnel. If the technical inspection visits did not take place, then the issue is why were the payments made, itself raising questions surrounding relationships with contractors and possible corruption[32].

Whatever the answers to these questions, and the evaluation would hope that it is a matter of technical competence rather than corrupt practices and relationships, since the former is easier to address, it is plain that monitoring was inadequate to ensure that the contractors delivered satisfactory infrastructure. Measures need to be taken to address any technical competence issues, commencing with a thorough needs assessment of the Clerk of Works office and, should it be necessary, competent technical support to ensure necessary, but absent, technical skills are developed.

[31] The department states it has trained WMAs, who have the capacity to monitor technical compliance by the contractor. Furthermore, a headquarters-based technical team are the ones to sign off the technical compliance at the four contracted payment points. This technical expertise was a contributory factor in the Department's better technical delivery of the project document targets.

[32] The evaluation explored these issues with the DC in the course of the debrief. His view was that the Clerk of Works office lacked capacity and while not discounting the possibility of corruption, this was not thought to be a major problem.

4.6 Conclusions

The evaluation concurs with the MTR's conclusion that the MBSP has been effective. While there have been challenges, the overall picture presented through field work and documentary review is the (over)achievement of most targets and the delivery of the identified outputs. These outputs have proved a substantial contribution to the achievement of the MBSP outcomes: education provision has improved, despite a generally challenging social environment. Further gains, in this regard, may depend more on a more positive community attitude towards education, which will add to the benefits of improved infrastructure and teacher training.

Similarly, there is clear evidence that more mothers-to-be are presenting at HCs for delivery, which will further reduce maternal mortality rates[33] and also HIV MTC[34]. In itself, this will be a major contribution to reducing infant and child mortality in the district. And, evidence from incidence of morbidity, emphasises the benefits achieved through the Water and Sanitation project: only one HC cited diarrhoea as one of the three most important causes of morbidity in their areas. All three sets of gains are clear evidence of effectiveness.

If the three projects fell short in any regard in terms of contributing to MBSP outcomes, it was in respect to the reality that the provision of staff housing was inadequate to respond to both existing and future demand. When a HC has over 50% of its staff living outside the immediate surrounds of the centre, it poses risks both in terms of responding to night-time demands and in the staff's personal security. Similarly, when education housing provision is inadequate, the additional financial burden on teachers forced to commute to and from work is severe: a majority of Chimbende Primary School teachers, for example, have to rent privately, a significant number in the district Boma, Mangochi. Their commute costs equate to approximately one-third of their take home pay; assuming that housing rental accounts for another third, this leaves them one-third of their salary on which to live, hardly an incentive to remain in the profession. It is clearly desirable that further support in this regard is addressed.

[33] The number of maternal child birth related deaths was minimal; in one HC's coverage area, one was reported; in another, the same number in the first quarter of 2018. Nor were any new birth mortalities reported.

[34] In one HC, the total number receiving ARVs monthly from the clinic is 575. Another reported that over 40% of mothers tested in the first trimester were HIV+.

CHAPTER 5 Impact

The MTR concluded positively about the MBSP impact:

"….early impacts generated by the programme [reflected in the] change in outcome indicators between the baseline period (2011 – 2012) and 2013 – 2014. [In] Health, the percentage of births attended by skilled health workers had increased (baseline 68%, MTE July 2014 results in target HCs 96.8%); under one year immunization rate had also increased (baseline 69%, MTE July 2014 results 83.5%).
[In] Water and Sanitation: access to safe water (baseline 62.8%), MTE results for areas where water facilities were provided saw this increase to 99.1%; the number of villages verified as ODF was rising gradually (baseline 0 village), 2013/2014 programme results 16 villages.
[In] Education, improvement [was identifiable across] 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%)."

"….results also showed 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."

The DAC defines impact as the

"….positive and negative changes produced by a development intervention, directly or indirectly, intended or unintended, involving the main impacts and effects resulting from the activity on the local social, economic, environmental and other development indicators. Both intended and unintended results as well as the positive and negative impact of external factors, such as changes in terms of trade and financial conditions, are addressed. Consideration of the following is suggested:

- *What has happened as a result of the programme or project?*
- *What real difference has the activity made to the beneficiaries?*
- *How many people have been affected?"*

Impact is understandably limited at this point in time. In the first instance, impact is usually measured ex post. This section reviews the conclusions of the MTR, subject to the above caveat, and discusses whether it remained valid.

5.1 School Data Trends

The evaluation collected data directly from charts displayed in the schools offices that were visited. [To provide a comparison with the DEMIS data, the data that the evaluation collected is appended at Annex .7].

Total enrolment at Chikomwe school in 2017 is 2314 but DEMIS is reporting 1934 a difference of 380.

Consultants directly from school data			**DEMIS data**			
Total enrolment			**Total enrolment**			
2017			2017			
Boys	Girls	Total	Boys	Girls	Total	Difference
1334	980	2314	925	1009	1934	380
Total repeaters			**Total repeaters**			
386	316	702	107	132	239	463

Table 5-1 Chikomwe School enrolment data

DEMIS data seems to have been changed and this has not only been effected on enrolment but on other indicators as well such as school drop-out, which has been reduced considerably in the DEMIS data. This has been applied to all data from programme schools. The evaluation was informed by DEMIS that when they received the data from the schools, they observed discrepancies. As a result, they had had to 'clean up the data'. Having noted the foregoing, the evaluation adopts the DEMIS data as the basis for evidence of impact.

Figure 5-1 clearly shows that enrolment in the 12 project schools has risen steadily over the MBSP period. Total boys enrolment has risen just under 71%, while that of girls is up by 72%.

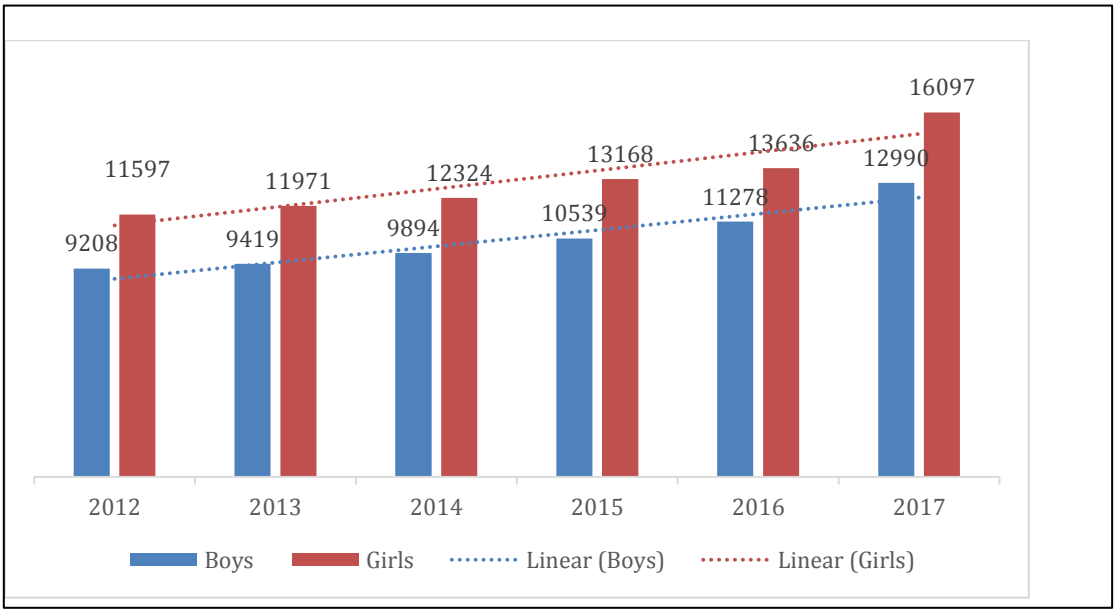


Figure 5-1 Total Annual Enrolment (12 Project Schools), 2012 - 2017

Source: DEMIS data

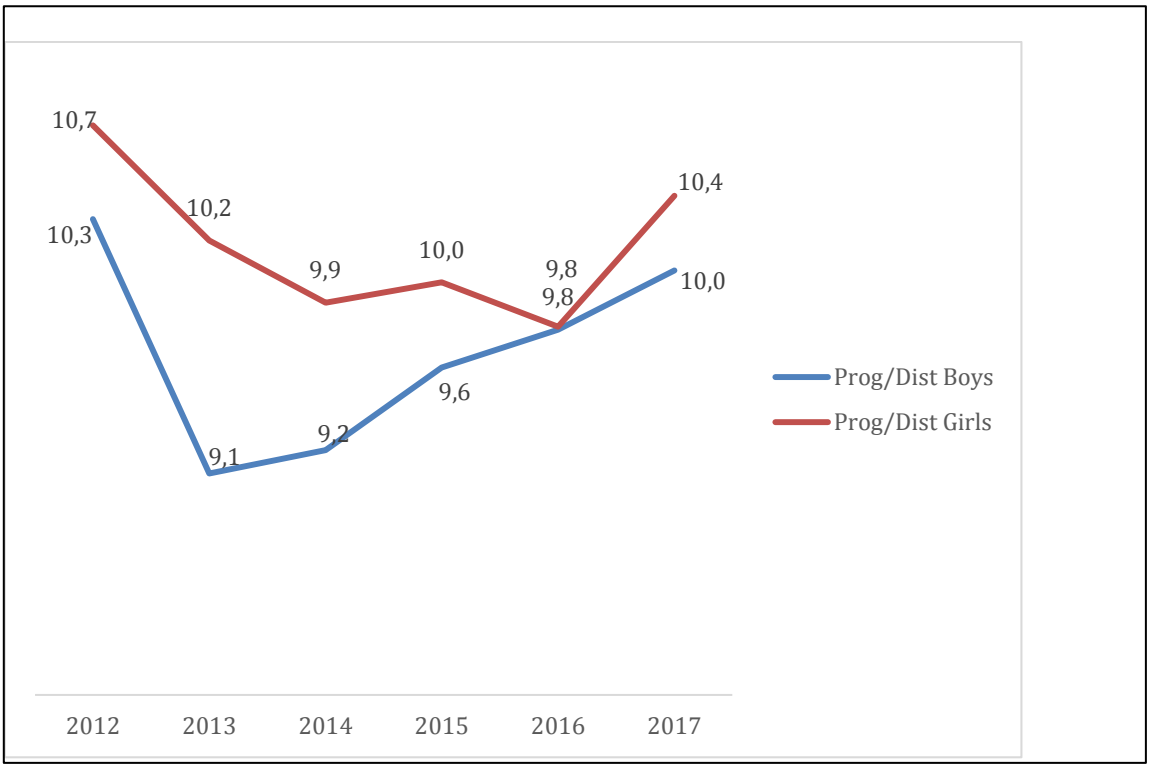


Figure 5-2 Percentage of Project Schools in Total District Enrolment, 2012 - 2017

Source: ibid

Aggregate annual increase for boys is 8% and that for girls 10%.

Complementing the increased enrolment is the downward trend of drop out for both boys and girls (Figure 5-3), falling 64% (boys) and 58% (girls) over the project's life.

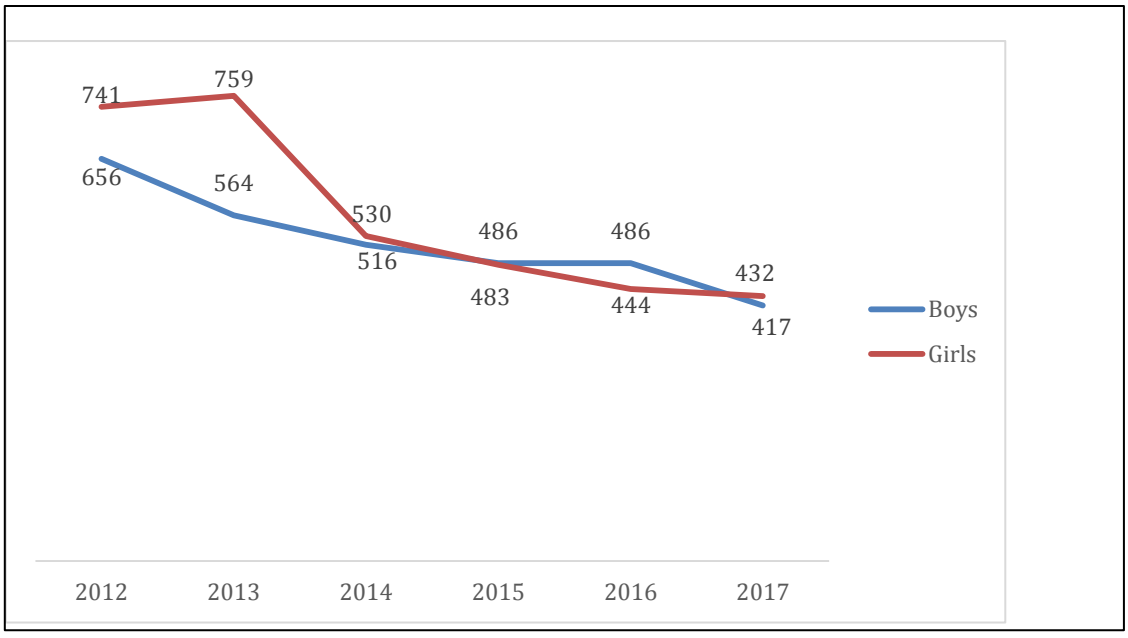


Figure 5-3 Drop-out in project Schools, 2012 - 2017

Source: ibid

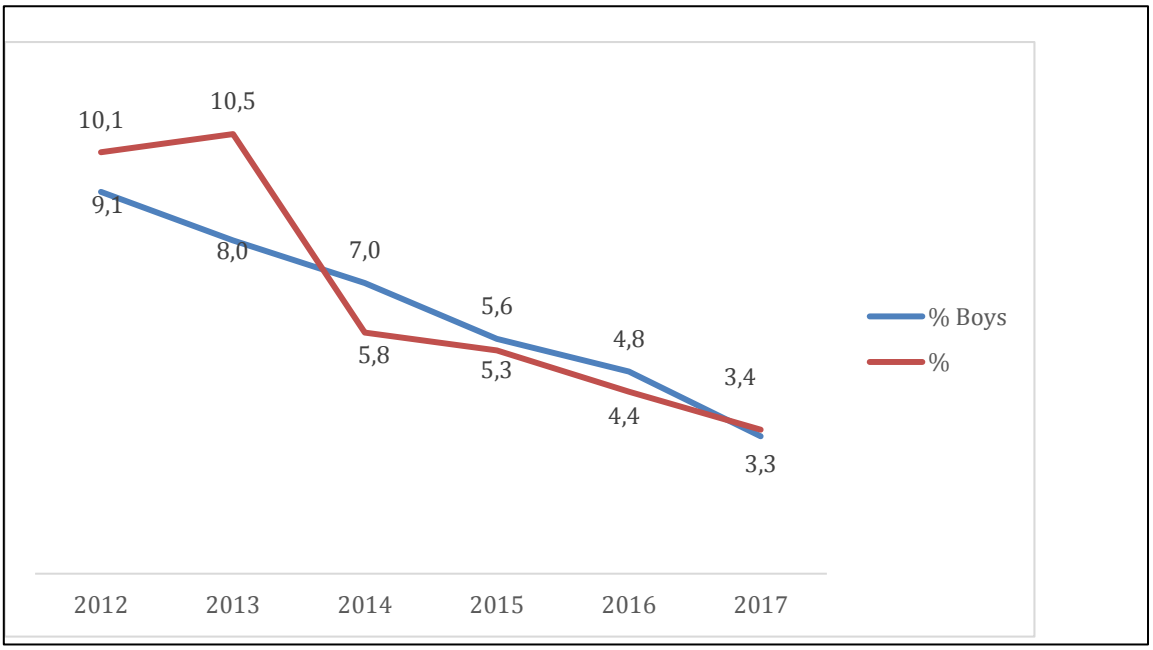


Figure 5-4 Percentage of School drop-out (Boys and Girls) of district totals, 2012 - 2017

Source: ibid

Average annual drop out over the period was 6% (boys) and 7% (girls).

The increase in enrolment is attributable to the project intervention, in particular to the availability of class rooms and additional teachers. Effectively, parents have voted with their children's feet; the Education department reported that pupils were transferring from neighbouring schools. Attribution with regard to the other drop out indicators is more problematic. However, the project clearly made a contribution to achieving this reported reduction.

5.2 Health

5.2.1 Maternal Care

The project aimed, inter alia, to reduce maternal mortality. In the course of the field work, the evaluation visited four Health centres and spoke to staff at three of them (at the fourth, the staff were too busy dealing with patients to meet with the evaluators). In two health centres, staff reported no maternal deaths in 2017; the other one reported a single death. This is borne out by DoH data, which reports a 60% decline in maternal mortality over the project period.

Figure 5-5 Maternal Mortality, 2012 - 2017

Source: DoH

Two contributory factors are the increase in attendance at ANCs (up 115% over the project's life – Figure 5-6) and the 146% increase in deliveries at Health Centres (Figure 5-7)[35]. Furthermore, although no data was available, the increased attendance at ANCs (in particular that at the first trimester), saw an increase in the number of expectant mothers tested for HIV, up 167% between 2013 and 2017 (Figure 5-6). Because of the associated treatment regime (for all positive expectant mothers and for delivered babies for between four and six weeks after delivery), the rate of mother to child transmission (MCT) has declined.

[35] 73% of deliveries at health centres (2015); 27% of population over 8 km from health centre.

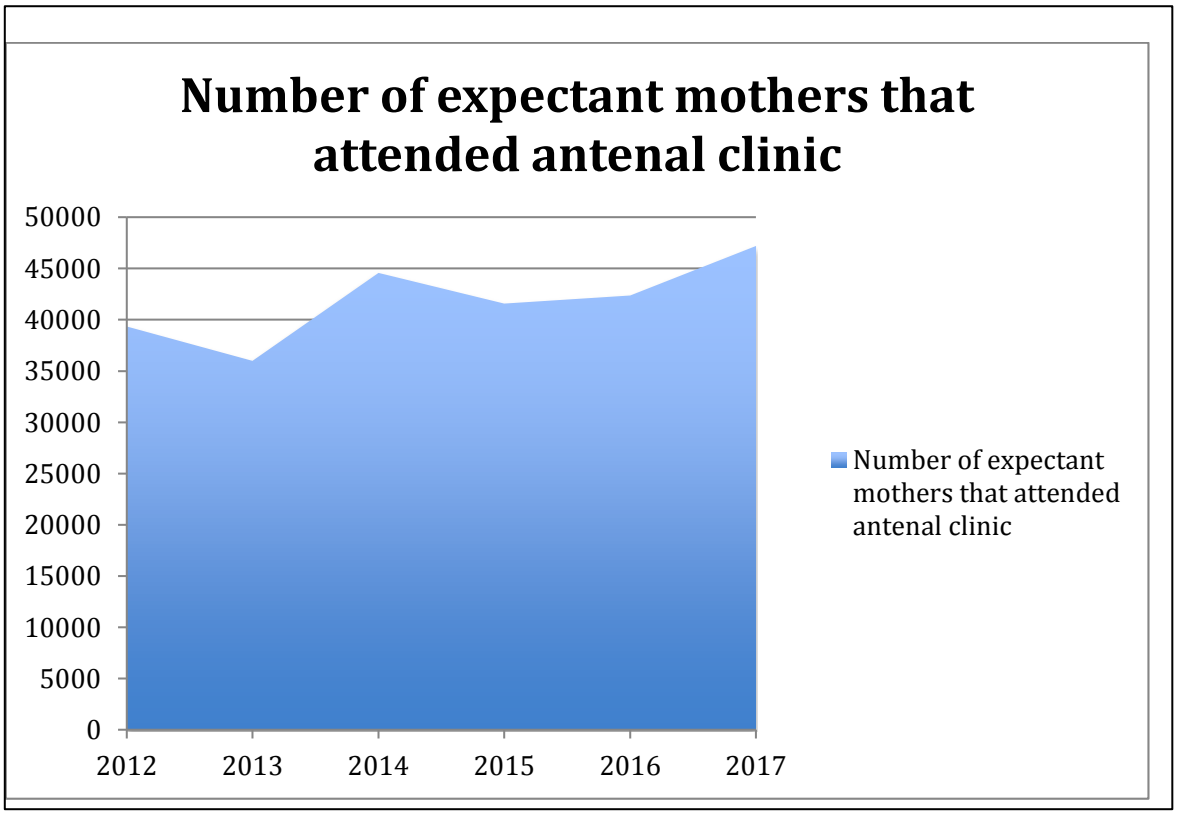


Figure 5-6 ANC Attendance, 2012 - 2017

Source: ibid

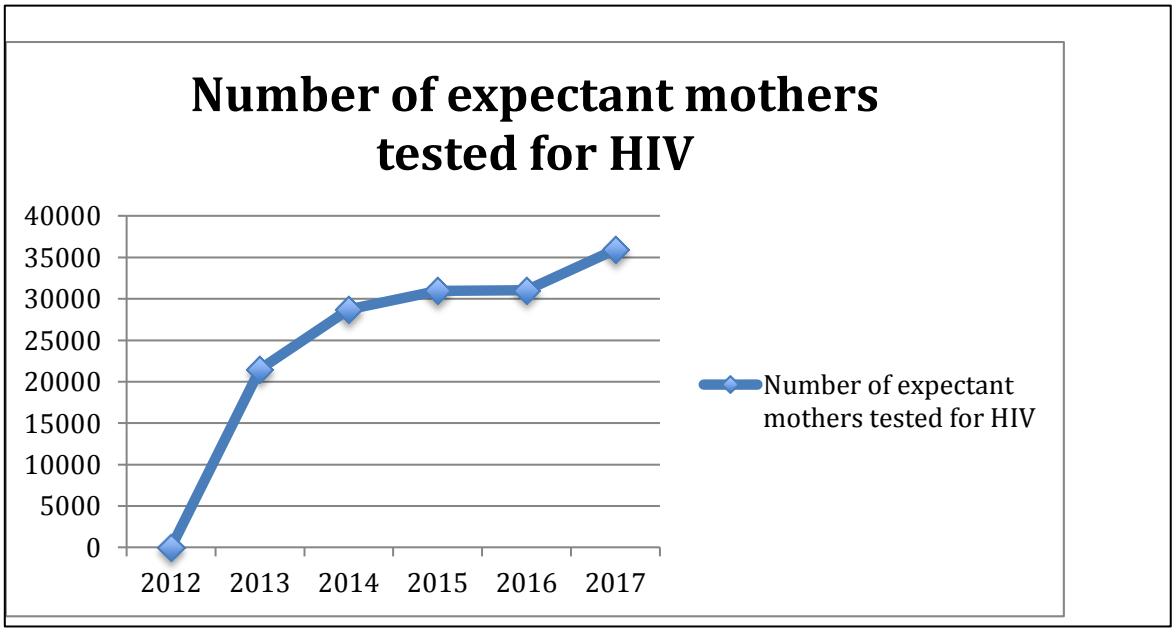


Figure 5-7 Number of Mothers Tested (usually in First Trimester), 2012 - 2017

Source: ibid

The benefits are reflected in the UNAIDS Databook, 2017[36].

5.2.2 Childbirth

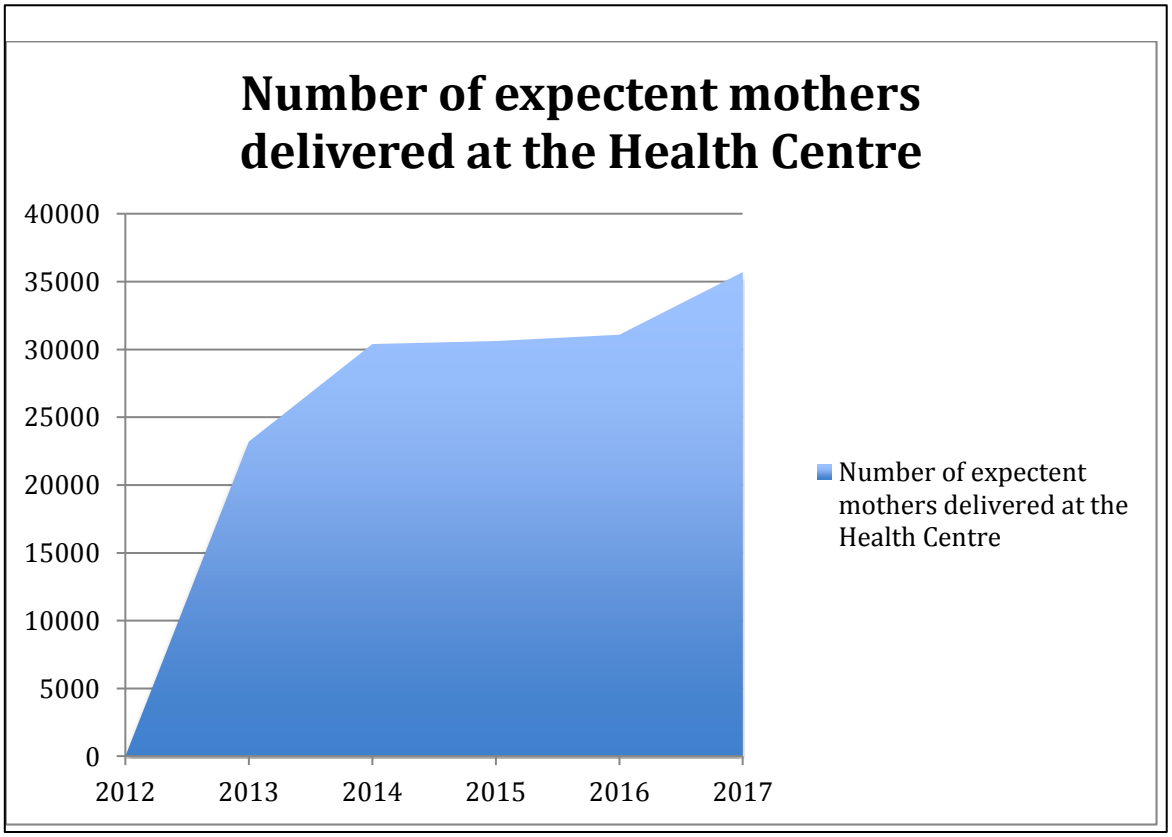


Figure 5-8 Deliveries at Health Centre, 2012 - 17

Source: ibid

[36]

	2010	2016
New HIV infections – children	17 000	4 300
Children living with HIV receiving treatment (%)	13	49
Pregnant women living with HIV receiving anti-retroviral treatment (%)	23	84

Databook, 2017

Figure 5-9 shows an overall (21%) increase in the number of expectant women experiencing complications.

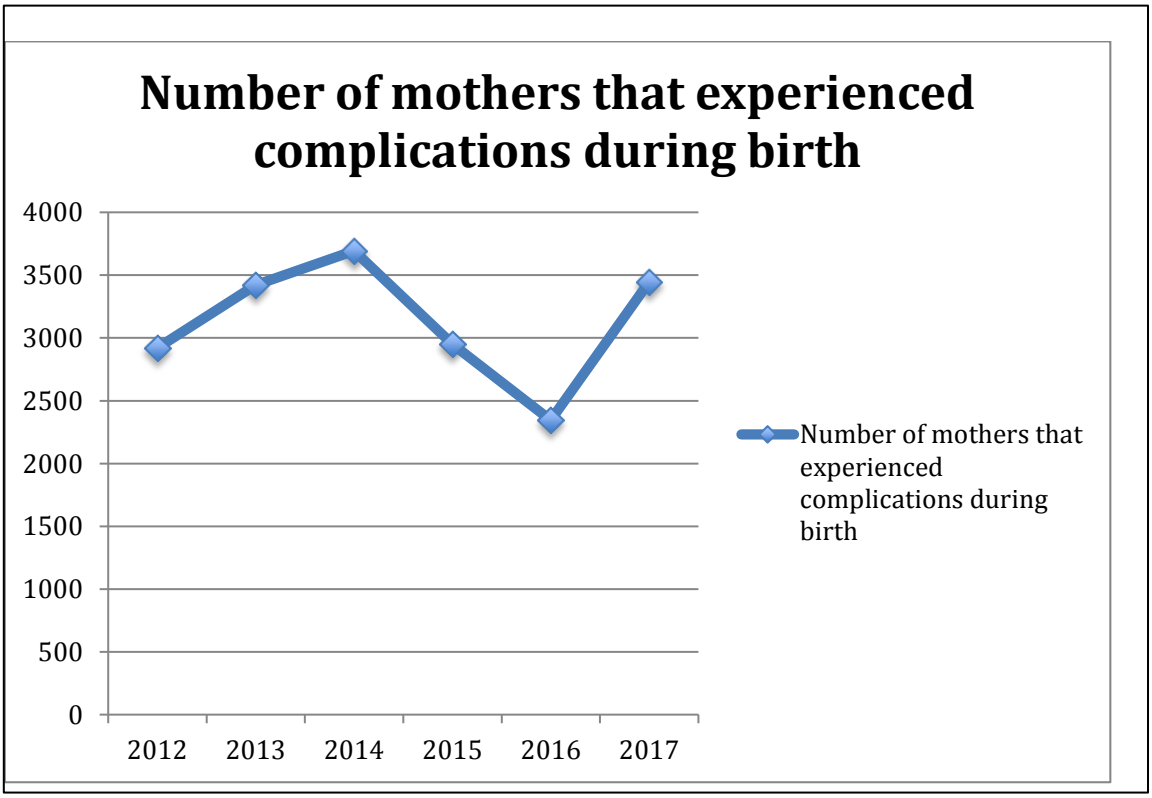


Figure 5-9 Number of Mothers Experiencing Complications, 2012 - 2017

Source: ibid

This is a contra-indicator and reflects the increase in the number of women delivering with trained health staff in attendance. As a result, complications are identified and reported. As such, it can be seen as a positive result of the increased availability of trained obstetric health care.

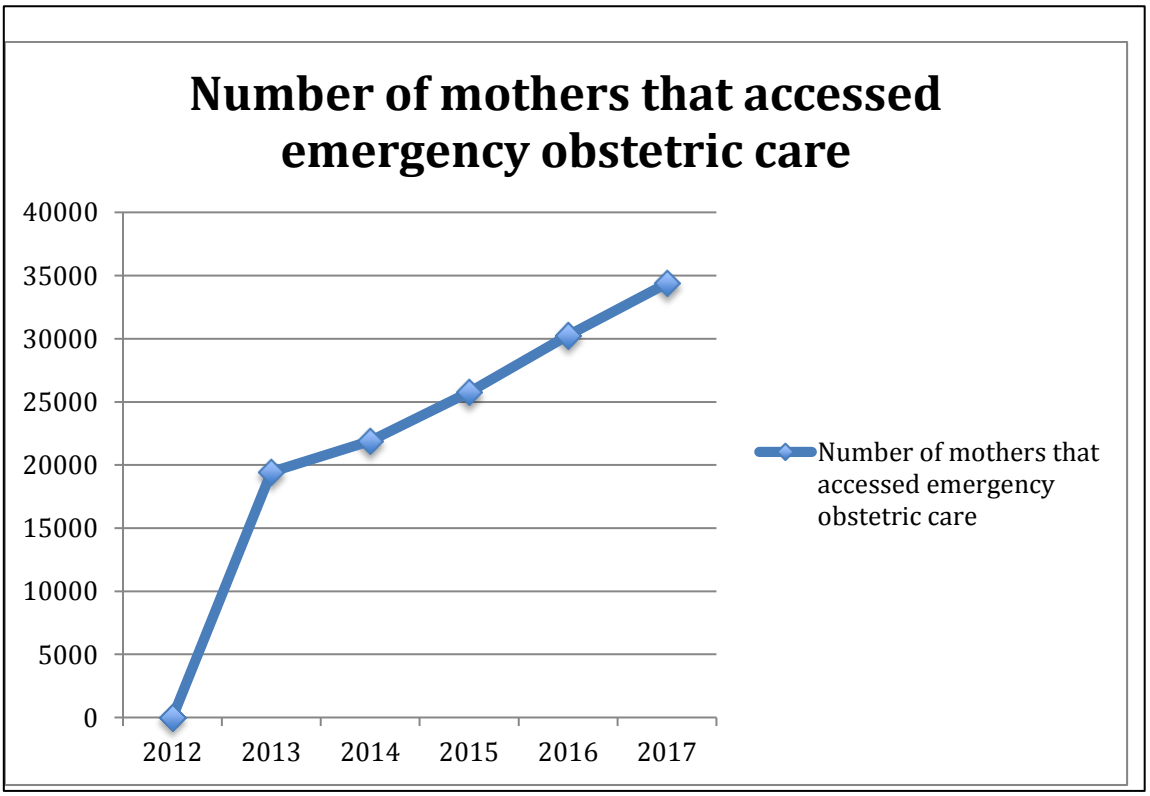


Figure 5-10 Number of Mothers Accessing Emergency Obstetric Care, 2012 - 2017

Source: ibid

It also is reflected in the increase in the numbers accessing emergency obstetric health care (Figure 5-10). Since they were present in health centres, this was far more accessible as a result.

5.2.3 Infant Mortality and Survival

Figure 5-11 shows the number of still births remained roughly constant (just under 500) throughout most of the project, having risen by just under 100 from the 2012 figure. This again is likely to reflect the increased attendance at health centres for delivery, which ensured that the still births were recorded, as well as the overall increase in the number of births (Figure 5-12).

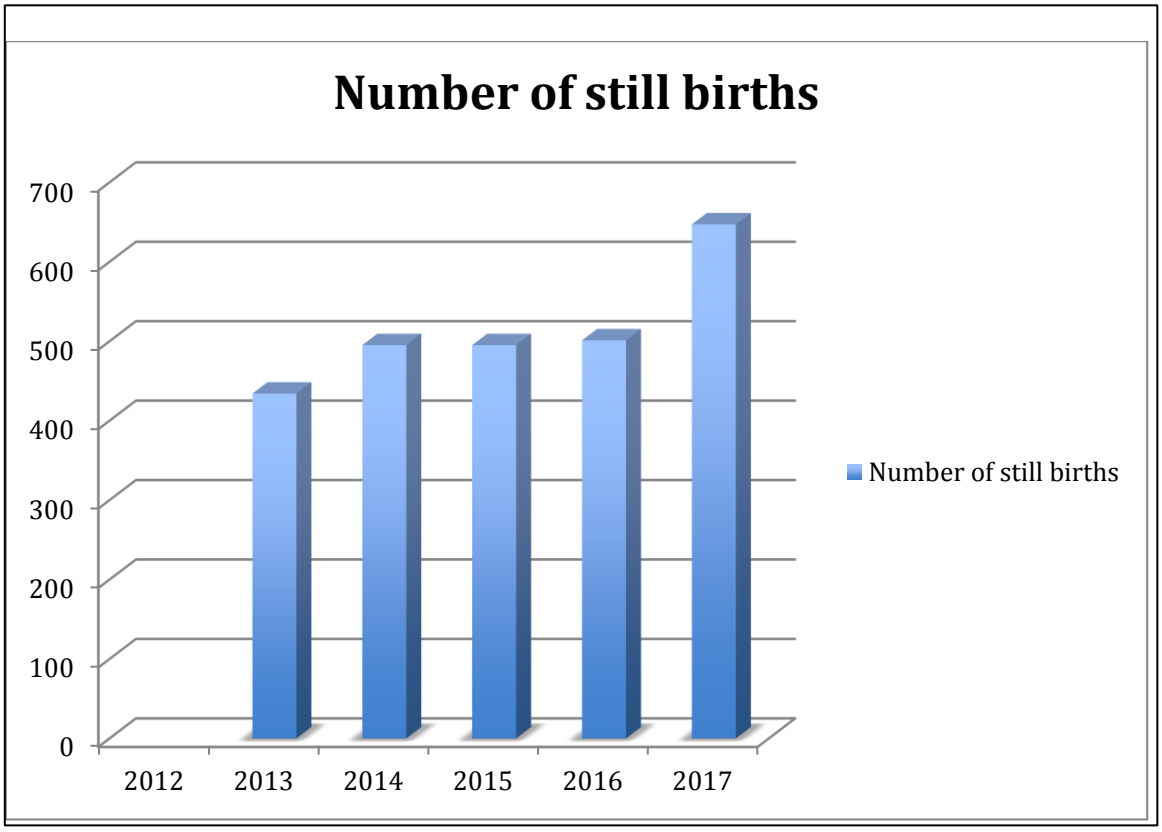


Figure 5-11 Number of Still Births, 2012 - 2017

Source: ibid

The sharp increase in 2017 (by roughly 100) was not explained, which has no information on this.

The number of live births has been broadly comparable throughout the project's life.

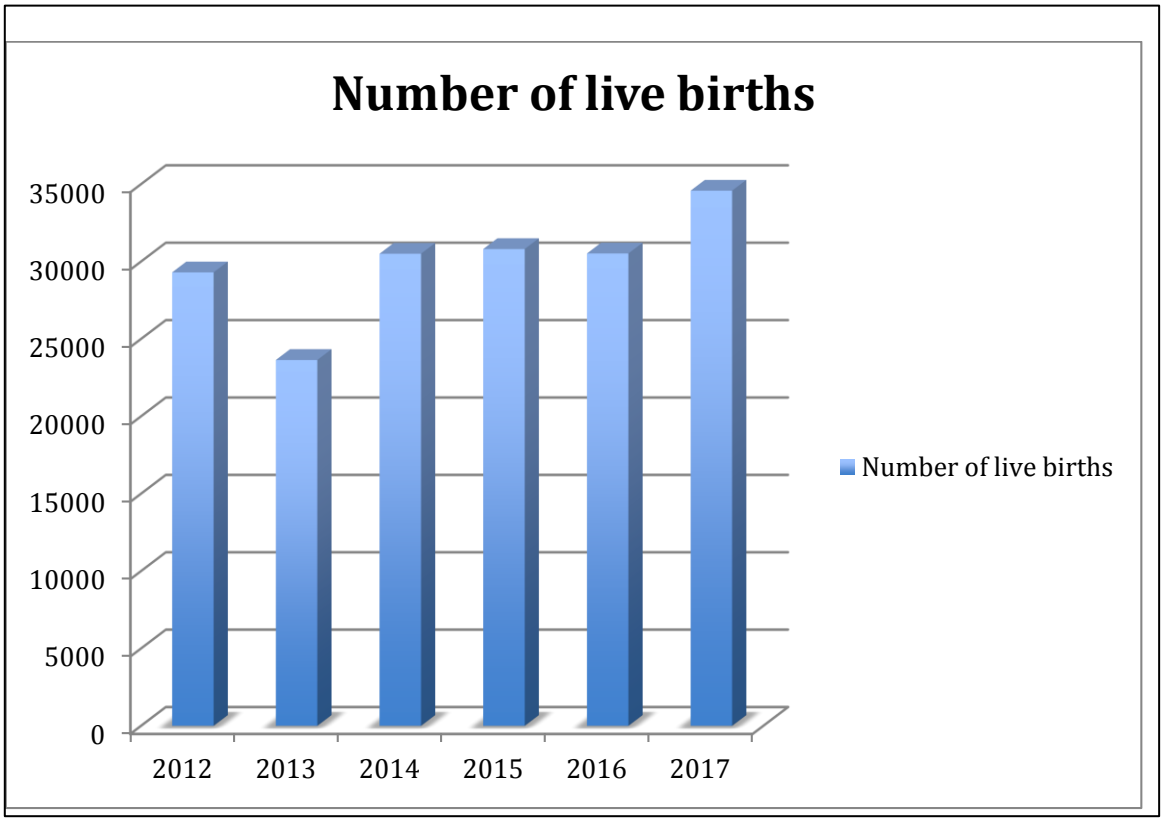


Figure 5-12 Number of Live Births, 2012 - 2017

Source ibid

5.2.4 Vaccinations

According to the Quarterly Report, in 2015, 76.4% of 12 – 23 months were fully immunised. Figures 5-13 - 5-15 suggest that this may have deteriorated overall, the number of children vaccinated against measles, polio and DPT (diphtheria, whooping cough and tetanus) has declined.

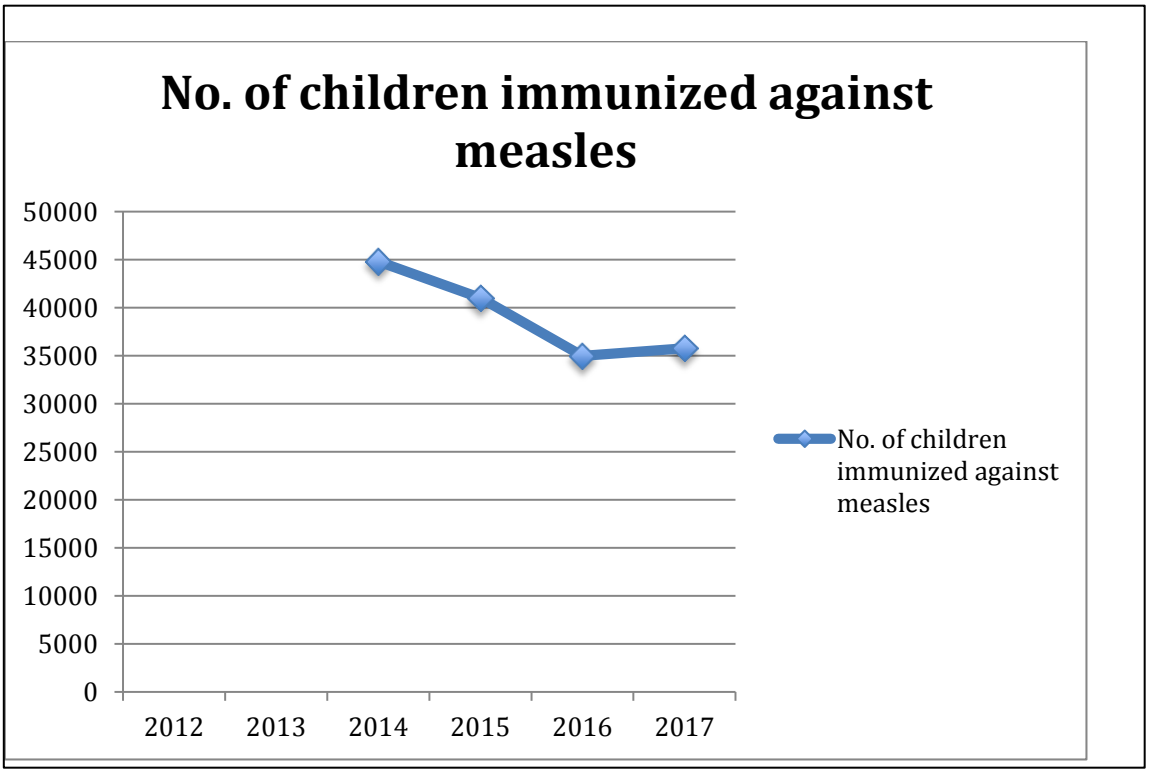


Figure 5-13 Immunisation against Measles, 2012 - 2017

Source ibid

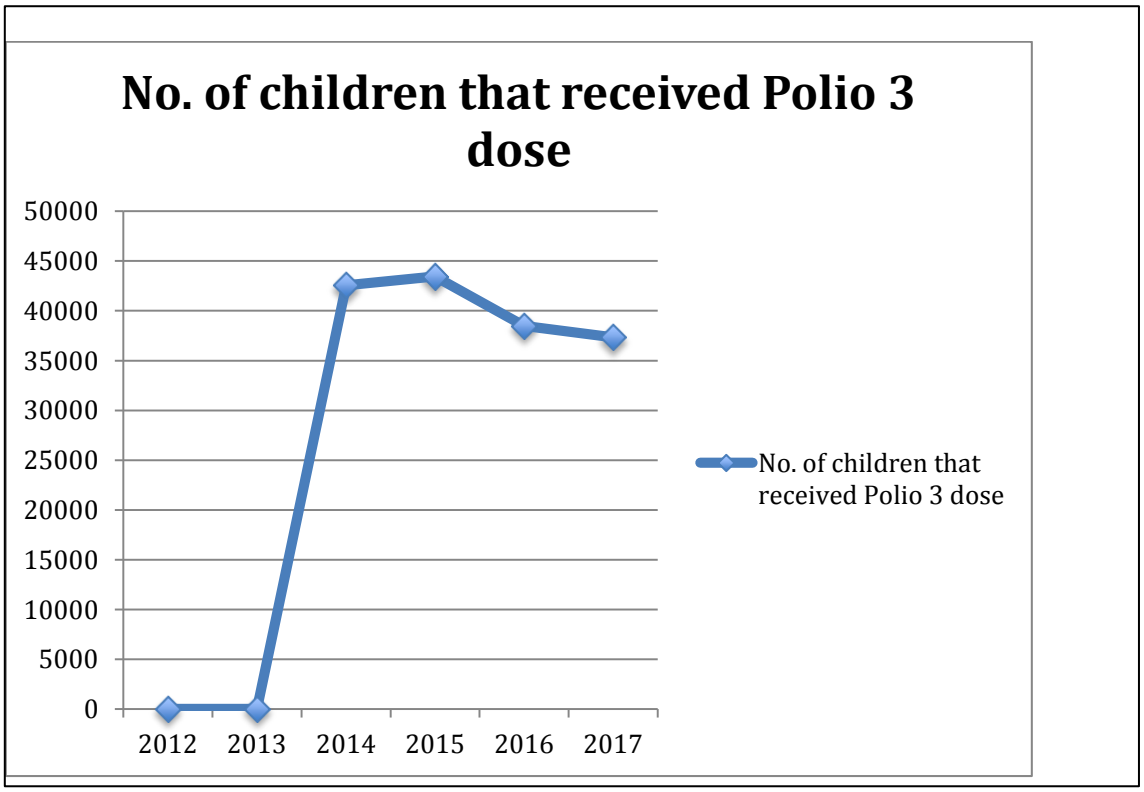


Figure 5-14 Immunisations against Polio, 212 - 2017

Source ibid

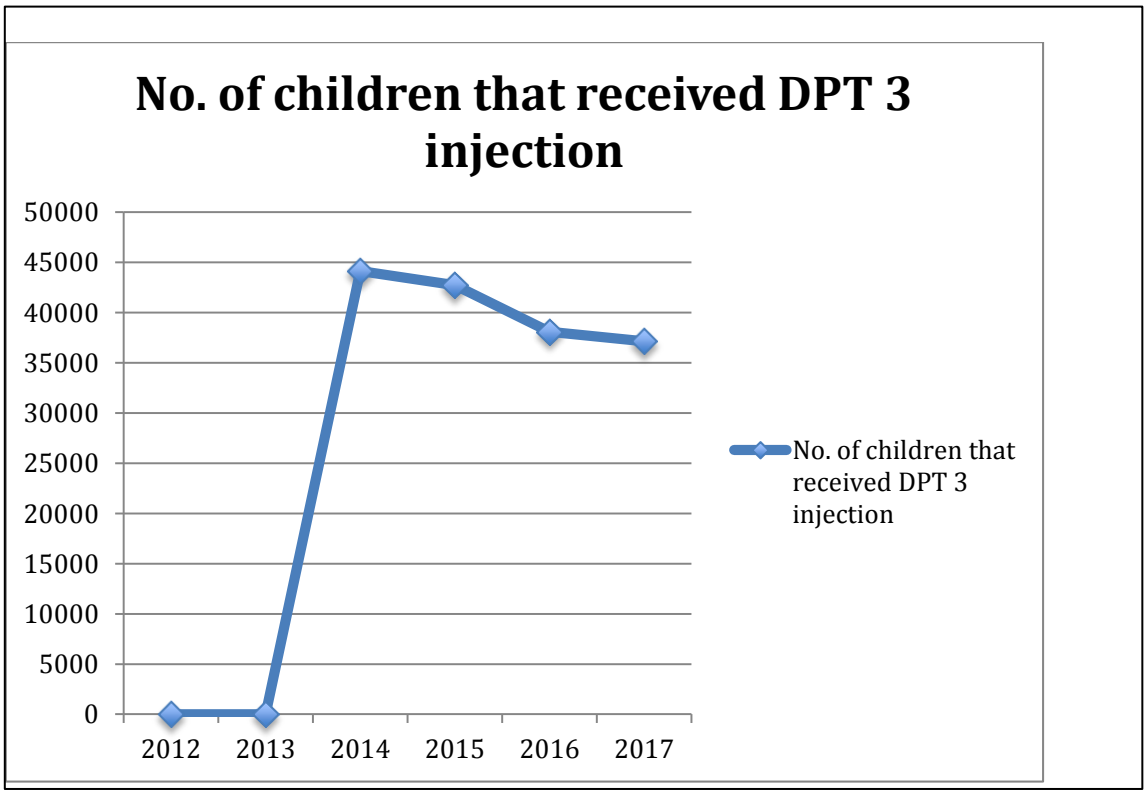


Figure 5-15 DPT immunisations, 2012 - 2017

Source ibid

The evaluation has no explanation for this. However, it notes that connections to the Eskom-supplied grid exceeded targets in the project's annual work plans. Eskom has experienced reduced generation capacity due for reduced water levels affecting its hydro-electric capacity in recent years; in 2017, for example, some areas of the country were without power for between nine and 25 hours (The Nation, 17 November 2017); scheduled load shedding has continued into the present (power being unavailable in Mangochi for c. 19 hours every Thursday while the evaluation was in the district). Given that vaccines have to be kept at low temperatures to retain their efficacy, it is possible that load shedding negatively affected the vaccination programme. It also might have been negatively affected by the DoH's delays in settling health centre electricity accounts; in the course of the field visit, one of the health centres visited was without electricity because it no longer had any credit with the supplier. When discussed with the DC, this was recognised to be a problem, as was the centralisation prevalent in the DoH. A possible way forward would be a specific budget for power and minor repairs being available to individual health centres.

5.2.5 Morbidity

According to health centre staff VHC and HAC members interviewed, the major morbidity challenges in the district are malaria and respiratory infections. Figures 5-16 – 5-18 reflect this.

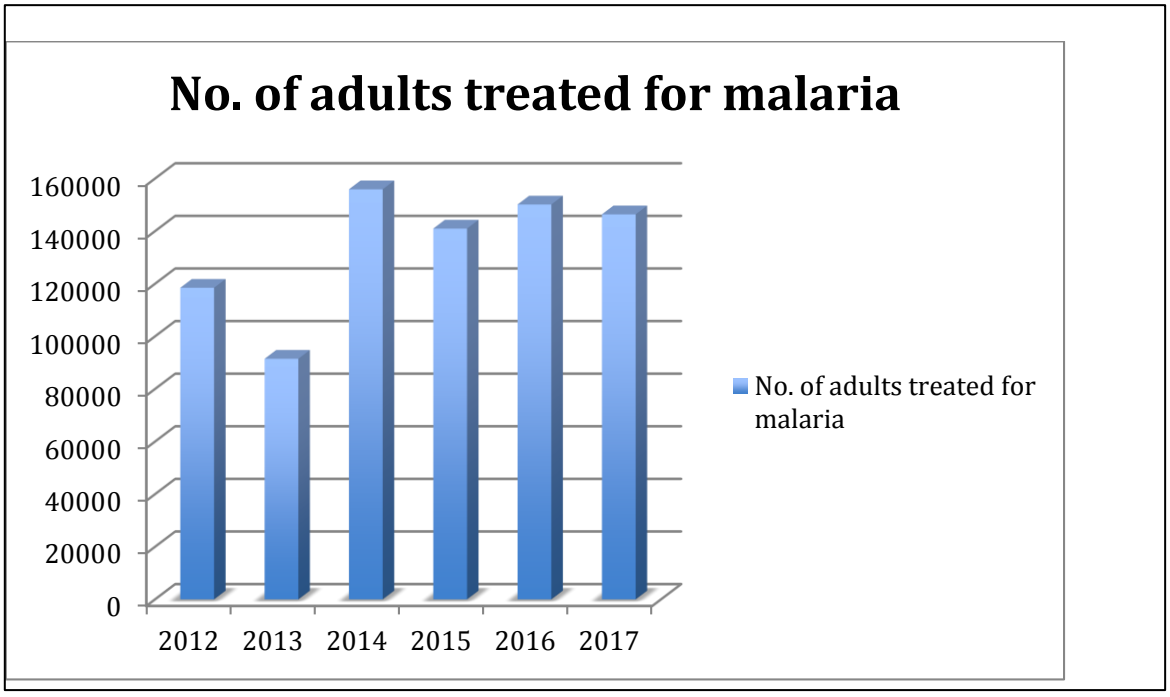


Figure 5-16 Number of Adults treated for Malaria

Source ibid

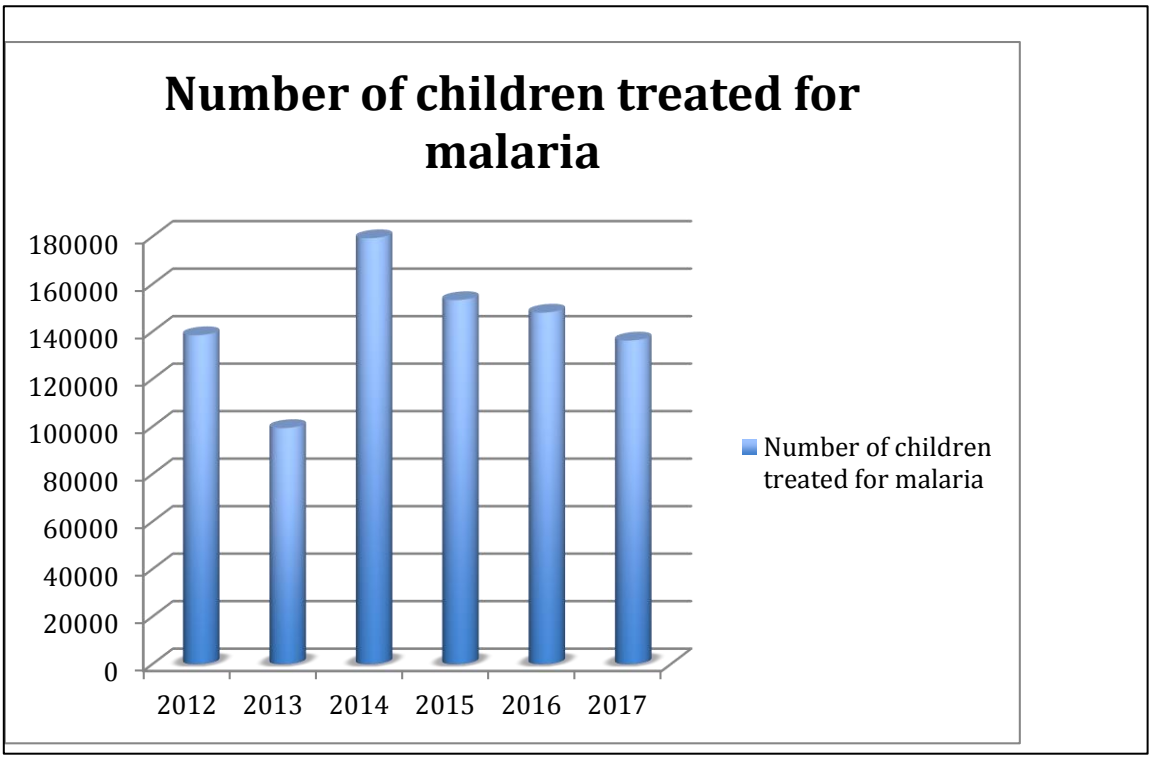


Figure 5-17 Number of Children treated for Malaria

Source ibid

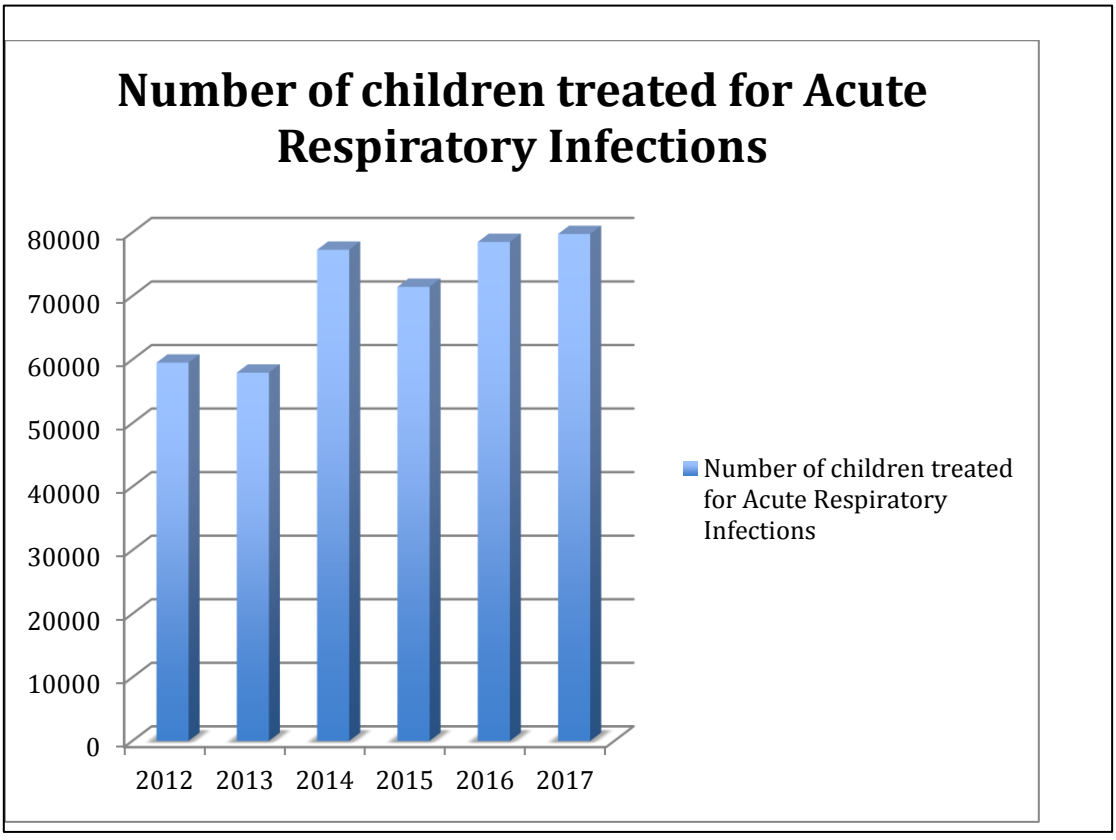


Figure 5-18 Number of Children treated for Acute Respiratory Infections, 2012 - 2017

Source ibid

By contrast, the numbers affected by water borne diseases (diarrhoea and dysentery) are lower, possibly reflecting the availability of safe water sources and the decline in utilisation of unsafe sources (see Figure 4-18 and Table 4-4 above).

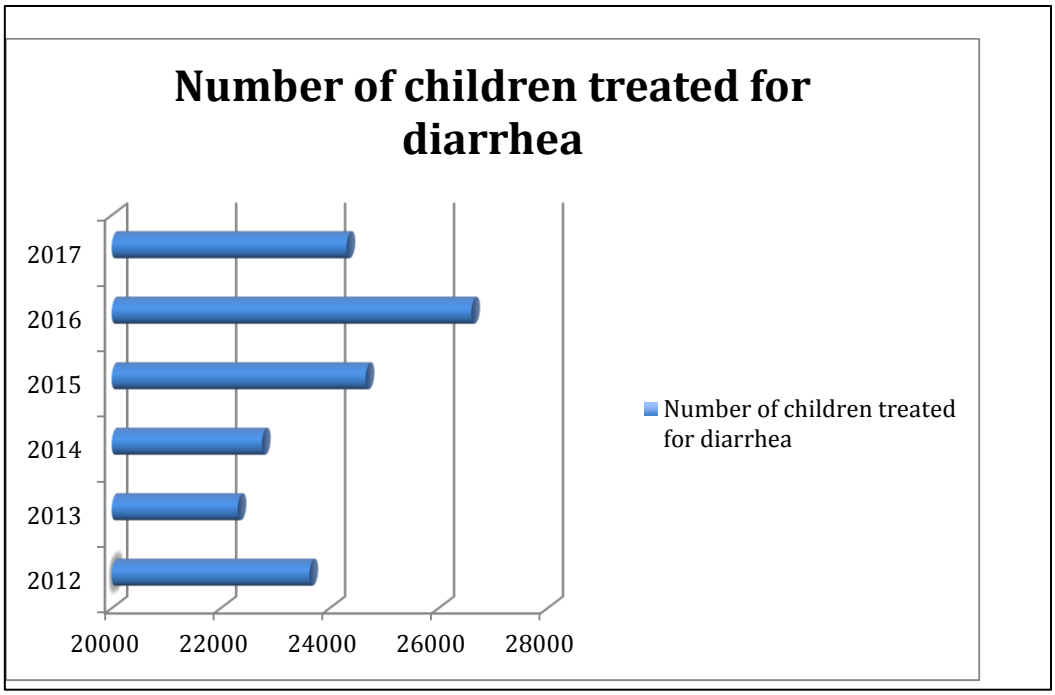


Figure 5-19 Number of Children Treated for Diarrhoea, 2012 - 2017

Source ibid

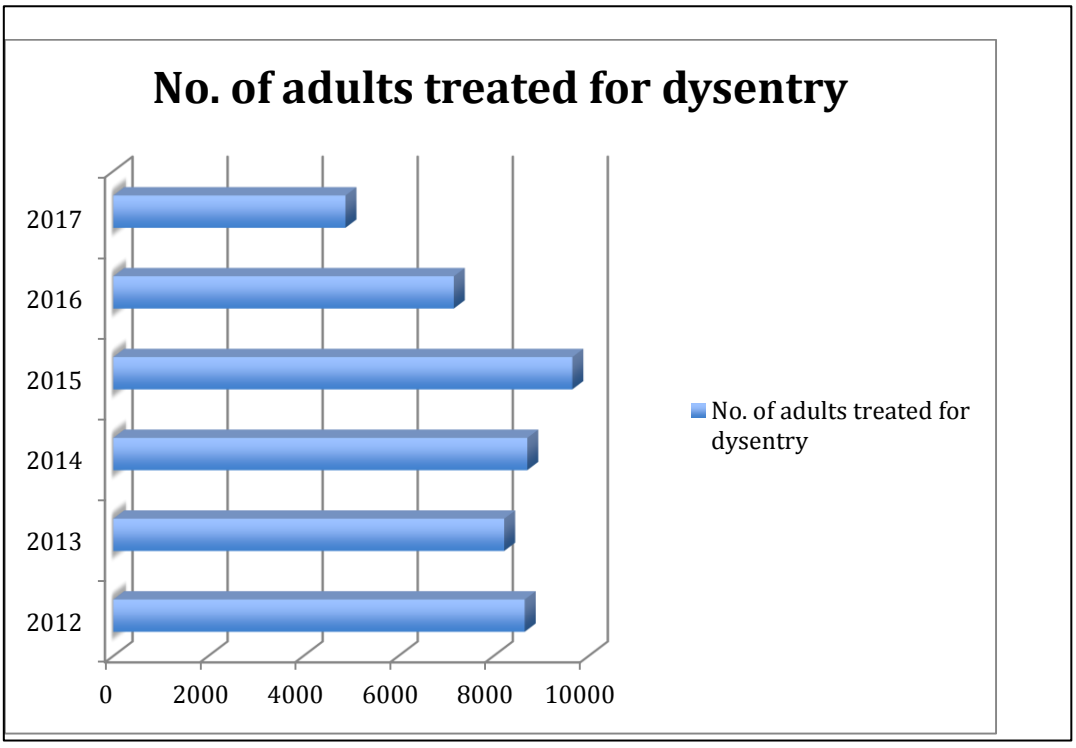


Figure 5-20 Number of Adults treated for Dysentery

Source ibid

5.3 Conclusion

Overall, the evaluation is of the opinion that there is clear indication that the MBSP has contributed to achieving impact. Data supplied by the DoE and DoH clearly shows increased enrolment and declining drop out in the targeted schools. Similarly, more expectant mothers are attending ANCs and delivering their babies at health centres. This has contributed to a decline in maternal mortality and increased access to emergency obstetric care. While the number of still births has remained roughly constant over the project's life, this is probably due to better recording of still births as a result of more expectant women delivering in health centres. It appears likely that this is the reason for the overall increase in the number of women experiencing complications during childbirth. Lastly, the increased access to and utilisation of potable water has seen water borne diseases no longer perceived as a major cause of morbidity in the district. Clearly, the additional (new and rehabilitated) boreholes and protected shallow wells has been a contributory factor in this regard.

CHAPTER 6 Sustainability

As might reasonably have been expected, the MTR

"….revealed that……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 had taken place. 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."

Sustainability is concerned with measuring whether the benefits of an activity are likely to continue after donor funding has been withdrawn. Projects need to be environmentally as well as financially sustainable, considering the following:

- To what extent did the benefits of a programme or projects continue after donor funding ceased?; and
- What were the major factors, which influenced the achievement or non-achievement of sustainability of the programme or projects?

If estimating impact is problematic, assessing sustainability at this point in time is even more so, principally for the same reasons. Nonetheless, this section seeks to assess the validity of the MTR's conclusions in this respect.

Sustainability is achievable but this is beset by a number of challenges

a) Quality of infrastructure limits sustainability. Because of poor quality, maintenance costs rise. Given the limited resources available to the district council, this militates against medium-term sustainability. In the first instance, contractors must be made to put right the identified defects.

b) Maintenance challenges exist. The project outputs indicated that maintenance targets were fully met. However, the technical audit observed that at least some of the new infrastructure was not well looked after, citing, in particular, some of the Waiting Homes. In this situation, infrastructure falls into disrepair and becomes more expensive to return to full functionality. Maintenance must be taken seriously; far too often, maintenance is deferred for budgetary reasons. Such short-term savings result in far greater costs in the medium-term as unmaintained infrastructure has to be replaced.

c) The additional staff already recruited (WNAs, 18 teachers) overhead costs were all met from project funds, as indeed were part of the Water Department's administrative and operational overheads. Unless these costs are absorbed into the Council's recurrent costs, these positions will become unsustainable and will have to be terminated. Similar observations can be made in respect of the operational and maintenance costs of the equipment (motor cycles, motor vehicles, ICT and related software/licensing costs) provided. Its continued functionality is likewise necessary to be absorbed into the Council's core recurrent budget.

d) The project emphasised community ownership of key aspects (e.g. boreholes, shallow wells, discouraging drop-out, especially by girls), establishing and capacitating community-level groups for these purposes. Maintaining these groups motivation and cooperation devolves to district officials (e.g. WMAs, school teachers and principals, school inspectors) with the projects' closure. Additionally, it is important to address attrition in these groups' membership early to ensure an equal balance of responsibilities and avoid overloading a few.

e) The evaluation was informed that authorisation to recruit additional nurses/midwives had been obtained. This recruitment, and associated additional training, has to be fully implemented and the new recruits in place for full operationalisation of the new maternity units. In addition, budgetary provision for their operation, including an adequate drugs and equipment budget, has to be available.

In the evaluation's view, sustainability is possible but it is dependent on there being the political will to ensure that maintenance and additional salaries are prioritised so as to achieve it. Furthermore, community partnership has to be a priority in the way the Council carries out its responsibilities, building and deepening existing partnerships.

CHAPTER 7 Cross-cutting Issues: Gender and Environment

7.1 Gender

Amongst the MBSP's aims was to (a) support the retention of girl children in school and (b) promote the empowerment of women in the community, in particular through ensuring their participation in school and community-based and facilities' management groups (HACs, VHCs, WMCs, SMCs, and PTAs). Brief comments in respect of both follow.

a) Support the retention of girl children in school: In general, the data provided through the DoE indicated rapid fall off in enrolment of both boys and girls from Year 3 onward, with another steep fall (particularly affecting girls) from Year 5. In large part this reflects the perception that in Years 1 and 2, many parents enroll their children in school, principally for reasons of childcare, there being no functional tasks children of this age can fulfill in the household. This is borne out by both teachers' comments (children come to school without paper or writing materials) and the evaluation's physical observations of the schools' visited. Thereafter, enrolment falls steeply, initially affecting boys more than girls. Enquiries by the evaluation suggested that this reflected piecework (principally fishing) opportunities available to boys, as well as possibilities for migration to Mozambique and South Africa (mainly for agricultural work opportunities). Girls enrolment declines falls more sharply than that of boys from Year 5 onwards, particularly in TAs where there are no bye-laws forbidding early marriage. Having noted this, the overall participation figures for girls (and boys) increased in the course of the project's implementation throughout the district and in the target schools visited. The evaluation has no data, all of which provided by the DoE, that directly attributes this increase to the MBSP intervention; however, engagement with teachers in the target schools visited suggests that both (i) the improved infrastructure (classrooms) and (ii) better teaching, the supply of school materials and, in particular, the debating contests, were important contributory factors in the increased enrolment.

b) Empowerment of women: The evaluation engaged with HACs, VHCs WMCs, SMCs and PTAs. [Mothers' Groups are not discussed as they are all women and membership has been from before the project.) This engagement strongly suggests that the breakdown of management positions (Chairs, Deputy-chairs, Secretaries, Treasurers) within HACs, WMCs, SMCs and PTAs is roughly evenly divided between men and women. There is a stronger representation of women in VHCs, which interlocutors explained was because, in general, VHCs' status in communities was perceived to be lower than other community management structures. It is worth emphasising the democratic base of the management positions; in the course of the project elections had taken place, in some cases replacing the whole management structure. In spite of this, the balance between men and women remained roughly equal at the time of the evaluation.

7.2 Environment

Leaving aside the potential infrastructure impact, which, given that this was on existing developed sites, is, in the evaluation's view limited, the major challenge to the environment relates to the Water and Sanitation component.

a) The infrastructure technical audit raises questions surrounding the environmental impact of the water infra-structure (in particular, soak aways) provided. Observation of the water points visited bore this out. In the evaluation's view, however, this challenge is relatively limited, particularly in the light of the decision taken to require contractors to make good the infrastructure provided.

b) A greater potential environmental threat is in respect of the support for improved sanitation. This primarily relates to the possibility of seepage into ground water and directly relates to the location of pit toilets and their destruction in the course of the rainy season. The evaluation does not possess the technical expertise to assess the scale of this threat, or, indeed, whether it actually exists. However, the evaluation's experience of other WatSan and WASH project interventions made it aware of this as a potential risk. Having made this observation, the Water Department's MBSP performance suggests to the evaluation that the department is aware of the risk.

CHAPTER 8 Conclusions and Recommendations

The MBSP was relevant when it was designed and remained so at the time of the evaluation. The three component projects responded to critical aspects of the DDP, which was itself developed in accordance with national priorities, the overarching Vision 20/2020 and the Malawi Growth and Development Strategy II. The overall programme and its component parts were in line with the ICEIDA – GOM Country Strategy Paper, 2012 – 16 and with Iceland's Strategy for Development Cooperation, 2011 – 14. Furthermore, the MBSP was designed in accordance with Iceland's international commitments, in particular the Paris Agreement, the Accra Accord and Busan Partnership Agreement.

While not all encompassing MBSP log or results framework exists, the three individual component projects (Education, Health and Water and Sanitation) logframes that are individually logically coherent, generally have SMART indicators and also have the potential to be utilitarian project management tools. If a gap exists, it is in respect of the fourth Capacity Building component, this being subsumed within the individual sector projects. This may have represented a missed opportunity for a more effective means of addressing capacity shortfalls within the district council and consideration to addressing this explicitly should be considered in future partnerships.

The MTR concluded that the projects were generally efficient and reflected a utilitarian flow of funds. In broad terms, the final evaluation concurs with this view. While there have clearly been hiccups in respect of both the education and health projects, in the main the resources have been utilised in accordance with plans and the infrastructure, albeit some of questionable quality, delivered.

In general, the flow of funds has been timely, the exception being when the implementers failed to report in a timely and comprehensive manner. The main exception to this general experience occurred with the decision to extend the projects by another year; the inevitable delays associated with this decision, resulted in funds being released at the beginning of the rainy season.

The water and sanitation resource utilisation (Figure 3-6) is an almost picture perfect representation over the life of a project. By contrast, both the education and health disbursement patterns are lumpier, reflecting the procurement challenges experienced at the projects' start and the need to sequence procurements. Resources across all three projects were utilised in accordance with plans and only one expenditure line had to be cancelled because of inadequate resources.

In part this might reflect the unusual budgetary approach ICEIDA pursued, establishing budgetary totals not on an existing budget but in accordance with emergent needs in the light of Malawi's economic crisis, exacerbated post-Cashgate. At the very least, the experiment in flexible budgeting proved costly.

The evaluation concurs with the MTR's conclusion that the MBSP has been effective. While there have been challenges, the overall picture presented through field work and documentary review is the (over)achievement of most targets and the delivery of the identified outputs. These outputs have proved a substantial contribution to the achievement of the MBSP outcomes: education provision has improved, despite a generally challenging social envi-

ronment. Further gains, in this regard, may depend more on a more positive community attitude towards education, which will add to the benefits of improved infrastructure and teacher training.

Similarly, there is clear evidence that more mothers-to-be are presenting at HCs for delivery, which will further reduce maternal mortality rates[37] and also HIV MTC[38]. In itself, this will be a major contribution to reducing infant and child mortality in the district. And, evidence from incidence of morbidity, emphasises the benefits achieved through the Water and Sanitation project: only one HC cited diarrhoea as one of the three most important causes of morbidity in their areas. All three sets of gains are clear evidence of effectiveness.

If the three projects fell short in any regard in terms of contributing to MBSP outcomes, it was in respect to the reality that the provision of staff housing was inadequate to respond to both existing and future demand.

Overall, the evaluation is of the opinion that there is clear indication that the MBSP has contributed to achieving impact. Data supplied by the DoE and DoH clearly shows increased enrolment and declining drop out in the targeted schools. Similarly, more expectant mothers are attending ANCs and delivering their babies at health centres. This has contributed to a decline in maternal mortality and increased access to emergency obstetric care. While the number of still births has remained roughly constant over the project's life, this is probably due to better recording of still births as a result of more expectant women delivering in health centres. It appears likely that this is the reason for the overall increase in the number of women experiencing complications during childbirth. Lastly, the increased access to and utilisation of potable water has seen water borne diseases no longer perceived as a major cause of morbidity in the district. Clearly, the additional (new and rehabilitated) boreholes and protected shallow wells has been a contributory factor in this regard.

In the evaluation's view, sustainability is possible but it is dependent on there being the political will to ensure that maintenance and additional salaries are prioritised so as to achieve it. Furthermore, community partnership has to be a priority in the way the Council carries out its responsibilities, building and deepening existing partnerships.

8.1 Lessons Learned

For the evaluation, three key lessons emerge from the foregoing review. First, despite the clear attempt to avoid this (limiting the sub-sector scope of the health project and the number of schools in the education one), as it turned out both were spread too thin. Second, greater concentration potentially would have resulted in greater benefits, albeit possible for a fewer number of immediate beneficiaries. Third, it is clearly desirable to ensure coherence between all aspects of an intervention. Finally, it is apparent that infrastructure and training is inadequate to achieve the education outcome.

[37] The number of maternal child birth related deaths was minimal; in one HC's coverage area, one was reported; in another, the same number in the first quarter of 2018. Nor were any new birth mortalities reported.

[38] In one HC, the total number receiving ARVs monthly from the clinic is 575. Another reported that over 40% of mothers tested in the first trimester were HIV+.

8.1.1 Spread too thin

In both the education and health sectors, the MBSP sought to provide infrastructure. In neither case was the infrastructure delivered sufficient to ensure that

a) all learners were taught in classrooms (in most at least two classes were either taught outside or under open-sided shelters);

b) sufficient maternity and delivery beds were available to meet existing need; or

c) housing was adequate to meet existing, not to say desirable, staffing levels in either education or health sectors.

In respect of (a), part of the challenge arose from 'parents voting with their children's feet' in that they moved children from schools with inadequate infrastructure to those with new classrooms. In some cases (e.g. Chikomwe Primary School) the enrolment increase was exponential (289% and, in fact, an average increase in the teacher-pupil ratio from 1:80 to 1:92); in others, enrolment remained roughly constant (e.g. Chimbende Primary and St Charles Lwanga, both of which had substantial enrolment pre-ICEIDA's support). In all instances, however, the new infrastructure was inadequate to ensure all learners now learn in classrooms although there has been a substantial increase in those who do.

The maternity units constructed have added recognisable capacity to maternal services in the district. Having said this, in all the Health Centres visited where maternity units and/or Waiting Homes were constructed, the existing number of deliveries already far outstrips the new capacity. In both Namwere and Jalasi Health Centres, for example, there are respectively up to 600 and 100 deliveries a month; the additional infrastructure (Waiting Homes in both cases) has potentially added two delivery beds (one each) and five and three new maternal beds. Given the scale of demand, the new infrastructure is inadequate.

Finally, staff housing provision was, and remains, inadequate. None of the schools or health centres visited had sufficient housing to house existing staff. As a result, staff live either in the local community (if they are fortunate and adequate housing exists) or in the district capital and commute on a daily basis. In the former case, this impacts negatively in the health sector on night call out and has attendant security risks. In the latter, there are significant financial costs associated with the commute: teachers resident in Mangochi and employed at Chimbende Primary School, for example, pay c. one third of their salary (MKW 23 000) every month for transportation to and from work.

8.1.2 Greater Concentration

The foregoing strongly suggests even greater concentration that attempted under the MBSP. The justification in the education support, for example, argues that the focus on the identified 12 schools increased the impact of ICEIDA's intervention. Similarly, the focus on maternal and child health (when the major causes of morbidity is malaria and in many others are respiratory diseases) was another effort to respond to a critical situation and achieve impact.

However, as discussed, even this level of concentration had its limitations. Had the same emphasis on concentration been applied to four schools and health centres, arguably, far more impact could have been achieved in respect of the communities they serve. Concentration is always a trade-off between total numbers and short- and medium term impact. The evaluation believes that the MBSP experience underlines the need to revisit this on a regular basis.

8.1.3 Coherence

The core message of the sanitation sub-project, including its associated ODF effort, was the central importance of sanitary practices at home, in school and in the wider community. This message needs to be reinforced at every opportunity and continuously, if it is to become embedded in everyday life. The absence of hand-washing facilities, particularly in government institutions, especially health centres, undermines the message for the users of these institutions.

8.1.4 Attitudinal Change Paramount

It is critical to tailor the intervention to the root causes of the challenge. The education intervention sought to improve education participation through improved infrastructure and teacher performance, leading to improved learner educational outturn. These are important influences on the expected result; but they fail to really address the root cause of the challenge: parental disinterest in their children's education.

There are a number of reasons for this: the levels of poverty, including

1) lack of alternative employment opportunities to existing fishing, agriculture and outward migration;
2) the visible lack of 'employability' of 'education stayers' as opposed to early 'drop outs';
3) financial pressures on individual households contributing to early marriage (reduction in costs, as opposed to lobola or bride price, which, reportedly, is not a factor); and
4) Examples of 'success' (houses, corrugated iron roofs, etc.) accruing from outward migration.

Such attitudes need addressing if the education outcome is to be successfully and sustainably addressed. DoE acknowledges it has a problem mobilising communities in support of education. Given the deep-rooted social attitude in favour of income generation and lack of visible evidence of the success potential of education, there is a need for an increased number of (Muslim) role models in this regard.

8.2 Recommendations

1) Require the contracted consultants to make good the necessary repairs and/or repair the identified defaults identified in the technical audit.
2) Conduct a technical audit of all new and rehabilitated boreholes to identify any shortcomings; require the consultants to make necessary repairs.
3) Prepare and maintain a reliable map referencing all safe water points in the district.
4) If not already done, absorb onto the government payroll all teachers, WMAs and other staff recruited through the programme.
5) If not already done, absorb onto the district council budget all maintenance and travel costs in respect of vehicles procured through the project.
6) Establish a list of unsatisfactory contractors based on objective measures of performance and ethical behaviour.

7) Measures need to be taken to address any technical competence issues in the Public Works Department and the Clerk of Works office, in particular, commencing with a thorough needs assessment of the Clerk of Works office and, should it be necessary, competent technical support to ensure necessary, but absent, technical skills are developed.

8) Develop means to address the community's negative/disinterested attitudes to education, including identifying suitable role models of value-added through education.

9) Consider mechanisms to address gaps, particularly in class room and staff housing provision, identified in the course of the MBSP.

10) Develop a decentralised pilot fund to support minor maintenance at health centres based on the principals established through the School Fund.

Annexes

Annex 1: Terms of Reference

Annex 2: Documents Consulted

Annex 3: Persons Met

Annex 4: Evaluation Matrix: Malawi and Uganda

Annex 5: MBSP Expenditure by Project and Category

Annex 6: Output Achievements

Annex 7: Schools Data Collected by Evaluation

Annex 8: Bamusi Village ODF Case Study

Annex 9: Household Survey Report

Annex 1: Terms of Reference

Terms of Reference: External Evaluation of District Development Cooperation Programmes in Mangochi District in Malawi and Kalangala District in Uganda

1. Introduction

Malawi and Uganda have been bilateral partner countries in Icelandic development cooperation since, 1989 and 2001 respectively. In 2006 Iceland started district development cooperation with Kalangala district in Uganda based on previous development project cooperation. This was the start of a district approach, focusing on support through district governments to improve livelihoods and provide basic services, which was later adopted more widely by the Icelandic International Development Agency (ICEIDA, which has now merged with MFA Iceland). In 2012 a formal district cooperation programme was started in Mangochi District in Malawi, building on previous development cooperation projects, which had been implemented in the district.

In both cases, the chosen approach has placed MFA-ICEIDA as a key external partner to the district authorities and as the single largest financier of investments in social infrastructure, such as water and sanitation (both countries), education (both countries), maternal and child health (Mangochi). In Kalangala, MFA-ICEIDA has been a key financier of economic infrastructure for fisheries. In both countries/districts financing for capacity building and administrative strengthening has been provided.

The two districts are very different in many aspects. Mangochi district has a population of more than one million people, while Kalangala has a population of less than one hundred thousand. While in Mangochi fisheries is a sizeable activity, and the reason Iceland started support there, agriculture is the dominant economic activity, whereas in Kalangala it is fisheries. The population in Kalangala is highly transient, while in Mangochi it is stationary and engaged in cultivation. Nevertheless, both districts face similar challenges in social infrastructure: insufficient access to clean water, insufficient provision of quality education, insufficient public health access.

The main purpose of the evaluation is to provide an external, independent and objective assessment of the two cooperation programmes, to strengthen mutual accountability for development results and provide lessons learned for stakeholders for future planning and decision-making.

Thus, the team of evaluators, henceforth referred to as the Consultant, have a twofold task within this assignment. The first and main task is to conduct an evaluation of the two distinct development programmes in Mangochi and Kalangala Districts with a focus on results achieved, potential impact and sustainability. The second task is to assess the effectiveness of the district level approach with reference to the two programmes, including benefits, challenges and risks, and provide recommendations as may be applicable with reference to district cooperation and strategic partnerships in the respective countries

MFA Iceland is now seeking a team of consultants (the Consultant) with at least 10 years of experience in evaluations in international development, including vast experience in evaluating projects in Southern and East Africa, knowledge and experience of working in Malawi and/or Uganda is required.

2. The Programmes to be Evaluated

Two district level development programmes under Icelandic bi-lateral cooperation are the subjects of this evaluation.

- Malawi – Mangochi Basic Services Programme 2012-2016 (extended to 2017) New phase has recently started.
- Uganda – Support to Kalangala District Development Programme 2006-2015 (extended to 2017)
- 2.1. Malawi - Mangochi Basic Services Programme: Programme Support by ICEIDA to the Mangochi District Council for the Improvement of Basic Services in Mangochi District 2012- 2016.
- Project Number: MAL16050-1201 Implementation period: 2012-2017
- Partners:
- Implementing Agent:
- Sector DAC: Multisector aid for basic social services – 16050
- Estimated Funding 15 million USD

A Country Strategy Plan (CSP) 2012-2016 (extended to 2018) for cooperation between Iceland and Malawi was approved by the Ministry for Foreign Affairs in Iceland and Government of Malawi. The CSP is aligned with the Malawi Growth and Development Strategy 2011-2016 (MGDS II) of the Government of Malawi. Prior to MBSP, ICEIDA had been collaborating on various development projects in the Monkey Bay area of Mangochi district. The Mangochi Basic Services Programme was subject to 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.

Under MBSP, ICEIDA provided programme based assistance to the District Council of Mangochi to achieve the goals of its development strategy in areas of social services, which included, water, sanitation, education and public health. The Programme has included capacity building at district level, which was incorporated into all relevant areas of support.

The overall objective of the MBSP 2012-2016 was to assist the Malawian Government and the Mangochi District Council to improve living standards in the rural communities in Mangochi District. This was expected to result in a more resilient population in adversity and a more resourceful one for self-sufficiency. The programme consisted of these four main components:

1. In **water and sanitation** the main objectives were to increase access of the population to potable water and improving hygiene practices with the use of adequate sanitation facilities to reduce waterborne diseases and to promote better health and well-being. The immediate objective of the water and sanitation programme was: Increased and sustainable access to and use of improved safe water sources and improved sanitation practices in TA Chimwala.
2. In **public health** the main goal was to reduce maternal and neonatal mortality through increased availability, access and utilization of improved maternal and neonatal health care services. The immediate objective of the Public Health Programme was: Increased availability, access and utilisation of high impact, quality maternal and child health services in Mangochi.

3. In **education** the programme objective was to provide more equitable access to education, to improve the quality of education facilities and to increase the pass rate in primary schools by means of improving school facilities and training of staff. The immediate objective of the Education Programme is: Improve quality of education in target schools to reduce drop-out and repetition and promote effective learning.
4. **Capacity building** to strengthen the ability of Mangochi District Council to deliver quality services and ensure successful implementation of the MBSP.

Throughout the MBSP, two cross cutting issues, gender and environment, were to be systematically considered and indicators developed to measure progress towards gender equality.

For monitoring and reporting purposes the MBSP has followed the District monitoring and reporting system. Furthermore a specific M&E plan was developed for the programme and extensive monitoring data are available for the programmes, which shall be incorporated in the evaluation.

In 2016, the current programme was extended for a period of one year, and in 2017 a new programme was designed and approved, which will be implemented from late 2017.

A mid-term review was conducted of MBSP in 20141.

Key documents:

- Malawi Country Strategy Paper 2012-2016
- Partnership Agreement 2012-2016
- Mangochi Basic Services Programme Master Programme Document 2012-2016
- Mangochi ICEIDA Partnership in Water and Sanitation 2012-2016 Part I
- Mangochi ICEIDA Partnership in Public Health 2012-2016 Part-II
- Mangochi ICEIDA Partnership in Education 2012-2016 Part-III
- Mangochi Basic Services Programme – Mid-term Evaluation – Final Report 2014

2.1. Uganda - Support to the Implementation of Kalangala District Development Programme

Project Number: UGA43040-0602

Implementation period: 2006-2015

Partners: Ministry of Local Government and Kalangala District Local Government Implementing Agency: Local government Kalangala with ICEIDA support

Sector – DAC: Multisector aid for basic social services – 16050

MFA-ICEIDA funding: 9.1 million USD

The project was initiated on the request of Kalangala District Local Government, through the Ministry of Local Government, to address deficiencies in service delivery in the district. The project preparations started in 2005 and the project plan of operation was signed in September 2006. Prior to KDDP, ICEIDA had been collaborating with the Ministry of Gender, Labour and Social Development and Kalangala district in the implementation of functional adult literacy programme (FALP) to improve literacy of the fishing communities in the district.

The project implementation commenced in December 2006, in 2010 a new logframe was approved for the second phase of implementation, which was finalized in 2015. Based on internal review in 2015 a four year consolidation phase for education was designed and approved, which is currently under implementation.

The development objective of the KDDP was conceived in line with Uganda's Poverty Eradication Action Plan (PEAP), to contribute to sustainable livelihoods and equitable socio-economic development in Uganda, particularly in Kalangala District. The overall strategy was to support Kalangala district local government to implement its development plan in the sectors of fisheries (integrating water and sanitation), education and health sectors, an integral part of the approach was to develop capacity for local governance to improve service delivery to the population of the district. In line with this strategy, the immediate objectives of the KDDP were fourfold:

1. *Under local administration sector;* to support the efforts of the Kalangala district local government to achieve efficient and effective leadership in the district together with quality administration and management of public services along with strong private sector and civil society organisations by 2015.
2. *Under Fisheries, and Water and Sanitation;* to support the efforts of Kalangala district local government to achieve sustainable quality fisheries production and marketing in the whole district 2015.
3. *Under Education and Sports sector;* to support the efforts of Kalangala district local government to achieve equitable access for the citizens to quality primary and secondary education 2015.
4. *Under Health sector;* to support the efforts of Kalangala district local government to achieve equitable access for the citizens to quality health services at district level by 2015.[2]

In the revised logframe from 2010, an additional immediate object is defined, following recommendations presented in the mid term review in 2010: 1. Improved exploitation of Kalangala District tourism potential by 2015[3] A Mid term review of KDDP was conducted in 2010[4]

Key documents:

- Project document 2006-2015
- Mid-term review 2010
- Revised logframe 2010-2015
- Internal review document for programme partners 2015
- Project Completion report 2017

3. Purpose and objectives of the evaluation

In accordance with MFA policy on development evaluations and Iceland's Strategy for Development Cooperation, evaluations shall be carried out on development interventions.

This evaluation is both carried out for accountability and learning purposes. It is meant to provide evidence on the outcome, impact and sustainability of the two respective programmes, and to provide MFA-ICEIDA, the respective district councils in Mangochi and Kalangala and other stakeholders with . The evaluation is expected to shed light on the degree to which outcomes have

been or are likely to be achieved in the two respective programmes, whether outputs have been produced as planned and as its impact on local communities (intended and unintended) and the likelihood that results are sustainable shall be addressed.

The three main objectives of this evaluation assignment are:

1. To provide independent and objective assessment of the results (outputs, outcome and *impact*, as well as relevance and sustainability) achieved by the respective programmes in the two districts.
2. To provide assessment of the relevance and effectiveness of working directly with district authorities as implementing partners in Iceland's development cooperation, including the main benefits, challenges and risks of such cooperation. This included an assessment of to what extent decentralization structures and linkages between local and central government support or hinder such arrangements?
3. To provide recommendation to strengthen further results-based management in the implementation of district development programmes

4. Scope of the evaluation

The scope of the evaluation is to assess, whether and to what degree the immediate objectives of the programmes were achieved and have contributed to the long term objectives of sustainable livelihoods in Kalangala (economic and social living conditions) and improved living standards of rural population in Mangochi district. It shall also assess whether the programme components were well implemented in terms of producing the planned outputs through efficient use of inputs.

Furthermore, the relevance of the programmes, its impact on local communities (intended and unintended) and the likelihood that results are sustainable shall be addressed. The evaluation shall address, but not be limited, to the following issues:

Relevance:

- Were the programmes an appropriate response to the needs of the identified beneficiaries in the two districts?
- Did the programmes address an important issue in relation to priorities in Malawi and Uganda development plans at the district level, and was it in line with Iceland's development strategy?
- How can the results of this evaluation inform the current and planned reviews of Country Strategy Papers for Malawi and Uganda?

Effectiveness:

- Have the intended outcomes, as defined in Programme Documents been achieved or are they likely to be achieved– and to what degree?
- To what extent, has the KDDP through the Kalangala District local government, contributed to:
    - Efficient and effective leadership in the district together with quality administration and management of public services along with strong private sector and civil society organisations.
    - Improved quality fisheries production and marketing in the Kalangala district.

- Equitable access to quality education in Kalangala district.
- Equitable access for the citizens to quality health services at district level (2006-2010).
- Improved exploitation of Kalangala District tourism potential (2010-2013).

- To what extent has the MBSP contributed to
  - Increased and sustainable access to and use of improved safe water sources and improved sanitation practices in TA Chimwala.
  - Increased availability, access and utilisation of high impact, quality maternal and child health services in Mangochi.
  - Improved quality of education in target schools to reduce drop-out and repetition and promote effective learning.
  - Improved institutional capacity for delivery of basic services, including health, water and
  - sanitation and education, at the Mangochi district government

Efficiency:

- To what degree have the programmed **outputs** been delivered in accordance with Programme Documents, at the appropriate quality and quantity and at planned cost?
- Assess the sharing of responsibility and accountability among the stakeholders, including MFA-ICEIDA, District governments and respective Ministries.
- To what degree has the use of **inputs** in implementation been efficient?
- Construction and procurement of goods and equipment
- Arrangement of training
- Monitoring and Evaluation (provide comments and recommendations on the implementation of M&E plans)
- The work of the "Programme Steering Committees" and project management
- Do the district councils have the absorption capacity to effectively manage and administer the funding and activities?

Impact:

- Have the two programmes and their implementation had an impact, beyond the defined outcomes and outputs, on benefitting communities.
- Have the programmes contributed to improved livelihoods – measurable and perceived - among beneficiaries, including indicators from the key sectors of health, education, fisheries and water and sanitation, as defined in the respective project documents and government strategies in Malawi and Uganda.
- To what extent has the KDDP contributed to sustainable livelihoods and equitable socio-economic development in Kangala district
- To what extent has the MBSP con tribute to improved living standards in the rural communities in Mangochi district and a more resilient population in adversity and a more resourceful one for self-sufficiency
- Has the capacity of the district local governments improved in terms of delivering basic services to the population.

The consultancy is expected to extract from its evaluation an overall analysis drawn from diverse resources of available indicators and information whether the programmes have had impact (positive or negative) on beneficiary communities, or specific groups within those, notably different socio-economic class

Sustainability:

- Is it likely that the outputs can be maintained and operated for the benefits of the population without programme support? This should in particular address matters concerning operations and maintenance of infrastructure. If not, what further support will be needed?
- Has the contribution from the programmes been within limits of the absorption capacity of the two districts?
- Are outcomes likely to be sustained without support from the Programmes? If not, what further support will be needed?
- To what extent has capacity building of the district governments been sustainable, for instance with regard to retention of qualified/trained district staff, and has it contributed to improved sustainability of project outputs and outcomes?
- What factors influence or challenge sustainability of the two programmes?
- In the case of Kalangala, what impact will the end of the project have for delivery of services in the supported sectors?

5. Crosscutting Issues

Gender:

- Have both genders benefited from the programmes on equal terms?
- Have the programmes contributed to increased gender equality?
- To what extent did the two programmes create equal opportunities for men and women / boys and girls to participate?

Environment:

- Have the programmes caused any significant environmental impact, positive or negative?
- To what extent have the programmes encouraged sustainable natural resource management?
- Were proper environmental considerations followed during implementation of activities where applicable?

With reference to the questions above and relevant M&E plans and available data for the programmes the Consultant will during the Inception phase, produce an evaluation framework in collaboration with the key stakeholders, including the district governments that identifies the relevant evaluation questions, formulated with reference to the objectives and indicators of each programme.

6. Methodology

The evaluation shall be based on study of relevant documents, available monitoring data and statistics for relevant indicators, surveys and interviews with relevant stakeholders and field visits. It is expected that mixed methods will be applied, qualitative and quantitative. It is expected that interviews will be carried out with key stakeholders and that field work will be carried out for about two weeks in Kalangala Wrap-up and validation meetings should be conducted with stakeholders at the end of field visits in each district.

It is expected that local experts will form a part of the evaluation team in each country to assist with surveys, interviews, translations etc. Such input shall be budgeted in the financial proposal, and qualified local consultants proposed.

During the preparation stages the Consultant will work on defining in detail the appropriate methodological approach, which is likely to yield evidence based assessment and develop a detailed evaluation matrix in cooperation with MFA and the respective stakeholders, which will be presented in the Inception report.

7. Deliverables

The deliverables for this consultancy consist of the following outputs:

- Inception report including an evaluation plan/matrix, key indicators and statistics to be used with reference to Project Document and M&E plans, workplan, interview guides, questionnaire etc. There may be one Inception report for the two programmes, but two evaluation matrixes shall be developed for the respective programmes.
- Draft report 1 including the two case study reports and analysis of the relevance and effectiveness of the district level cooperation mechanism and lessons learned.
- Draft report 2 incorporating feedback from Draft report 1.
- Organizing a feedback meeting with stakeholders in Malawi and Uganda to present the findings of the Draft 2 report and discuss comments and feedback.
- Final report including Executive summary and recommendations
- Evaluation brief not exceeding 4 pages

8. Timeframe

It is expected that the assignment will be carried out from the beginning of February 2018 and be finalized by June 2018. The Inception report shall be submitted within four weeks from the start of the assignment. The assignment is budgeted with an estimated input from the Consultant of up to 30 weeks (150 days), thereof 10 weeks allocated for local consultants.

9. Management and Logistics

The evaluation will be managed by the Evaluation Unit at MFA. The evaluation shall be led by a team leader. With respect to the overall management and execution of the evaluation the following assignment of responsibilities is expected:

The Evaluation Manager at MFA:

The Evaluation Manager at MFA will be the primary MFA representative for this evaluation and be a focal point for communication with other MFA personnel when required. The Evaluation Manager is responsible for:

- Facilitating the Consultant's access to pertinent MFA documents and personnel.
- Providing overall management responsibility for the evaluation.
- Approving all deliverables.

The Icelandic Embassies in Malawi and Uganda:

- Will contribute appropriately to all steps in the evaluation process without affecting the independency of the evaluation proper.
- Assist the consultant in establishing contact with all stakeholders as applicable.
- Arrange and provide transportation for the Consultant for field visits.
- Provide the Consultant with access to relevant documents.
- Provide feedback and comments on the reports.
- Arrange stakeholder meeting for feedback on draft evaluation report.

The Consultant:

The consultant is responsible for

- Conducting the evaluation in accordance with the ToR and the approved Inception report and evaluation plan.
- Managing day-to-day operations related to the evaluation.
- Making relevant travel arrangements related to the assignment and Consultant's work.
- Arranging all applicable visa's and health procedures as may be required.
- Providing regular progress updates to MFA's Evaluation Manager.
- Producing deliverables in accordance with the contractual requirements.

10. Consultant's Qualifications

The evaluation team (The Consultant) shall be comprised of two key experts and one or two local non-key experts in each country. The evaluation team shall combine core evaluation competencies with strong experience in international development evaluations in particular in Southern and East Africa. The evaluation team leader shall be proposed who will manage and coordinate the work, and provide the overall editorial guidance and synthesis of the evaluation report.

Specific qualifications and experience of the two key experts:

1. An advanced university degree in relevant discipline
2. A minimum of 10 years experience in evaluations for international development, demonstrated by at least two evaluation reports for development project of considerable scope.
3. Experience from working in Malawi and/or Uganda.
4. Experience in evaluations covering at least three of the following sectors; decentralization, education, health, water and sanitation and institutional capacity building.
5. Demonstrated professionalism in all aspects of work, possess excellent communication and interpersonal skills as well as good planning and organizational skills.
6. Excellent command of oral and written English

The two key experts shall complement each other's qualifications.

Specific qualifications of the local, non-key experts (one or two may be proposed for each country):

1. An advanced university degree in relevant discipline.
2. A minimum of 5 years evaluation experience.
3. Experience in evaluations covering at least two of the following sectors; decentralization, education, health, water and sanitation, fisheries (for Uganda) and institutional capacity building.
4. Knowledge and experience in relevant social science methods, including interview s and household surveys.
5. Demonstrated professionalism in all aspects of work, possess excellent communication and interpersonal skills as well as good planning and organizational skills.
6. Fluent in relevant local languages in Mangochi (Chichewa and Yao) and Kalangala (Luganda) districts and excellent command of oral and written English.

11. **Application procedure**

The Consultant shall prepare and submit the following:

1. A cover letter, outlining the qualifications of the consultant/team for the assignment, including references to previous relevant work.
2. Technical proposal (4-5 pages), responding to this ToR, outlining the envisioned evaluation process, proposed methods and workplan.
3. CV's of the two key experts and the local experts proposed for each country, detailing relevant skills and experience.
4. Two examples of recent evaluation reports for international development.
5. Financial proposal, in a separate file, based on the premises outlined in this ToR, including expected travel costs. The budget shall include:
    a. Remuneration for the two key experts for a period of 100 days in total
    b. Remuneration for the local experts for a period of 50 days in total
    c. Inception mission to Malawi and Uganda, 3 working days expected in each country.

d. Fieldwork in Uganda and Malawi for a period of 2 weeks in each country, for both key experts.
e. Reimbursable costs associated with the evaluation

6. Two contactable references from similar assignments, or reference letters.

Evaluation of proposals will be based on Quality and Cost Based Selection (QCBS), the evaluation of quality will be based on the following criteria:

- Adequacy and quality of the proposed methodology, work plan and team composition in
- responding to the Terms of Reference (50%)
- Approach and methods
- Workplan and team composition, including the non-key experts

The minimum score for quality required to pass is 75.

For inquiries or clarifications on this assignment, please send an email to tenders@mfa.is. Responses to all inquiries will be posted on the website: http://www.iceida.is/english/tenders/

MFA is not bound to accept any proposal, and reserves the right to annul the selection process at any time prior to the Contract Award.

Proposals shall be submitted in electronic format to tenders@mfa.is, before 16:00 Icelandic time, 15 December 2017. Proposals received after this time will not be considered.

Annex 2: Documents Consulted

ICEIDA

- Malawi Country Strategy Paper, 2012 – 16
- Mangochi Basic Services Programme – Master Programme Document MAL16050-1201
- Partnership Agreement between Government of Malawi and ICEIDA for Mangochi Basic Services Programme
- Mangochi ICEIDA Partnership in Water and Sanitation
- Mangochi ICEIDA Partnership in Public Health
- Mangochi ICEIDA Partnership In Education
- MTR, Mangochi Basic Services Programme
- Technical Audit [Draft]

National

- Malawi Growth and Development Strategy III

ICEIDA

- Uganda Country Strategy Paper, 2014 - 17
- Assessment of the Capacity of Kalanga District to Manage Donor Funds
- Support to the Implementation of the Kalanga District Development Programme
- Mid-term Review of ICEIDA's Support to Kalanga District Development Programme
- KDDP Revised Logframes
- Kalanga District Development Programme, Internal Review for Partners
- Support to the Implementation of the Kalanga District Development Programme, 2006 – 15: Project Completion Report

National

- Vision 2030
- Poverty Eradication Action Plan
- National Development Plan

Annex 3: Persons Met

- Thordis Sigurdardottir, Director, Bilateral Cooperation, Ministry of Foreign Affairs

Malawi

- Agusta Gisladottir, Charge d'Affaires, Embassy of Iceland, Malawi
- Lilja D. Kolbeinsdottir, Programme Director, Embassy of Iceland, Malawi
- Levi Soko, Programme Manager, MBSP
- Everson Machika, Partner, Design Studio Architect
- Kiswell D Dakamau, Principal Secretary, Ministry of Local Government and Rural Development (MLGRD)
- Flemmings Nyirenda, Chief Economist and Planning Officer, MLGRD
- Sylvester Gonarnadzi, Deputy-director, Monitoring and Evaluation, MLGRD
- Francis Salcale, Chief Rural Development Officer, MLGRD
- Moses Owen Chimphepo, District Commissioner, Mangochi District Council
- Joseph Magambo, District Education Manager, Mangochi District Council
- White Jali, Senior Inspector of Schools, Mangochi District Council
- Davis Issah, Accountant, Mangochi District Council
- Kondwani Andreah, District Water Development Officer, Mangochi District Council
- Davis Issah, Accountant, Education, Mangochi District Council
- Kondwain Mamba, District Environmental Health Officer, Mangochi District Council
- Hassan Maluwe, WMA, Mangochi District Council
- Jonah Gllrol, WMA, Mangochi District Council
- Dr Henry Chibona, District Health Officer, Mangochi District Council

Extension Workers: Health Surveillance Assistants (HSAs), Water Monitoring Assistants (WMAs) and Community Development Assistants (CDAs)

- Bryer Kawelenga, HSA
- Dorothy Chimphamba, HSA
- Stella Mazengera, HSA
- Supply Gomani, HSA
- Verson Chirombo, WMA
- David Malaza, WMA
- Doreen Njalela, WMA
- Yona Mwala, CDA
- Ruth Nyirenda, WMA

Mangochi District Hospital

- Zachaus Solomoni, Environmental Officer
- Samuel Katundu, Assistant Environmental Officer
- Vincent Dumba, Senior HSA

- Changali Primary School
- Edson Mwanyansi, Head Teacher
- Rrighton Makungwa, Deputy Head
- Willard Chazima, Teacher
- Chipililo Ngwangwa, Teacher
- Johanes Ali, Teacher
- Charity Chisale, Teacher
- Fales Thawale, Chair, Mothers Support Group (MSG)
- Ida Jalu, Treasurer, MSG
- Kasam Haji, Secretary, PTA
- Mafula M'madi, Chair PTA

Lupetele Primary School

- Douglas Masimbe, Head Teacher
- Arifa Bakali, Teacher
- Alinafe Lawisoni, Teacher
- Fanny Phiri, Teacher
- James Asani, Teacher
- Steve Banda, Teacher
- Roman Chisale, Chair, School Management Committee (SMC)
- Aisha Yisa, Secretary, SMC
- Wyson Dala, Member, SMC
- Dija Rashid, Member PTA
- Hawa Kauye, Treasurer, MSG
- Eunice Julius, Vice-Chair, MSG
- Mariam Kasim, Member PTA
- Ali Ndala, Vice-Chair, PTA
- Bertha Chimwaza, Chair, SMC
- St Joseph's Primary School
- Donald Sulani, Teacher
- Hassan Saidi, Teacher
- Akib Binoni, Deputy-Head
- John Paul, Teacher
- Ishmael Mkwanda, Teacher
- Alinafe Mthinda, Teacher
- Eubert Chimwaza, Teacher

Chikomwe Primary School

- Gloria Nkhani, Teacher
- Asiyatu Jafali, Teacher
- Harry Mwinjilo, Teacher
- Rhoda Maulidi, Teacher
- Nellie Kathembwe, Teacher
- Blandina Chongolera, Teacher
- Agness Makunyange, Chair, PTA
- Lucy Jota, Secretary, MSG
- Hawa Mpuwa, Chair, MSG
- Nellie Panjira, Member, SMC
- Jusa Nkhata , Treasurer, SMC
- Sani Bulala, Vice-Chair, PTA
- Imedi James, Treasurer, PTA
- Chiwome Twaibu, Vice-Chair, SMC

Chimbende Primary School

- Loyce Chingwalu, Teacher
- Babra Chisale, Teacher
- Ruth Kapita, Teacher
- Khadija Chifisi, Teacher
- Shadrick Enock, Teacher
- Fostina Kabango, Head
- Augustine Kalembela, Teacher
- Idrissa Kasim, Teacher
- Chikondi Mapanga, Teacher

Lwanga Primary School

- Nellie Lipenga, Head
- Prisca Kumwanje, Teacher
- Anna Gama, Teacher
- Habib Mtenje, Teacher
- Maxwell Ng;omba, Teacher
- Juliet kachingwe, Teacher
- Thomas Msusa, Teacher
- Yusuf Mbalaka, Teacher
- K T Msikawandeu, Chair, PTA
- Samuel Munthali, Chair, SMC
- Eliza Gwandali, Vice-Chair, SMC

- Dyna Billy, Vice-Chaor, PTA
- Mariam Kamwendo, Secretary, MSG
- Florida Zimba, Vice-Chair, PTA
- Maria Frank, Vice-Chair, MSG
- Cecilia Zimba, Treasurer, MSG
- Febie Mwenda, Secretary, SMC

Mwachikumbe Village: Water Point Management Committee

- Limbile Ayibu, Chair
- Labiya Meya, Treasurer
- Simao James, Vice-Treasurer
- Sigele Anusa, Member
- Suwilanga Asamu, Member

Ukala Village: Water Point Management Committee

- Fanny Absent, Member
- Sumani Mtalika, Treasurer
- Marry Belo, Member
- Lukiya Ajasi, Member
- Emily Jambo, Secretary
- Joyce Wisiki, Chair

Zimukalimba Village: Water Point Management Committee

- Gladesi Isa, Secretary
- Halima Afana, Vice-Secretary
- Ester Miliasi, Member

Mtenue Village: Water Point Management Committee

- Fatima Bakali, Secretary
- Rose Adini, Member
- Isha Chale, Member
- Mercy jafali, Member
- Peter White, Member
- Duma Mtala, Chair
- Lucy Vidichi, Vice-Chaor

Nnolo Village: Water Point Management Committee

- Lucy Chaima, Chair
- Falida Haji, Treasurer
- Tumale Saoneka, Vice-Secretary
- Patuma Ali, Vice-Chair

- Laja Ali, Member

Kukalanga 2 Village: Water Point Management Committee

- Magret Brown, Chair
- Estere Bulaimu, Member
- Joyce Beni, Member
- Lucy Alidi, Member
- Mariam Wochi, Secretary
- Kugwesa Saikolo, Treasurer

Kwejeke Village: Water Point Management Committee

- Alice Sili, Secretary
- Hawa Mwenyehaka, Treasurer
- Emily Labana, Chaior

Katuu Health Centre Health Advisory Committee (HAC)

- Traditional Authority Katuli, Chaor
- Maxwell Duncan, Member
- Seka Morris, Member
- Veronica Chindevu, Secretary
- Violet Asima, Member
- Hawa Alisa, Treasurer
- Maria Kabiresi, Member

Katuu Health Centre - Kwituza Village Health Committee

- Obrian Thawani,m Member
- Ailu Mnambala, Chair
- Doreen Kapelepele, Member
- Fatuma Banda, Member
- Donex Saidi, Member
- Alics Mkali, Secretary
- Zione Matinga, Vice-Secretary
- Stawa James, Vice-Chair

Malombe Health Centre HAC

- Julius Nampesiya General, Chair
- Zimbabwe Kapalamula, Vice-Chair
- Hawa Makiyi, Secretary
- Felina Kalima, Vice-Secretary
- Joyce Kaselemba, Member
- Esnati Mambo, Member

Malombe Health Centre – Chip[ole Village Health Committee

- Hawa Makiyi, Chair
- Jennifer Majeka, Treasurer
- Hawa Shaibu, Secretary
- Joyce Makiyi, Vice-Secretary
- Shakira Disi, Member
- Fatima Maxson, Member

Malombe Health Centre – Staff

- Josephine Masache, Medical Assistant
- Benard Matola, Nurse/Midwife
- Stanford Daputala, Health Surveillance Assistant (HAS)

Namwere Health Centre HAC

- Jafar Khalid
- B M Imed
- Abdul Rashid
- Abam Khilasya
- Samoor Cuaswena
- Maganizo Games
- Alesi Yasim
- Shelly Raphael
- Elizabeth Chisale

Jalasi Health Centre (Staff)

- Ellen Mwatsetza, Midwife Nurse
- James Jesinaw, HSA
- Frank Alli, HAS
- Leonard Kamkwalala, HSA
- Bessie Sulani, HSA

Group Village Headmen, Village Headmen, Care Group Volunteers: ODF Case Study

- Group Village Headman Bamusi
- Village Headman Pondani
- Village Headman Mika
- Village Headman Selemani

Annex 4: Evaluation Matrix: Malawi and Uganda

Criteria	EQs	Key Indicators Source
Relevance	Were the programmes an appropriate response to the needs of the identified beneficiaries in the two districts? Did the programmes address an important issue in relation to priorities in Malawi and Uganda, development plans at the district level, and was it in line with Iceland's development strategy? How can the results of this evaluation inform the current and planned reviews of Country Strategy Papers for Malawi and Uganda?	• ICEIDA Malawi and Uganda CSPs (Country Strategy Papers) • Programme Documents (Situational Analysis/Baseline Needs Assessments, etc.) • Strategic change in programme focus in Uganda in Phase 2 (2011-2015) as compared to Phase 1 (2006-2010) • National Development Plan • Vision 2030 • Malawi Growth and Development Strategy
Efficiency	To what degree have the programmed **outputs** been delivered in accordance with Programme Documents, at the appropriate quality and quantity and at planned cost? Assess the sharing of responsibility and accountability among the stakeholders, including MFA- ICEIDA, District governments and respective Ministries. To what degree has the use of **inputs** in implementation been efficient? • Construction and procurement of goods and equipment • Arrangement of training • Monitoring and Evaluation (provide comments and recommendations on the implementation of M&E plans) The work of the "Programme Steering Committees" and project management Do the district councils have the absorption capacity to effectively manage and administer the funding and activities?	• Project Reports, notably Completion Report in Uganda, capturing Phase 2 (2011-2015) • Mid-Term Reviews. (In Uganda MTR reported on initial logframe: New logframe was developed for Phase 2) • Key Informant/Stakeholder interviews, especially at district HQs, schools, health centres (in Malawi) • Household Survey Results • Project Steering Committee/Project Supervisory Committee and Project Management Team (PMT) Minutes • Financial/Audit reports

Criteria	EQs	Key Indicators Source
Effectiveness	Have the intended **outcomes**, as defined in Programme Documents been achieved or are they likely to be achieved– and to what degree? <u>To what extent has the MBSP (Malawi), contributed to:</u> 1. Increased and sustainable access to and use of improved safe water sources and improved sanitation practices in TA Chimwala 2. Increased availability, access and utilisation of high impact, quality maternal and child health services in Mangochi. 3. Improved quality of education in target schools to reduce drop-out and repetition and promote effective learning. 4. Improved institutional capacity for delivery of basic services, including health, water and sanitation and education, at the Mangochi district government. <u>To what extent has the KDDP (Uganda), contributed to:</u> 1. Efficient and effective leadership in the district together with quality administration and management of public services along with strong private sector and civil society organisations 2. Improved quality fisheries production and marketing in the Kalangala district. 3. Equitable access to quality education in Kalangala district. 4. Equitable access for the citizens to quality health services at district level (2006-2010). 5. Improved exploitation of Kalangala District tourism potential (2010-2013).	• Programme Documents. Project Completion Report /MTR Report • Project Reports • Key Informant/Stakeholder Interviews in district, health centres and schools. • Household Survey Results, Uganda focusing on livelihood indicators in relative terms over time (income, distribution of family expenditures, standard of housing, etc.): ▪ % increase in access to potable water and improved sanitation, including reduced incidents of waterborne and hygiene-related diseases. ▪ % Improvement in Maternal and Neo-natal health ▪ % increase in utilisation of health services ▪ % School drop out ▪ % School repetition ▪ Stakeholder perception of district council service provision ▪ Uganda: programme effect on fishery (catch, fish quality, sales, etc.).

Criteria	EQs	Key Indicators Source
Impact (beyond output and outcome level)	Have the two programmes and their implementation had an impact, including and **beyond the defined outcomes and outputs,** on benefitting communities. Have the programmes contributed to improved livelihoods, measurable and perceived - among beneficiaries, including indicators from the key sectors of health, education, fisheries and water and sanitation, as defined in the respective project documents and government strategies in Malawi and Uganda. To what extent has the MBSP and KDDP contributed to improved living standards in the rural communities in Mangochi and Kalangala Districts and a more resilient population in adversity and a more resourceful one Has the capacity of the district local governments improved in terms of delivering basic services to the population?	• Programme Documents/ Completion Report • Project Reports • Key Informant/Stakeholder Interviews • Household Survey Results • Stakeholder perception of district council service provision
Sustainability	Is there improved institutional capacity for delivery of basic services, including health, water and sanitation and education, at the Mangochi and Kalangala district governments Has the capacity of the district local governments improved in terms of delivering basic services to the population? Is it likely that the **outputs** can be maintained and operated for the benefits of the population without programme support? This should in particular address matters concerning operations and maintenance of infrastructure. If not, what further support will be needed? Has the contribution from the programmes been within limits of the absorption capacity of the two districts? Are **outcomes** likely to be sustained without support from the Programmes? If not, what further support will be needed? To what extent has capacity building of the district governments been sustainable, for instance with regard to retention of qualified/trained district staff, and has it contributed to improved sustainability of project outputs and outcomes? What factors influence or challenge sustainability of the two programmes?	• Programme Documents • Project Reports • Key Informant/Stakeholder Interviews • Household Survey Results • Stakeholder perception of district council service provision. • Sustainability ▪ Institutional ▪ Financial/economic

Criteria	EQs	Key Indicators Source
Cross-cutting: Gender	Have both genders benefited from the programmes on equal terms? Have the programmes contributed to increased gender equality? To what extent did the two programmes create equal opportunities for men and women / boys and girls to participate? Have the programmes caused any significant environmental impact, positive or negative?	• Programme Documents • Project Reports • Key Informant/Stakeholder Interviews • Household Survey Results ▪ % increase (disaggregated) in access to potable water and improved sanitation ▪ Additional time available to women and girls ▪ How the time is utilised ▪ % Improvement in Maternal and Neo-natal health ▪ % increase (disaggregated) in utilisation of health services ▪ % Drop out (disaggregated) ▪ % repetition (disaggregated) ▪ School attendance (esp. girls) ▪ Stakeholder perception of district council service provision
Cross-cutting: Environment	To what extent have the programmes encouraged sustainable natural resource management? Were proper environmental considerations followed during implementation of activities where applicable?	• Programme Documents • Project Reports • Key Informant/Stakeholder Interviews • Stakeholder perception of district council service provision

Annex 5: MBSP Expenditure by Project and Category

EDUCATION US $						
Goods & Services		100 406	149 203	377 435	616 661	0
General Purchases		10 111	8 943	5 373	4 837	0
Contractors/Building Materials		569 748	823 289	524 176	306 591	259 367
Assets		177 024	84 276	0	0	0
Travel Costs/Meetings		47 274	70 164	63 265	27 753	0
Books, Tuition, Fees		336 849	232 602	125 268	111 478	0
Scholarships		88 988	0	0	0	0
Salaries/Salary Support		0	5 635	0	23 253	14 864
Sub-total		1 330 400	1 374 112	1 095 517	1 090 573	274 231
HEALTH US $						
Item	2012	2013	2014	2015	2016	2017
Goods & Services		48 266	182 915	97 384	47 256	0
General Purchases		1 419	3 626	0	0	0
Contractors/Building Materials		1 515 787	1 202 117	619 420	741 287	131 051
Assets		300 576	198 039	121 742	510 490	140 840
Travel Costs/Meetings		185 718	105 160	56 372	36 691	0
Books, Tuition, Fees		0	0	0	0	O
Scholarships		916	33 840	43 191	0	0
Salaries/Salary Support		0	0	0	0	0
Sub-Total		2 052 682	1 725 697	938 109	1 335 724	271 891

WATER AND SANITATION US $						
Goods & Services	66 647	77 268	71 127	79 389	100 728	15 495
General Purchases	3 617	36 257	8 413	15 607	8 856	3 850
Contractors/Building Materials	266 394	376 687	549 814	543 611	370 571	22 835
Assets	36 507	6 489	6 428	6 735	24 488	0
Travel Costs/Meetings	25 607	99 231	76 103	64 550	115 970	78 518
Books, Tuition, Fees	0	10 884	11 770	8 309	671	2 568
Scholarships	0	0	0	0	0	0
Salaries/Salary Support	11 796	34 905	20 565	47 426	41 950	8 299
Sub-total	411 108	641 721	744 220	765 627	663 234	131 565
TOTAL	411 108	4 024 803	3 844 029	2 799 253	3 089 531	677 688

Annex 6: Output Achievements

Outputs (Education Sector)	Project Target			Achievement		Comments
	2012-16 Targets	2017 Targets	Total	Achieved	%	
1. Improved capacity and support to learners in target schools						
1.1. Capacity building of teachers and school managers						
1.1.1.1. Trained teachers on what to teach and how to teach by MIE	4 sessions	1 session	5 sessions	5 sessions	100	126 teachers have exposed to 5 training sessions by MIE
1.1.2.1. Trained School Managers on school management by MIE	4 sessions	1	5 sessions	5 sessions	100	72 school teacher-managers have exposed to 5 training sessions
1.1.3.1. Teacher trainee candidates identified from local areas and trained	60	0	60	60	100	20 student teachers have graduated
1.1.5.3 Trained teachers hired to teach in target schools	0	20	20	18	90	18 student teachers hired. 2 teachers absconded
1.2. Teaching and learning material provision						
1.2.1.1. Telular centres established	4	0	4	1	25	
1.2.2.1. School textbooks for three subjects in standard 1-4 procured, at a ratio of 1:1	68,000	187,225	255,225	219,060	86	Supplier (MIE) was not able to supply all the books in time.
1.2.2.2. Junior school textbooks distributed to schools						Done
1.2.2.3. School textbooks for three subjects in standard 5-8 procured, at a ratio of 1:1		Included in the 1.2.2.1figures above				Included in 1.2.2.1

Outputs (Education Sector)	Project Target			Achievement		Comments
	2012-16 Targets	2017 Targets	Total	Achieved	%	
1.2.2.4. School textbooks senior classes distributed						Done
1.2.3.1. Supplementary books according to MIE list acquired and distributed	11,000	0	11,000	4,400	40	Cost was under estimated in the budget, less no. of books procured
1.2.4.1. Basic sports equipment procured and distributed	192	0	192	192	100	
1.2.5.1. Procure 40-page and 80-page notebooks	326,000	0	326,000	326,100	100	
1.2.6.1 Teacher's guides for all primary school subjects procured and distributed					100	All teachers in target school received teachers' guide. However, teachers' guide for some subjects were not available on the market
1.2.7.1. Standardised tests acquired and administered	3	0	3	3	100	
1.3. Community mobilization						
1.3.1.1. School committees trained to actively performing their roles	2	0	2	1	50	
1.3.2.1. Organize theatre for development	12	0	12	3	25	
1.3.3.1. Role models visit schools and give talks for learners	4	0	4	0	0	
2. Improved teaching and learning environment						
2.1. New infrastructure and equipment in target schools						
2.1.1.2. New classrooms constructed	52	16	68	70	103	
2.1.2.2. Teacher's houses constructed	36	6	42	42	100	Construction of 6 houses is still in

Outputs (Education Sector)	Project Target			Achievement		Comments
	2012-16 Targets	2017 Targets	Total	Achieved	%	
						progress
2.1.3.2. Improved and secure latrines constructed	48	0	48	56	117	
2.1.4.3. Water and sanitation facilities installed in target schools	384	0	384	288	75	
2.1.5.1. School furniture procured and distributed in at least 200 classrooms	6,000	0	6,000	5,000	83	
2.1.6.1. Teacher's tables and chairs procured and distributed in target schools	220	0	220	220	100	
2.1.7.1. Situational analysis for feeder + secondary schools performed					100	Done for secondary school but it was not within the target area
2.2. Infrastructure rehabilitated in target schools						
2.2.1.1. Establishment of maintenance fund						Done
2.2.1.3. General maintenance of school infrastructure	12	6	18	18	100	
3.1. Strengthen the role of Mother Groups in the Schools						
3.1.1.1 Procure 24 pushbikes	24	0	24	24	100	
3.1.2.1. Mother groups trained	2	1	3	3	100	
3.1.3.1. Provide financial support for Mother Groups	1	0	1	0	0	
3.1.4.1. Organize exchange visits for members of the mother groups	1	0	1	0	0	
3.3. Support to OVCs						
3.3.1.1. Provide bursaries to the OVCs	18	0	18	19	101	
3.3.2.1. Provide scholarships to OVCs in Secondary schools	18	0	18	19	101	
3.3.3.1. Provide psychosocial support to OVCs						This is on-going activity

Outputs (Education Sector)	Project Target			Achievement		Comments
	2012-16 Targets	2017 Targets	Total	Achieved	%	
3.4. Increase enrolment of special needs learners into target schools						
3.4.1.2. Management support for children with special needs provided	20	0	20	8	40	Not done
3.4.2.1. Special needs teaching and learning materials procured						
3.4.2.2. Provide training on how to use special needs teaching and learning materials	3 sessions	0	3 sessions	3 sessions	100	
3.4.3.1. Resource centres for children with special needs established or rehabilitated	1	0	1	1	100	
3.5. Increased attendance and participation of learners						
3.5.1.1. Train teachers to administer de-worming and bilharzia prevention tablets	6 sessions	0	6 sessions	1 session	17	
3.5.2.1. Procure de-worming and bilharzia prevention tablets	3	0	3	1	33	
3.5.2.2. Distribute de-worming and bilharzia prevention tablets	3	0	3	1	33	Done in all target schools
3.5.2.3. Monitor and supervise the de-worming and bilharzia prevention exercise	6	0	6	0	0	Not done
4. Improved management of target schools						
4.1. Capacity building and training						
4.1.1.1. Develop data management training package	1	0	1	0	0	
4.1.2.1. PEAs trained in data management according to training by MIE	18	0	18	18	100	
4.1.3.1 Staff at DEM's office trained in the use of ICT	1 session	0	1 session	1 session	100	
4.1.4.1. PEAs trained by MIE	4	0	4	5	125	

Outputs (Education Sector)	Project Target			Achievement		Comments
	2012-16 Targets	2017 Targets	Total	Achieved	%	
4.2. Strengthening of DEM´s office operations						
4.2.2.1. Procure ICT equipment based on needs assessment	1	0	1	1	100	
4.2.3.1. Procure a vehicle for use at DEM's office	1	0	1	1	100	
4.2.4.2. Rehabilitate DEM´s office	1	0	1	1	100	
4.2.5.1. Procure 4 motorcycles for TDCs in target zones	4	0	4	4	100	

Outputs (Health Sector)	Project Target			Achievement		Comments
	2012-16 Targets	2017 Targets	Total	Achieved	%	
1.0 Improved health services infrastructure						
1.1 General infrastructure in the network of the MoH health centres strengthened						
1.1.1.1. Safe Water Supply installed in health facilities	13	0	13	13	100	
1.1.2.1. Sanitation facilities (pit latrines) constructed	26	0	26	17	65	Hand washing facilities installed in 9 latrines only
1.1.3.1. Electricity installed in Health facilities (SOLAR)	12	0	12	11	92	
1.1.3.2. Electricity installed in Health facilities (ESCOM)	7	0	7	9	129	
1.1.4.1. Placenta pits and incinerators construct in health facilities	10	0	10	10	100	6 Placenta pits, 14 incinerators done
1.1.5.1. Assess and plan general maintenance HCs	13	0	13	13	100	
1.1.5.2. Health facilities maintained	13	0	13	13	100	On-going activity
1.1.6.1. Buildings and equipment maintained at Mangochi District Hospital						

Outputs (Health Sector)	Project Target			Achievement		Comments
	2012-16 Targets	2017 Targets	Total	Achieved	%	
1.2 Improved Infrastructure and equipment in matenal and child health services in HCs						
1.2.1.1 Maternity Wards constructed	4	4	8	8	100	
1.2.2.1. Main maternity ward constructed at the MDH	1	0	1	1	100	
1.2.3.1. Beds and Equipment for maternity wards procured	6	13	19	19	100	
1.2.4.1. Waiting homes constructed	11	5	16	15	94	
1.2.5.1. Staff Houses constructed	10	0	10	10	100	
1.2.6.1. Health Posts constructed	10	10	20	20	100	
1.2.7.1. Vaccine Refrigerators procured	20	0	20	11	55	Procurement process is in progress
1.2.8.1 Furniture for health facilities procured	5					
2.1. Improved Referral System						
2.1.1.1. Motor vehicle ambulances procured	5	0	5	5	100	
2.1.2.1. Bicycle ambulances procured	8	0	8	8	100	They are efficiently used
2.1.3.1. Motorcycle ambulances procured	5	0	5	0	0	Not procured. No supplier
2.1.4.1. Conduct a feasibility assessment on the effective communication system						
2.1.4.2. Radio communication system implemented	5	0	5	5	100	Wireless radio communication installed in all 5 Health zones

Outputs (Health Sector)	Project Target			Achievement		Comments
	2012-16 Targets	2017 Targets	Total	Achieved	%	
2.2. Strengthened Community based health services						
2.2.1.1. Health Surveillance Assistants(HSAs) are trained in PHC (initial training)	35	0	35	35	100	
2.2.2.1 Bicycles for HSAs are procured	550	0	550	555	101	
2.2.3.1. Community midwives trained	8	0	8	0	0	Government took over the initiative
2.2.4.1. Equipment for HSAs is procured	550	0	550	550	100	
2.2.5.1. Village Health Committees (VHCs) trained in the management of PHC	874	0	874	874	100	Training report was not submitted to ICEIDA
2.2.6.1. Health Advisory Committees (HACs) trained on their roles and responsibility	30	0	30	30	100	Training report was not submitted to ICEIDA
3.1. Improved Working Conditions for Public Health Support Staff at the DHO						
3.1.1.2. Public Health Office at DHO renovated	1	0	1	1	100	
3.1.2.1. Public Health Office equipped	1	0	1	1	100	
3.1.3.1. 4x4 vehicle handed over to the P/Health office, to be used for supervision	1	0	1	1	100	
3.1.4.1. Motor cycles procured	12	0	12	11	92	
3.2. Institutional capacity strengthened at the DHO						
3.2.1.1. Conduct training needs assessment						Not done
3.2.1.2. A 4-year training plan developed	1	0	1	0	0	
3.2.1.3. Selection committee established and education fund	1	0	1	1	100	
3.2.1.4. Education fund (for sponsoring training needs) established						Done

Outputs (Health Sector)	Project Target			Achievement		Comments
	2012-16 Targets	2017 Targets	Total	Achieved	%	
3.2.1.5. Hospital staff trained in various courses	10	5	15	25	167	
3.2.2.1. Research strategy established	1	0	1	0	0	
3.2.2.2. Research selection committee established	1	0	1	1	100	
3.2.2.3 Research funding established	1	0	1	1	100	
3.2.2.4 Disseminate research findings	12	0	12	?		Done
3.2.3.1. Computer lab established at the DHO	1	0	1	0	00	
3.3. Improved /Strengthened Health Management Information Systems						
3.3.1.1 Internet service and computer procured for the DHO and 4 other health zones	5	0	5	5	100	
3.3.1.2 Internet services and computers installed at DHO and 4 other health zones	5	0	5	1	20	Services installed only at DHO
3.3.2.1. Program Coordinators and H/Centre Management Teams trained in HMIS	1	0	1	1	100	
3.3.3.1. Village Health Register books procured	874	0	874	874	100	Training report was not submitted to ICEIDA
3.3.3.2. HSAs and 18 supervisors trained in VHR	373	0	373	373	100	Training report was not submitted to ICEIDA
3.3.3.3. Conduct data collection week using VHR	1	0	1	0	0	
3.3.3.4. Research to Compare facilities performing well better in VHR with those not performing well	1	0	1	0	0	
3.3.3.5. Data base for VHR developed	1	0	1	0	0	
3.3.3.6. Stakeholders oriented on Village Health Registers (VHRs)	1	0	1	1	100	

Outputs (Health Sector)	Project Target			Achievement		Comments
	2012-16 Targets	2017 Targets	Total	Achieved	%	
3.3.3.7. Quarterly Review meetings on VHR conducted	12	4	16	16	100	
3.3.3.8. Supervision on VHR conducted						Done

Outputs (Water and Sanitation Sector)	Project Target			Achievement		Comments
	2012-16 Targets	2017 Targets	Total	Achieved	%	
1.0 Increased and sustainable access to and use of improved potable water sources						
1.1 New boreholes drilled	150	59	209	208	100	
1.2 Protected shallow wells constructed	100	40	140	124	89	
1.3 Defunct boreholes rehabilitated	100	30	130	145	112	
1.4 Local community's technical and management skills strengthened						
1.4.1. Consultancy on WPCs gender analysis on the WPCs conducted	1	0	1	0	0	
1.4.2. WPCs formed/Re-activated (at least 50% of committee members are women)	350	134	484	477	98	
1.4.3. Pre-construction/drilling training	350	134	484	477	98	
1.4.4. WPCS Trained in VLOM 1 (Village Level Operation & Maintenance)	350	134	484	477	98	
1.4.5. Strategies to facilitate the availability of spare parts to communities developed	1	1	2	2	50	
2.0 Access and use of sanitary facilities improved						
2.1. All extension workers (WMAs, HSAs, and CDAs) trained in sanitation issues	1	0	0	0	100	
2.2. CLTS introduced in communities and mobilization to trigger communities conducted						Done. This was on-going activity

Outputs (Water and Sanitation Sector)	Project Target			Achievement		Comments
	2012-16 Targets	2017 Targets	Total	Achieved	%	
2.3. Sensitization meetings with community leaders on ODF conducted	364	0	364	283	78	
2.4. Awareness raising on sanitation conducted in TA Chimwala						Done. This was on-going activity
2.5 ODF verification conducted						48 villages have been confirmed ODF in TA Chimwala
2.6 Recognize and award villages which achieve ODF verification						Done in TA Chilipa
3.0 Increased capacity of the District Water Office						
3.1.1. Additional WMAs employed at the DWO and supplied with supporting	14	0	14	16	115	
3.1.2. Motorcycles procured for District Water Office	9	0	9	12	133	
3.1.3. Motor vehicles provided to DWO	2	0	2	2	100	
3.1.4. Capacity building needs assessment workshop conducted (by EWB)	1	0	1	1	100	
3.1.5. DWO provided with funding for monthly administrative and operational use					100	Done quarterly

Annex 7: Schools Data Collected by Evaluation

Chikomwe Primary School (Total 2 143)

1		2		3		4		5		6		7		8		Total	
M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
452	662	267	304	153	148	67	59	53	60	27	22	11	14	8	7	1 334	980

Source: School Records

Pass and Selection Rate (%)

Year	Pass Rate - %	Selection Rate - %
2013	68	28
2014	45	28
2015	85	28
2016	92	41
2017	93	50

Source: ibid

Repeaters (2017 – 8) (Total 329 (m); 339 (f)

1		2		3		4		5		6		7		8	
M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
225	162	77	66	59	56	9	23	9	16	6	12	6	3	1	1

Source: ibid

Orphans

	1		2		3		4		5		6		7		8		Total		
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	Total Male	Total Female	Total
D	1	2	3	9	4	3	4	1	1	1	3	6	0	1	10	0	15	20	35
S	9	5	17	17	16	5	3	3	3	5	0	1	1	0	1	3	45	58	103
Total	10	7	20	26	20	8	7	4	4	6	3	7	1	1	11	3	70	78	138

Source: ibd

Chimbende Primary School (Total 1 821)

1		2		3		4		5		6		7		8		Total	
M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
303	347	154	140	168	200	84	102	53	88	30	42	21	53	16	21	828	993

Source: School Records

Pass Rate (2017) (Overall Rate 46%)

	M	F
Enrolled	29	30
Sat	27	26
Passed	14	10
Failed	13	16
Pass Rate (%)	52	38

Source: ibid

Pass Rate (2013 – 16)

2013		2014		2015		2016	
M	F	M	F	M	F	M	F
40	12	32	18	41	38	42	27
52		50		79		69	

Source: ibid

St Charles Lwanga Primary School (Total 2 855)

1		2		3		4		5		6		7		8		Total	
M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
296	336	225	231	321	371	128	175	164	185	98	118	53	78	32	41	1 317	1 539

Source: School Records

Attendance (April 2018)

	1		2		3		4		5		6		7		8		TOTAL		
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
# Days	2368	2696	2053	2314	2874	3141	1108	1352	1642	1804	978	1121	483	738	332	371	11843	13537	25380

Source: ibid

Enrolment and Drop out

Year	Enrolment			Drop Out #	Drop Out Rate
	M	F	Total	91	4.2
2010	1036	1096	2132	90	3.7
2011	1202	1203	2405	85	3.7
2012	1105	1178	2283	87	2.9
2013	1432	1531	2963	84	2.8
2014	1444	1543	2987	79	2.8
2015	1349	1414	2763	42	1.5
2016	1375	1335	2710		

Source: ibid

Teachers and Teaching Assistants (5) by Class and Pupil Teacher Ratio

Class	Teachers			Students	Teacher – Pupil Ratio
	M	F	Total		
1	2	7	9	632	70.2
2	2	5	7	456	65.1
3	2	6	8	692	1 : 86.5
4	3	6	9	303	1 : 33.66
5	6	2	8	349	1 : 43.6
6	2	2	4	216	1 : 54
7	2	0	2	131	1 : 65.5
8	3	0	3	73	1 : 24.33
Overall	22	28	50	2 852	1 : 57

Source: ibid

Pass Rate (2017)

Year	Entered - #		Passed #		Passed - %	
	M	F	M	F	M	F
1	163	202	106	108	65	54
2	236	232	99	103	42	44
3	230	245	58	60	25	25
4	130	140	75	78	58	56
5	148	198	36	46	24	23
6	69	80	34	41	49	51
7	32	52	13	11	41	21
8	35	30	9	5	26	17
Total	1043	1209	430	452	41	37

Source: ibid

Annex 8: Bamusi Village ODF Case Study

Case Study: MBSP Final Evaluation - Malawi

ICEIDA support empowers communities to eliminate Open Defecation (OD) in Traditional Authority Chilipa in Mangochi District through the CLTS approach: The case of Bamusi Village.

1. The CLTS approach

The Community Led Total Sanitation (CLTS) approach involves facilitating a process to inspire and empower rural communities to stop open defecation and to build and use latrines. According to Water Aid, there are several variants of the of the CCTLS approach but all with two common elements: (i) all approaches attempt to work with the entire community rather than with selected individuals and households; and (ii) the focus is always on the elimination of open defecation rather than on the construction of particular types of latrine.

2. CLTS approach in the Mangochi Basic Services Programme (MBSP) supported by ICEIDA

The MBSP's objective on sanitation is to promote adequate sanitation to reduce water borne diseases, and promote better health and well-being through the CLTS approach. According to the Environmental Health Department at Mangochi District Health Office, the CLTS approach is premised on PRA techniques to inspire communities to construct and use latrines. The approach has three tenets (i) shaming households that do not have latrines and engage in open defecation; (ii) creating fear about the implications of open defecation including disease outbreaks; and (iii) facilitating a community Action Plan that leads to total elimination of open defecation in the community. The MBSP CLTS process entails the following:-

a. Establishing the CLTS facilitation teams: at district level there is a district facilitation team comprising of professional staff from the District Health Office (DHO – Environmental Department); District Community Development Office (DCDO); and the District Water Office (DWO). The district team orients and backstops frontline staff who in turn facilitate the CLTS approach at community level. The community level team comprises of Health Surveillance Assistants (HSAs) from the DHO; Community Development Assistants (CDAs) from the DCDO; and Water Monitoring Assistants (WMAs) from the DWO.
b. Once a Work Plan has been developed for delivering CLTS, the village chiefs are informed about the dates in their respective communities and in turn the chief mobilizes the community for the meetings on due.
c. During the meeting, the first exercise is village mapping by the community. This involves drawing a large map on the ground with all dwelling houses plotted in the map. Community members are then requested to identify their houses and are given cards. Households with latrines get colored cards and those without latrines get plain cards, no color.
d. Households with latrines are then asked to walk out of the village map while households without latrines are asked to locate on the map the places where they defecate and this turns out to be nearby bushes. The community facilitators then ask those who defecate in the bush to lead them in a transit walk through the village to the bush. This is the point of shaming the households that defecate in the bush.
e. When the community gets to the point of realizing the shameful act of defecating in the bush, it is said to be *triggered* or *ignited*.

f. The 'ignition' is followed by a community Action Plan which amongst other things (i) identifies a lead person to oversee the construction of latrines and (ii) sets a time frame for completing the task.

g. The facilitators' role is thus to monitor progress on the implementation of the Work Plan on regular basis.

3. How the community under Group Village Headman (GVH) Bamusi qualified for ODF status

There are three villages under GVH Bamusi with 291 households: Mika, Pondani, and Selemani, all declared ODF. As one enters GVH Bamusi's area there is a large placard with a clear welcome message that cannot be ignored. It reads:

"***Welcome to Bamusi village. Do not litter but dispose waste in a rubbish pit and always use a latrine***"

The placard is also a symbol of ODF status for the GVH's community. Not far from the placard (<50 metres) there is a community latrine solely constructed for people passing through the village to prevent them from defecating in the bush because this is no longer accepted in the community. Actually there are three such latrines along the path, all clean and well maintained (pictures below one with a message).

Words written on the latrine wall: '***Latrine for people passing through the village***"

4. The sanitation situation in GVH Bamusi before CLTS interventions in 2017

The sanitation situation before the CLTS was described as pathetic as follows: '*Mu mudzi muno* ndiochepa *amene anali ndi zimbudzi ambiri timapita kutchire kukazithandiza ndipo matenda a cholera anali ochuluka. Mwachisanzo pa mabanja 10 ali onse ndi mabanja 6 okha amene anali ndi zimbudzi*" (in our community there were few people with latrines and the rest used the bush for defecation and cholera outbreaks were common. For example out of every 10 households only 6 had latrines).*' Amene anali ndi zovundikilila pa chimbudzi analipo 13 okha pa mabanja 291 ndipo amene anali ndi mpondagiya anali 8 okha pa mabanja 291'*(Only 13 households out of 291 had latrine hole covers and only 8 had hand washing facilities out of 291 households). The grim situation before MBSP intervened with CLTS was summarized as follows:-

Description	Before CLTS	Current Situation (May 2018)
Latrine ownership (% households)	60%	100%
Latrines with hole covers	13	291
Hand washing facilities outside latrines	8	280
Households with bathrooms	241	291
Households with rubbish pits	0	280
Households with dish racks	Not sure	262
Drying lines for clothes	Not sure	233

It is evident from the Table that the CLTS approach has been instrumental in exciting the community in GVH Bamusi to do away with open defecation. The MBSP's CLTS approach has thus been very effective in improving sanitation not only in in GVH Bamusi but in the entire Chilipa Traditional Authority. The shortfall on rubbish pits, dish racks, and drying line for clothes are expected to be fixed during this dry season when the community is through with crop harvesting.

5. How the CLTS approach eliminated OD in GVH Bamusi – the care group concept and its effectiveness

The entry point for community level interventions which has government approval is the Care Group, a concept developed by Save the Children. Each Care Group has a trained volunteer and comprises of ten households which means that in Bamusi GVH there are number of care groups (photo for the GVH, village headmen, and volunteers below). The community Action Plan for the construction of latrines is therefore entrusted to care groups with the members collectively encouraging one another and monitoring progress within the 10-member cells.

A care group conducts door-to-door visits to ensure that all its members are on track to construct latrines; ensure that pit covers are made, acquired and used; and members have installed hand washing facilities outside the latrines with ash or soap on site. The care group approach has been very effective in supporting the CLTS concept because the support to members and monitoring progress are localized within the ten households otherwise the village chiefs would find it very

difficult to monitor the progress. During scheduled community meetings all care group volunteers report on the progress and the remaining tasks to achieve 100% latrine coverage in their cells. The local chiefs (village headmen) also play an important role in promoting the CLTS approach. They are responsible for mobilizing the community for meetings; monitoring the construction of pit latrines and installation of hand washing facilities; ensuring that the three community latrines are well looked after and hygienic; and enforce the sanitation bye-laws.

Latrine sharing is prohibited in GVH Bamusi – if a latrine gets destroyed it has to be repaired immediately. There are also bye-laws on sanitation: households that do not comply with sanitation bye-laws are reported to the GVH or village headman and are asked to either pay in the form of a goat or forced to hire casual labour to dig the pit and pay for the labour. This acts as a deterrent for non-compliant community members and most households prefer to act correctly rather than pay the fines. Thus the success rate of the CLTS approach in GVH Bamusi besides 'ignition' is also largely attributable to the care group concept and involvement of local leaders.

Since care groups are the entry points for multi-sectorial interventions at community level besides sanitation, the trained volunteers also disseminate various messages including: family planning; balanced nutrition with the 6 food groups; malarial care and use of mosquito nets; safe motherhood; etc.

GVH Bamusi (in purple shirt) and three other village headmen in front row with volunteers in the back

A household demonstrating use of a hand washing facility outside a latrine in Bamusi village

6. Cost of constructing a latrine and durability

About 60% of the latrines are semi-permanent constructed from burnt bricks, have wooden and mud floor, and grass thatched; 30% constructed with unburnt bricks; and 10% with walls constructed with wooden poles (*community estimates*). The area under GVH Bamusi has natural forests hence it is easy to access poles for construction and grass for thatching. However, for the future generation the situation may not be the same as deforestation is also extending to the community forest. A mud floor last 2 – 5 years depending on the type of wood used but the harder tree species are increasingly becoming scarce in the area due to high demand for various uses. A grass thatch has to be replaced every year or twice a year due to heavy rains and this is proving to be a burden to the community. Only about 20% of the households use plastic paper to prevent water seepage in the roof when it rains.

It is estimated that to construct a semi-permanent latrine it costs about MK 18,100 (€21.7) using a combination of household's own and hired labour. The cost breakdown is as follows:-

Digging pit	MK 5,000 (€6)
Poles (4 for the floor)	MK 1,600 (€1.9)
Bricks (600)	MK 7,500 (€9)
Builder	MK 2,500 (€3)
Roofing including plastic sheeting	MK 1,500 (€1.8)
Total	MK 18,100 (€21.7)

Due to a high poverty rate in Malawi most households cannot afford a semi-permanent structure hence opt for cheaper alternatives (temporary structures) using poles and grass thatch. The consequences are susceptibility to heavy rains and frequent replacement. The dome slabs which government subsidized in the past are no longer provided to communities in the country due to policy change. This means that poor communities have to grapple with temporary latrines and this may be a threat to the sustainability of ODF status in GVH Bamusi in the long-term.

7. Challenges in adapting to the CLTS approach in GVH Bamusi

- GVH Bamusi, village headmen, and care group volunteers all acknowledged the upward battle for the community to accept change from defecating in bush to latrines. The CLTS approach did the trick mainly through shaming those who engaged in open defecation.
- The type of soil structure has implications on the life span and durability of a latrine. Households residing along sandy soils are more likely to have their latrines collapsing than households that are settled along compact soils.

8. Criteria for declaring a village ODF

The National ODF Task Force has developed a Village ODF Verification Form that is used to assess whether or not a village qualifies for ODF status. Hence each village is verified by the District Coordinating Team (Health, Water, Community Development, Education, etc.) and vetted by the National ODF Task Force. The two-stage process ensures consistency in the application of the verification criteria. The ODF Verification Form is comprehensive and gathers information such as:-

- Village name, number of households, and households with a latrine;
- Status on use of the latrine and sharing;
- Disposal methods of children's feces;
- Safety of latrine from collapsing;
- Privacy for those who use the latrine;
- Whether a latrine has a roof to prevent rains from entering;
- Use of proper latrine hole covers to prevent flies from leaving the latrine; and
- Checking signs of OD in the village;

GVH Bamusi had scored well in all the criteria to get the ODF status.

9. Sustainability

The frontline staff (HSAs, WMAs, and CDAs) working with the GVH, village headmen, Village Health Committees (VHCs) and Care Groups regularly monitor the situation to ensure that the communities do not turn back to OD status. However, the volunteers suggested that in the long-term it is ideal to have access to concrete slabs which provide permanent latrine floors.

10. Conclusion

There is clear evidence from GVH Bamusi that ICEIDA's support to the CLTS approach has inspired change in sanitation. There are three main factors that has driven change in GVH Bamusi:

a. The CLTS approach which triggered the community to realize the shameful act of OD; instilled fear about disease outbreaks if OD continued unstopped; facilitated Action Plans for the construction of latrines; and monitored the process of latrine construction on regular basis;
b. The care group concept which encourages and motivates community members in small groups to adopt change; and
c. Direct involvement of local leaders (village chiefs) in community mobilization, monitoring the community sanitation programme, and enforcing bye-laws to ensure that OD is no longer acceptable in the community.

Annex 9: Household Survey Report

ANNEX 9.1

HOUSEHOLD SURVEY REPORT – HEALTH PROGRAMME

Introduction

The HH Survey for the Health Programme was conducted in the catchment areas of six Health Centres namely: Katuli, Chikole, Namwela, Jalasi, Malombe and Chimwala. A three-stage random sampling procedure was employed as follows: (i) a list of villages in the catchment area was prepared with assistance from Health Centre staff and 2 villages were randomly selected; (ii) in each village a listing of all mothers with 2 – 2.5 years was prepared; and (iii) 12 mothers/guardians were randomly selected from the list in each village. The notion of targeting mothers with 2 – 2.5 year olds was basically premised on the assessment of child immunization which covers a 2-year cycle. Children less than 2 years would not have completed the immunization schedule therefore it was going to be difficult to assess child immunization. Other tools used in the final evaluation for the health component were: Key Informant Interviews (KIIs) with Health Centre personnel; Focus Group Discussions (FGDs) with Health Advisory Committees (HAC); and FGDs with Village Health Committees (VHC).

Summary of key findings

a. The results reflect high attendance by expectant mothers during Antenatal care (ANC) as presented in Chart 4: 100% of the sampled mothers attended ANC sessions with a coverage of 1.5 times per trimester; 97.3% of the sampled mothers had delivered at a health facility; 94.6% of the deliveries were attended by nurse/midwife; and 100% of the mothers were tested for HIV during ANC.

b. There was good adoption of some of the post-partum care recommended practices as presented in Chart 8: 76.7% of the sampled mothers practiced exclusive breastfeeding while 80.8% kept the baby's body warm most of the times mainly to avoid pneumonia infection. However for other practices there was low adoption some <50% and others <30%.

c. The HH Survey results have revealed good practices in health seeking behaviors. The HH Survey results (Chart 11) show that there were more children suffering from Acute Respiratory Infections (ARI) as reported by 44.9% of the sampled mothers with 96.8% of the HHs having sought assistance from a health facility; Malaria infection amongst children was reported by 39.6% of the sampled mothers with 96.2% having sought treatment from a health facility; and mothers whose children suffered from diarrhea was reported by 18.9% of the sampled mothers with 89.7% having received treatment at a health facility. Seeking assistance from a health facility is a recommended practice or behavior in order to save a child from dying.

d. Prevention of malaria in children: the HH Survey (Chart 12) has shown that 79.2% of the sampled mothers (households) had mosquito nets and 77.9% had their children sleeping under mosquito nets every night. Malaria is a deadly disease that can lead to a child's death.

e. The HH Survey has revealed high immunization rates for children (Chart 13): 100% immunization rate was reported by sampled mothers for BCG, Polio, and DPT; 98.7% for Measles, and an average of 88.5% for Vitamin A.

f. However despite the commendable progress, there were issues of poor attitude of Health Centre staff towards expectant mothers which can derail the gains made in safe motherhood if not attended to. This was reported in all the villages that were sampled except in Malembo where the women had not experienced the same treatment because the maternity ward was not in use yet.

HOUSEHOLD SURVEY RESULTS

1. Summary characteristics of sampled households

Table 1 below presents a summary of household characteristics. Overall 149 households were interviewed: 76 MHHs representing 51%, and 73 FHHs (49%)

Table 1: General characteristics of the Mothers Interviewed			
	MHHs	FHHs	All HHs
Total number of Households interviewed	76	73	149
Minimum age	18	17	17
Maximum age	43	60	60
Average age	27	27	27
Average household size	4.9	4.5	4.7
Average # children born 2012 - 2017 per HH	1.6	1.4	1.5
Average # of children born 2012 - 2017 per HH still alive	1.6	1.0	1.5

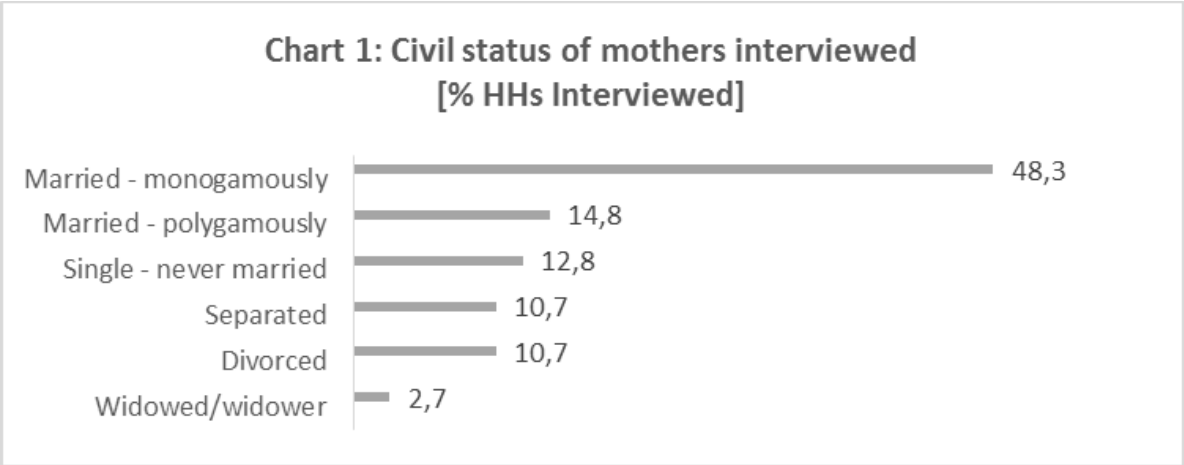
1.1 Age, family size, and average number of children

The results are presented in **Table 1** above. The minimum age of all the respondents was 17 years and the maximum age for MHHs was 43 and 60 for FHHs. The average age was 27 all the HHs.

The overall family size was 4.7. The average number of children born 2012 – 2017 was 1.5 and the average number of children born 2012 – 2017 and still alive was 1.5 which means that overall there was no child mortality except in FHHs who experienced a loss 0.4 child on average

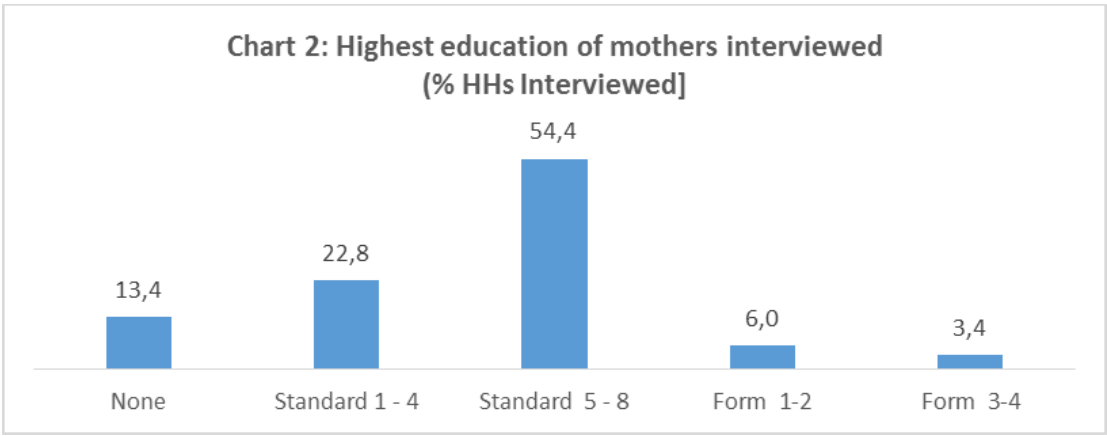
1.2 Marital status of sampled parents/guardians

The majority of sampled households (48.3%) was married monogamously with 14.8% in polygamous marriage **(Chart 1**). Other forms of civil status were as follows: 10.7% were separated; 10.7% were divorced and divorced respectively; and 2.7% were widowed. Overall 34.2% of the mothers interviewed were single mothers. Being a single mother can have implications on the support and care of the family especially in poor households.



1.3 Highest education

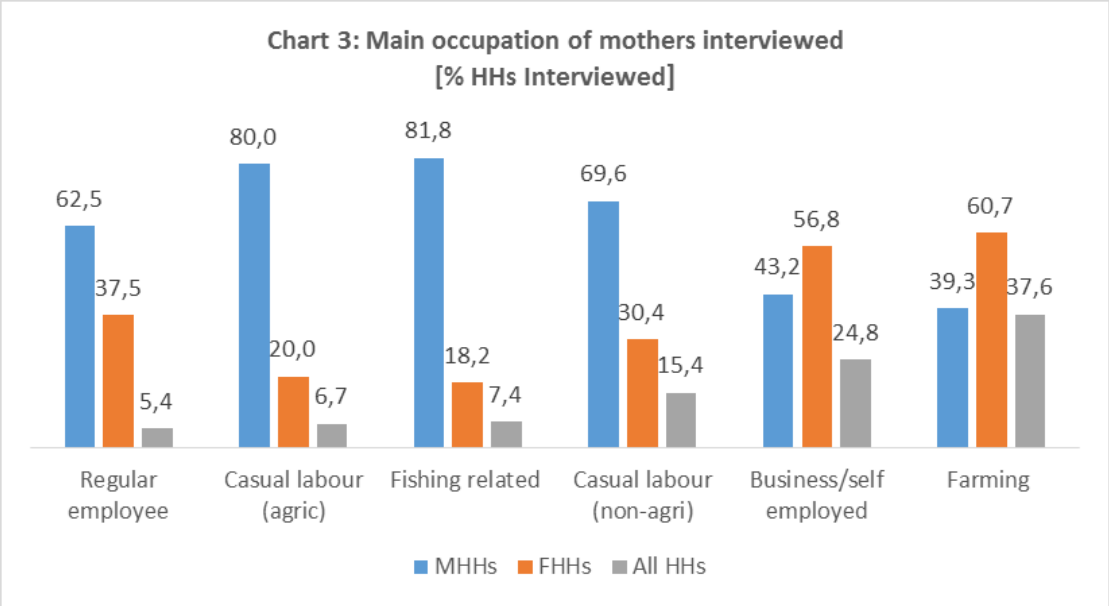
Overall, 13.4% of the sampled mothers/caregivers interviewed had never attended school at all (**Chart 2)**. The results also show that the largest proportion (54.4%) of mothers/caregivers dropped out of school in Standards 5 – 8 with only 9.4% of the respondents having accessed secondary education. Illiteracy is therefore a common phenomenon in the programme area and this may have implications on the understanding and application of messages on health education.



1.4 Main occupation of mothers/caregivers

The HH Survey results in **Chart 3** show that mothers/caregivers are mainly engaged in two economic activities which are also dominated by women in MHHs: (i) Fishing-related activities involving buying and selling fish (81.8% of mothers/caregivers interviewed), and (ii) providing agricultural casual labour (80%). FHHs were mostly engaged in business/self- employment (56.8%) and farming 60.7%. Income earning opportunities are important to expectant mothers to enable them prepare well for the new born as well as pay for services if private health services providers are used e.g. in Malembo

HC catchment area where the maternity ward is not yet operational all deliveries are done at a private clinic where payment is required.

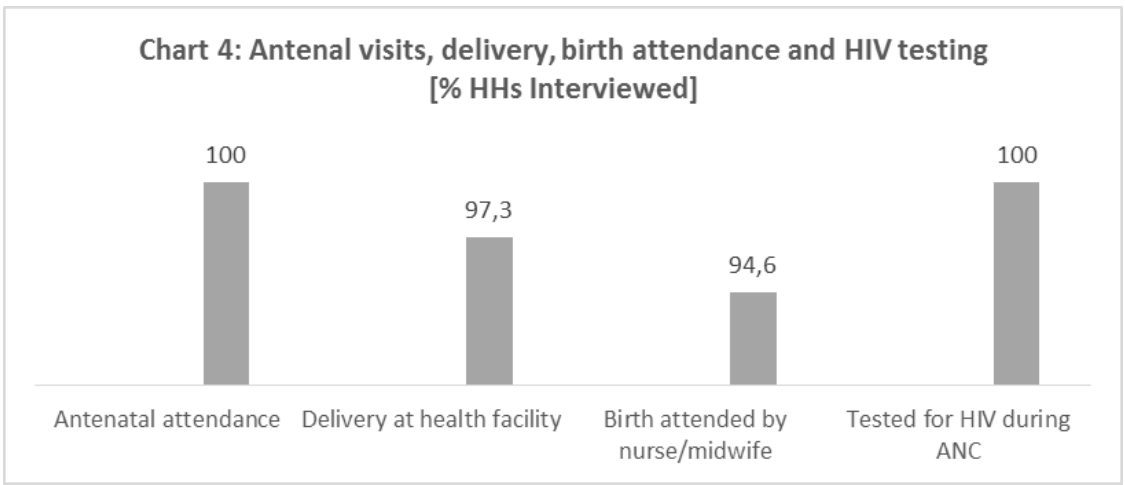


2. Antenatal care, care during birth, post-partum and neo-natal care

2.1 Antenatal care and delivery at a health facility

Antenatal care (ANC) is defined as health care (medical and support services) of the pregnant woman and her fetus from conception to the onset of labour[1]. ANC helps to ensure that the expectant mother and her fetus survive pregnancy and child birth in good health. ANC is also important for early detection and treatment of problems and complications, prevention of complications and diseases, birth preparedness, complication readiness, and promotion of good health**.**

HH Survey results **(Chart 4)** show that all the sampled mothers (100%) attended antenatal care, 97.3% delivered at a health facility, and 94.7% were assisted by skilled health personnel during delivery. The Traditional Birth Attendants (TBAs) seem to have been eliminated from the system. The results also show that all the mothers (100%) were tested for HIV during antennal visits. These results reflect the MBSP's effort towards safe motherhood.



[1] Ministry of Health (March 2009): Manual for Integrated Maternal and Neonatal Care.

2.2 Antenatal visits by trimester

There has been a remarkable increase in antenatal visits during MBSP implementation coupled with national initiatives and enforcement of community bye-laws on safe motherhood by chiefs. In the MBSP design document, it was reported that most expectant mothers did not attend ANC and particularly in the first trimester. The results in **Table 2** show that on average there are 1.7 and 1.8 ANC visits during the first and third trimesters respectively. This achievement is partly attributed to the MBSP programme which has supported health education.

Table 2: Expectant mothers Antenatal visits by trimester (All HHs)			
	Minimum	Maximum	Mean
Number of ANC visits in the first trimester	1	3	1.7
Number of ANC visits in the second trimester	1	2	1.0
Number of ANC visits in the third trimester	1	3	1.8
Mean			1.5

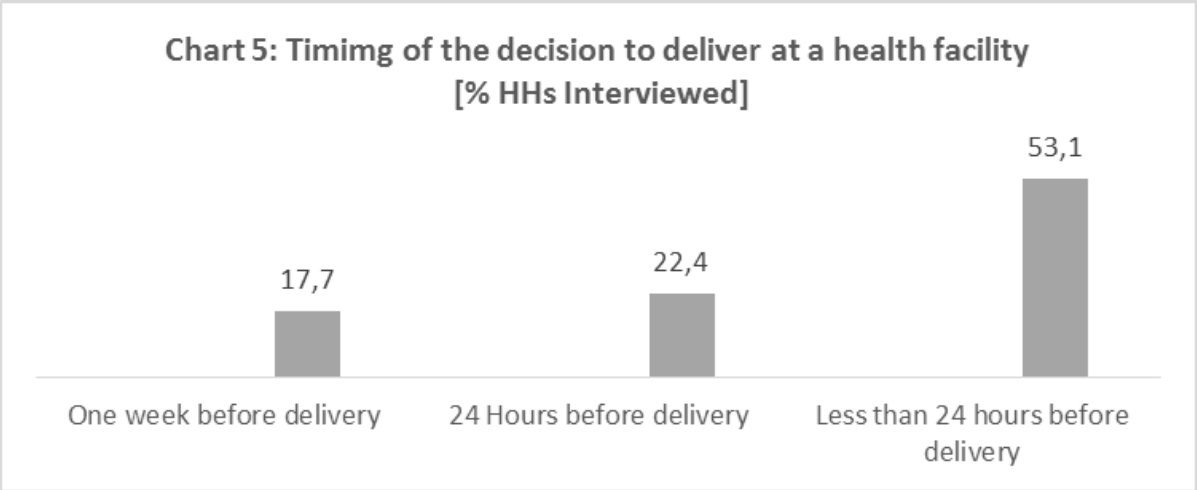
2.3 Health education during Antenatal care

The World Health Organization (WHO) developed ANC Guidelines in 2016 with recommendations on ANC for a positive pregnancy experience. ANC sessions provide a range of information through health education. The HH Survey results and FGDs with Village Health Committees (VHCs) drew a list of topics that expectant mothers accessed during ANC visits (**Table 3**). This further signifies the importance of ANC to expectant mothers.

Introduced to danger signs during pregnancy
HIV testing for prevention of PTCT
Prevention of HIV infection
Importance of family planning
Importance of delivering at a health facility
Birth preparedness
Cleanliness during pregnancy to prevent infections
How to take care of a new baby
No fighting during pregnancy
Advance preparation e.g. purchasing essentials like basin and, lazor blades
To decide in good time where to deliver
Importance of sleeping under mosquito net
Importance of taking malarial drugs at least two times during pregnancy

2.4 Timing of the decision to deliver at a health facility

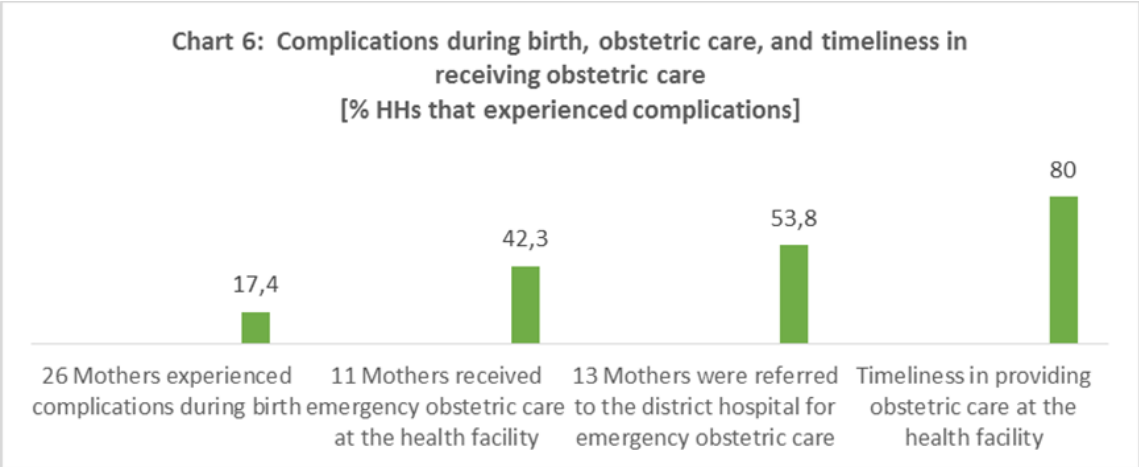
A paper in the Malawi Medical Journal 2007[2] acknowledged that women's inability to access care was related to three delays and a combination of two is usually responsible for maternal deaths. The delays are: - (i) deciding to seek medical care; (ii) accessing a health facility in time; and (iii) receiving medical care at a health facility. HH Survey results in **Chart 5** indicate that of the 149 mothers interviewed, 53.1% decided to deliver at a health facility less than 24 hours before delivery which was very close to delivery time. Only 17.7% of the mothers decided a week earlier while 22.4% decided 24 hours before delivery. During FGDs with Village Health Committees (VHCs) it transpired that women were afraid to go to a Health Centre in good time because of the somewhat unfriendly treatment they get from nurses/midwives which prompts them to decide to go the Health Centre when delivery is almost due and leave as soon as possible after delivery. The poor attitude of nurses/midwives which was reported in almost all the Health Centres' catchment areas visited by the evaluation team except Malembo. These concerns need to be addressed by the District Health Office otherwise the progress made in safe motherhood may be reversed.



[2] Lily C. Kumbani (2007), Maternal and new borne health in Malawi. Malawi Medical Journal 2007, March 19 (1) 32-33

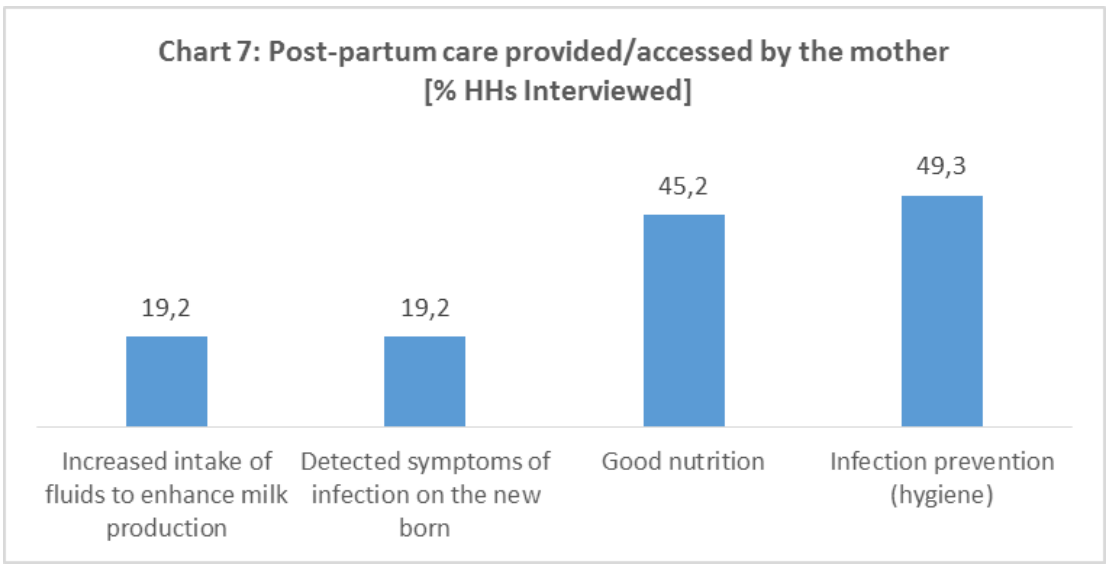
2.5 Complications during birth and obstetric care

Based on the HH Survey results (**Chart 6**), 17.4% of the mothers interviewed experienced complications during birth; 42.3% received emergency obstetric care; 53.8% were referred to Mangochi district hospital with 80% having received timely obstetric care. The results show that obstetric care and referral systems seem to work well as no maternal deaths were reported. Possibly the ANC visits had helped medical personnel to spot and monitor complications from an early stage.



2.6 Post-partum care

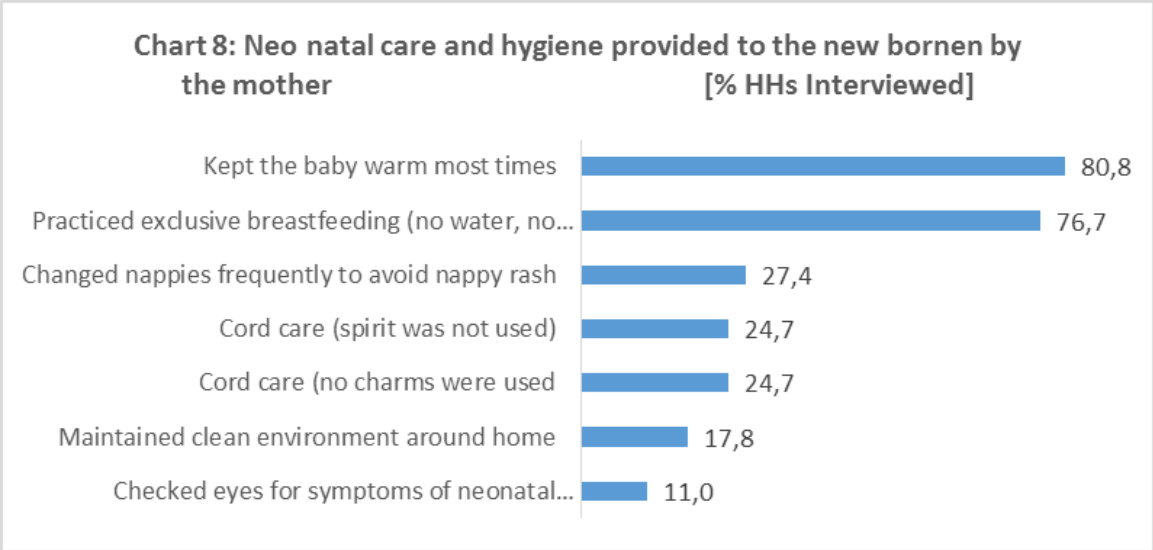
According to WHO[3] post-partum or postnatal care begins the period immediately after birth of a child and extends for about 6 weeks as the mother's body including hormones and uterus size returns to non-pregnancy state. The post-partum care is critical as the risk of death is high for the new borne. Post-partum provides timely detection and management of symptoms of complications during birth and can reduce maternal and new borne mortality. There are various forms of post-partum care for the mother and the new borne. HH Survey results in **Chart 7** indicate that to a larger extent the recommended practices for post-partum care were not widely adopted as all the practices were rated by less than 50% of the mothers interviewed. Therefore there is need for extensive health education including post-partum care.



[3] WHO: www.euro.who.int/en/health

2.7 Neonatal care

According to WHO[4] a new born or infant is a child under 28 days of age. During the first 28 days of life, the child is at the highest risk of dying and therefore appropriate feeding and care should be provided during this period to improve the child's chances of survival. HH Survey results in **Chart 8** indicate that the mothers adopted two main recommended neonatal care practices: keeping the baby warm by 80.8% of the mothers interviewed, and exclusive breastfeeding (76.7%). Other recommended neonatal care practices were not highly adopted. Hence the need for extensive health education.



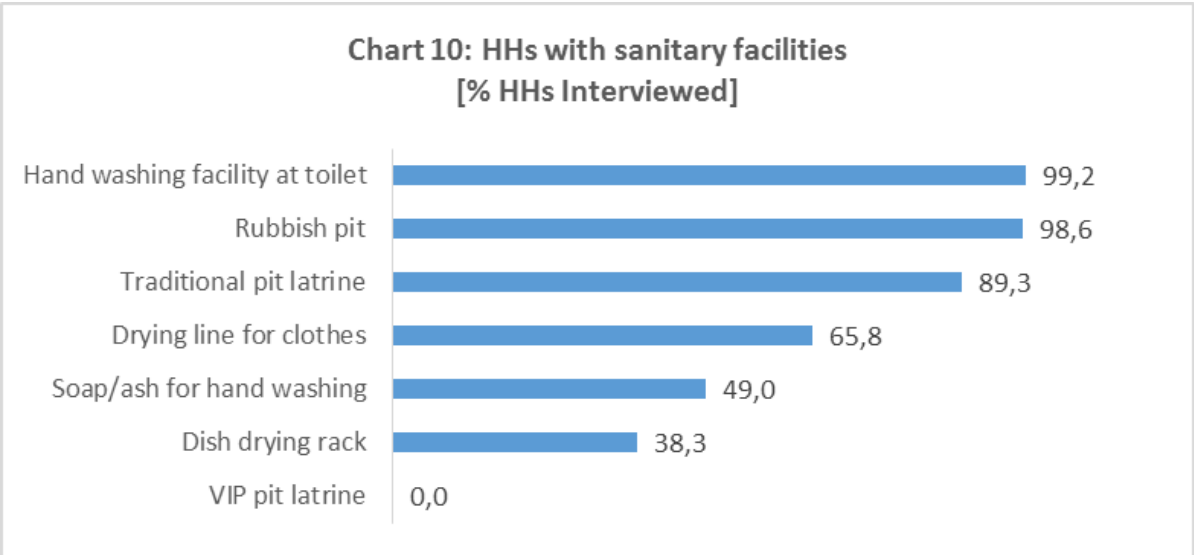
2.8 Critical hand washing times during neonatal care

Hand washing is essential during neonatal care to prevent the baby from getting infected. HH Survey results presented in **Chart** 9 indicate that over 75% of the mothers interviewed washed their hands: after changing baby's nappies to avoid nappy rash (93.1%); before preparing baby food (88.9%); after using the latrine (84.6%) and before feeding the baby (78.6%). However, only a very small / negligible proportion of the mothers interviewed (1.4%) washed their hands before and after baby's eye care to avoid neonatal conjunctivitis. The quest for extensive health education is critical.

[4] Ibid

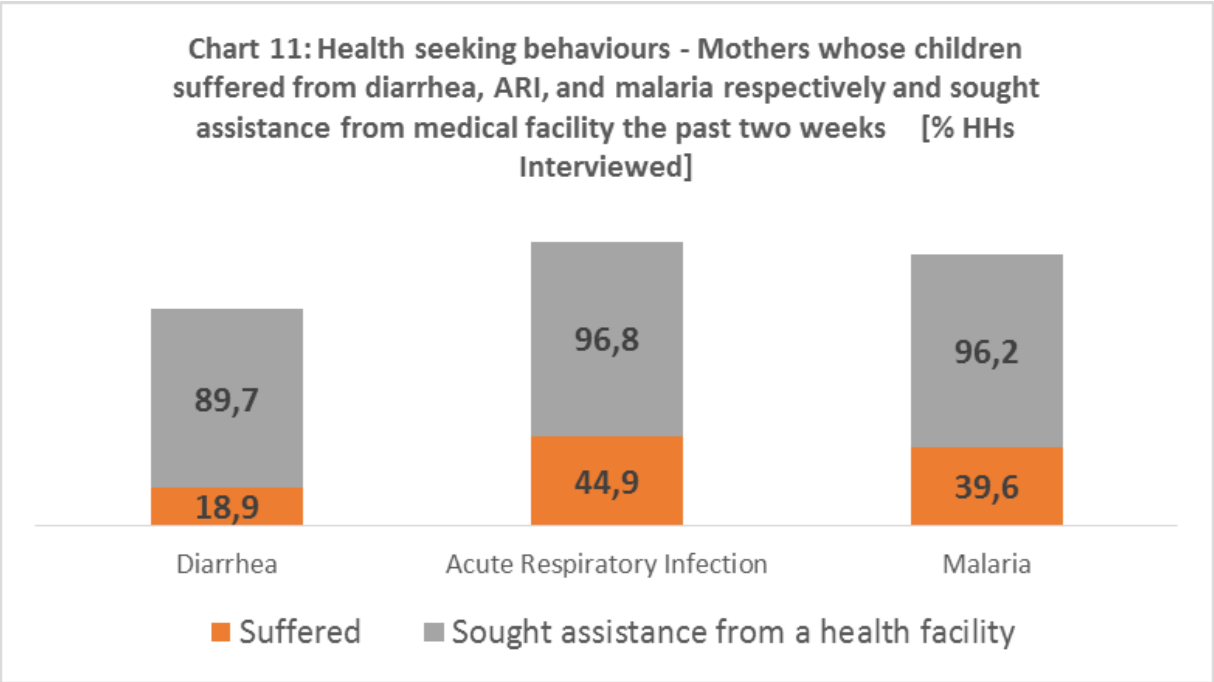
3. Availability of sanitation facilities in the households that were interviewed

Hygiene and good sanitation are essential elements in the health of the mother and new borne. During the HH Survey mothers were asked about the type of sanitation facilities that were available in their families. The results in **Chart 10** show three sanitation facilities that were widely adopted: traditional pit latrines (89.3% of HHs); rubbish pits (98.6%); and hand washing facilities (99.2%). The hand washing facility context is described under Water and Sanitation Programme Survey Results. In short what is described as hand washing facility here is not in a true sense a hand washing facility but water placed in a bathroom which is adjacent to the latrine. The notion is that there is always water available for hand washing when one leaves the latrine. The adoption of other sanitation facilities was moderate or low: drying line for clothes (65.8%); soap/ash for hand washing (49%); and rack for drying dishes (38%). The adoption rates could be improved through regular delivery of sanitation, hygiene, and health education.



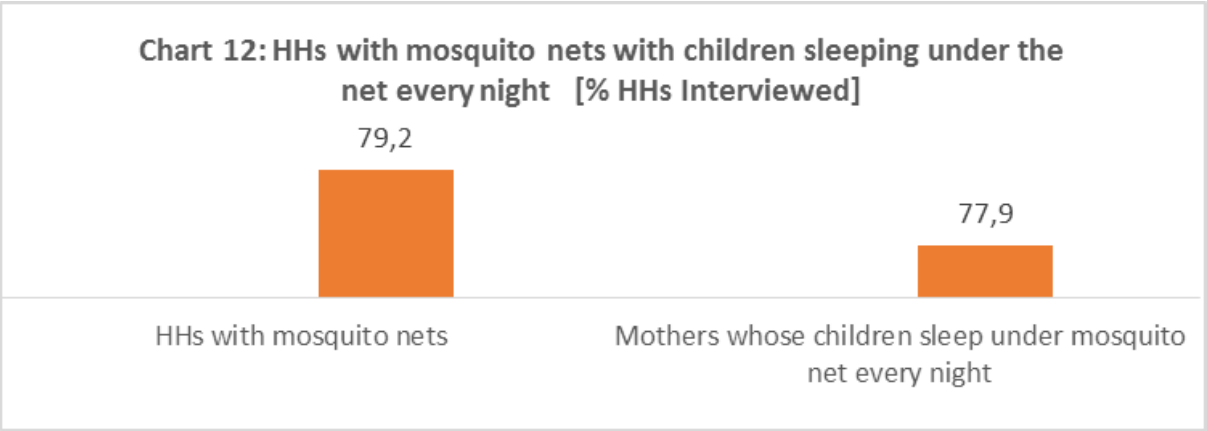
5. Health seeking behaviors

The HH Survey assessed the incidence of diarrhoea, ARI, and malaria amongst 2-year old children and the practices mothers and caregivers provided regarding prompt treatment. The results in **Chart 11** indicate that Acute Respiratory Infection (ARI) had the highest incidence reported by 44.9% of mothers interviewed with 96.8% of mothers having sought treatment from a health facility; 39.6% of mothers reported that their children were infected by malaria and 96.2% sought assistance from a health facility; and 18.9% of the mothers reported diarrhoea with 89.7% having sought assistance from a health facility. Overall, the results show that mothers prioritized assistance from health facilities. This behaviour culminates from health education delivered with MBSP support.



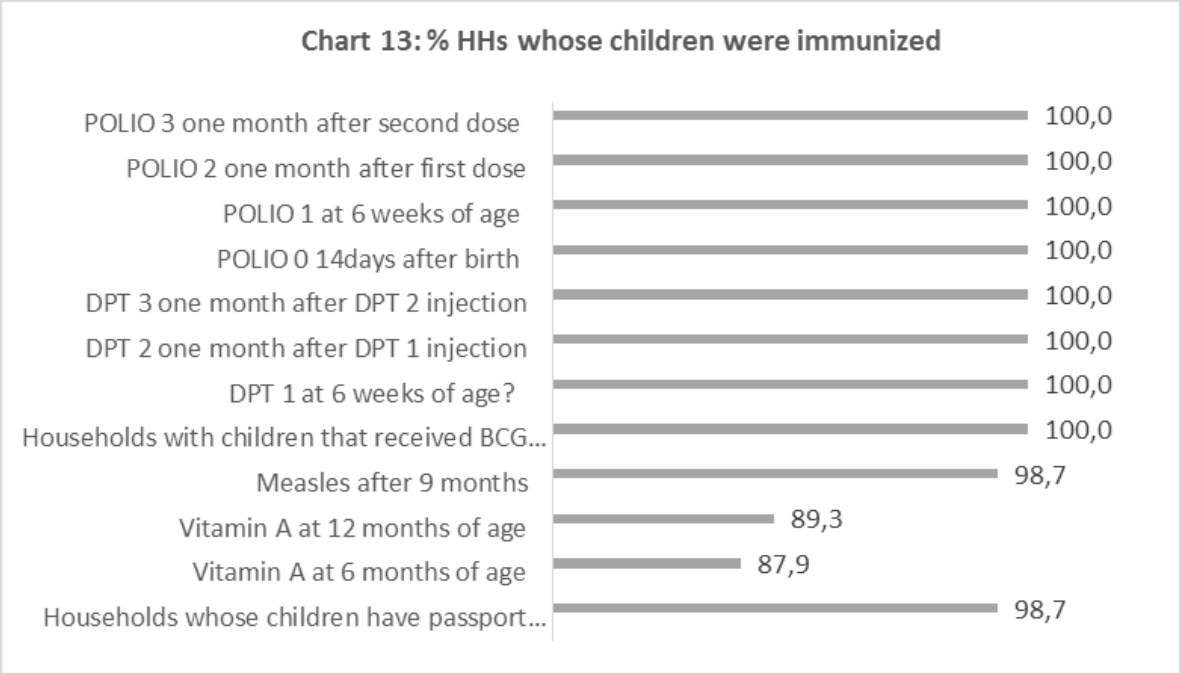
4.1 Access to and use of mosquito nets to prevent malaria

Access to and use of mosquito nets for malaria prevention in mothers and children was moderate (**Chart 12**): 79.2% of the HHs interviewed had mosquito nets and 77.9% of HHs had children sleeping under mosquito nets every night. The remaining sampled mothers responded as not having mosquito nets.



6. Child immunization

The HH Survey results on child immunization are presented in **Chart 13** below. The results show a very high immunization rate almost 100% except for Measles and Vitamin A. This is a result of the health education being delivered in Health Centres and through HSAs and the VHCs. The explanation for non-completion of Measles and Vitamin A doses were: (i) the families were in Mozambique during the due dates; and (ii) some HHs had lost health passport books for their children and the enumerators could not verify whether or not Vitamin A doses were administered as scheduled. An observation on health passport books by the enumerators was that some passport books were not well looked after with others having torn cover and inside pages; some were miscoloured due to leaking roofs; while some had been partly chewed by rodents. Therefore there is also need for education on how to look after a health passport book which contains vital health information for the child.



7. Functionality of Village Health Committees and Health Advisory Committees

7.1 Village Health Committees

Village Health Committees are ideal local institutions that facilitate the delivery of health, sanitation, and hygiene education and messages to fellow community members. The committees work in collaboration with HSAs who provide technical backstopping and the village chiefs for community mobilization for village meetings. With regard to safe motherhood the VHCs disseminate information on:-

- Birth preparedness;
- Antenatal care - should start during the first three months of the pregnancy;
- Importance of mothers and children sleeping under mosquito nets;
- Importance of delivery at Health Centre;
- Exclusive breastfeeding

- Male support during and after pregnancy; and other relevant messages

However, the composition of VHC membership has changed over time in that some members left and have been replaced by new members. The training of VHC members was done way back and with the new membership there is need for additional training or refreshers. Hence some VHCs are active while others are dormant. There is therefore need to revitalize the VHCs in light of the vital role they play in the delivery of health education. Besides training on health, sanitation and hygiene education other VHCs also need training in First Aid and leadership.

6.2 Health Advisory Committees

According FGDs with Health Advisory Committee (HAC) members, the HAC is a coordinating institution between the Health Centre staff and the community and also plays a conflict resolution role between the two sides to ensure that each party's rights are not violated. Other roles include monitoring of drugs utilization at the Health Centre; monitoring services delivery; disseminating health-related messages in the communities during meetings organized by village headmen; and working with HSAs and VHCs in disseminating messages. However, it was clear from the FGDs that the HACs were not fully activated to provide the required services based on their Terms of Reference partly due to lack of training. On face value the HACs seem to be important institutions that require support for them to deliver. Hence the need for training.

8. Recommendations

a. From the preceding paragraphs it is clear that there is need for more intense and extensive health education in safe motherhood from the mother's health before pregnancy; through pregnancy and child birth; to post-partum and neonatal care. This can be done through refreshers and/or additional training for Health Centre medical and nursing/midwifery personnel. HSAs, and Village Health Committees.

b. The attitude of Health Centre medical/nursing/midwifery personnel to expectant mothers need serious redress by the District Health Office to avoid slippage of the gains already made in safe motherhood. The negative attitude was reported in all the HCs visited by the evaluation team except Malembo HC where maternity services had not been operationalized.

c. There is also need to training HAC and VHC members in order to enhance their delivery capacity.

ANNEX 9.2

HOUSEHOLD SURVEY RESULTS – EDUCATION PROGRAMME

Introduction

The HH Survey for the Education Programme was conducted in the catchment areas of 8 primary schools namely: Lupetele, St Joseph, Chikomwe, Chimbende, Koche, Lwanga, Changamile, and Chimwala. The survey targeted parents/guardians with children in school and in total 197 households were interviewed. A three-stage random sampling procedure was employed as follows: (i) a list of villages in the catchment area of each school was prepared with assistance from the Head Teachers and other teaching staff and from the list 2 villages were randomly selected; (ii) in each village a list of all parents/guardians with children in school was prepared with the assistance of the village headman and other community members; and (iii) 12 parents/guardians were randomly selected from the list in each village. The idea of targeting parents/guardians was mainly to get perceptions on performance of their children in school; teachers' performance and attitude towards leaners; and performance of the school governance committees. Besides the HH Questionnaire, the other tools were: Key Informant Interviews (KIIs) with teachers and Focus Group Discussions (FGDs) with school governance committees.

Summary of key findings from the HH Survey, FGDs, and KIIs

a. There is high appreciation of ICEIDA's investment in education in the programme area because it has improved the teaching and learning environment in the targeted schools. This was reported during KIIs with teachers and FGDs with school governance committees comprising the School Management Committees (SMC), Teacher Parent Associations (PTAs), and Mother Support Groups (MSGs).

b. To a greater extent the performance of the school governance committees has improved with the training supported by ICEIDA. The Mother Support Groups' performance had the highest rating by 89.6% of the sampled households; PTA 79.3%, and SMC 77.9% based on HH Survey results in Chart 4. However, it was also evident from FGDs with school governance committees that some of the committees remained weak and had little understanding of their roles and responsibilities. Understandably there were elections prior to the final evaluation where some committee members were retained while others were left out. The new committee members have not been trained and are undergoing 'on-the-job orientation'. This partly explains why some committees are weak and non-performing.

c. Children's performance in school has been rated moderately by 57.1% of the parents/guardians interviewed (Chart 2). There are several factors affecting children's performance in school the main ones being lack of leaners interest in school, absenteeism, and sickness (Table 7). This is an issue that cannot be addressed locally but requires concerted effort at district level involving multi-stakeholders.

d. 84.9% of parents/guardians reported that teachers attitude towards learners has improved following short duration courses for teachers which ICEIDA supported.

e. ICEIDA's introduction of standardized tests in programme schools was highly acknowledged by teachers and school governance committees because they have helped learners to customize to real examination environment, a departure from the past where tests were written in exercise books. Although ICEIDA's support to the standardized tests has shifted from senior primary classes to standards 3 and 4, the school management committee have adopted the concept and

some schools are mobilizing resources from parents/guardians to continue with the practice in senior primary classes.

f. The introduction of quiz amongst programme schools is another ICEIDA's innovation that has been widely acknowledged in schools. The quiz motivates both teachers and learners to prepare adequately for the competition and in the process improve learners' ability to read and gain knowledge widely.

g. The skills development programme for teachers has empowered teachers to be more assertive and confident in delivering topics that were usually skipped prior to the training. For example teaching expressive art was elusive to most teachers before the training. The only challenge with expressive arts is that there are no materials for learners to practice what they learn in theory.

HOUSEHOLD SURVEY RESULTS

1. Characteristics of sampled households

Table 1 below presents a summary of household characteristics. Overall, 197 households were interviewed: 121 MHHs representing 61.4%, and 76 FHHs (38.6%).

Table 1: General Information on Households Characteristics

	MHHs	FHHs	All HHs
Number of parents/guardians interviewed	121	76	197
Minimum age	19	19	19
Maximum age	80	68	80
Average age	39	42	40
Average household size	7	5	6
Average # of children per HH	5	4	5
Average # of children in school	3	3	3
Average # of children not in school	2	2	2

1.1 Age, family size, average number of children in school and not in school

The results are presented in **Table 1** above. The minimum age of all the respondents was 19 years and the maximum age for MHHs was 80 and 68 for FHHs. The average age was 40 for all the HHs.

The overall family size was 6, which was higher than the national average of 4.6[5]. The average number of children per HH was 5, which is on the higher side considering the subsequent cost of education beyond primary school. The average number of children in school was 3 while the average number of children not in school averaged 2, which means that not all children were in school.

[5] National Statistical Office: 2008 Population and Census

1.2 Marital status of sampled parents/guardians

The majority of sampled households (46.7%) were married monogamously with 17.2% in polygamous marriage **(Table 2**). Other forms of civil status were as follows: 14.2% were divorced; 13.7% were widowed; 4.5% were single and never married; and 3.5% were separated. Overall 35.9% of the parents/guardians interviewed were single parents excluding the 17.2% in polygamous marriage. Being a single parent/guardian can have implications on the support and care of children in school especially for poor households. Polygamous marriages are common in the district based on the religious faith. However, more spouses means more children to support and this has implications on children's education.

Number of parents/guardians interviewed	121
Married - monogamous	46.7
Married - polygamous	17.2
Divorced	14.2
Widowed/widower	13.7
Single - never married	4.5
Separated	3.5

1.3 Highest education of parents/guardians interviewed

Overall, 36% of the sampled parents/guardians interviewed had never attended school at all (**Table 3)**. The illiteracy rate is higher than the national average as reported in the 2008 Population and Census where about 31.8% of adults aged 15 years and above were illiterate. The results generally show that there were more male primary school drop outs than female with only 4.5% of the respondents having attended secondary school education. Focus Group Discussions (FGDs) with School Governance Committees and Key Informant Interviews (KIIs) with teachers acknowledged high illiteracy rates for parents/guardians which constrained them from appreciating the value of education and support their children in school.

Table 3: Highest Education of Parents/Guardians			
% HHs Interviewed			
	MHHs	FHHs	All HHs
None	57.7	42.3	36.0
Standard 1 4	62.0	38.0	25.4
Standard 5 8	67.2	32.8	34.0
Forms 1- 2			2.0
Forms 3- 4			2.5

1.4 Main occupation of parents/guardians

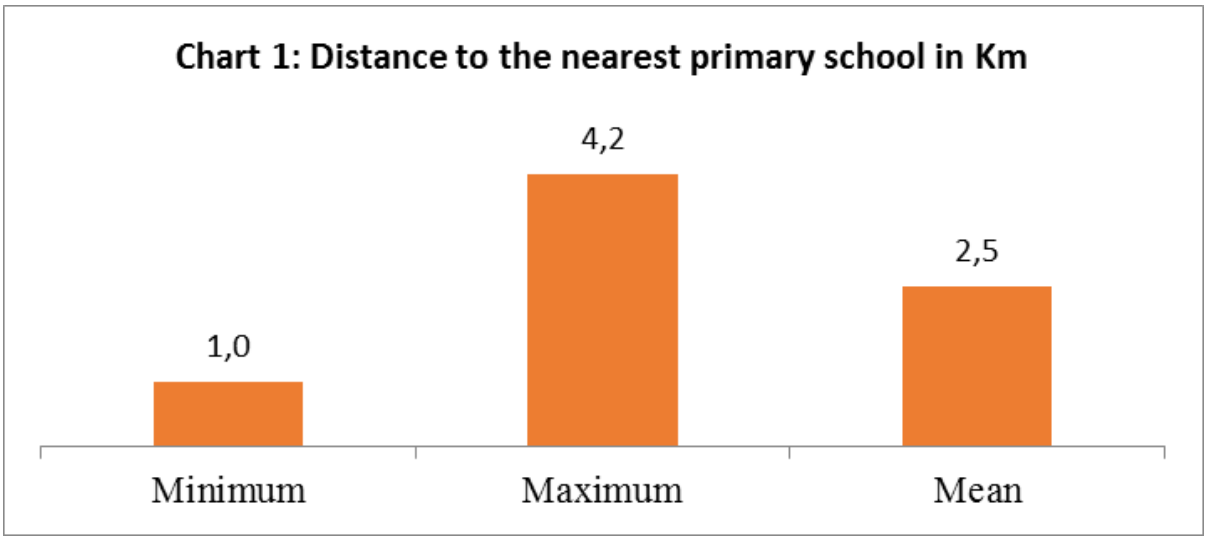
Farming is the main occupation of parents/guardians interviewed accounting for 31.5% of the respondents seconded by business/self-employment constituting 29.4% of parents/guardians (**Table 4** below). Doing business or being self-employed is a common phenomenon in Mangochi district and acts as a magnets for learners to drop out of school. FGDs with school governance committees and KIIs with teachers alluded to the fact that the majority of children who drop out of school are attracted by financial gains in their teens. Some of them as young as 13 years old travel to South Africa to seek employment and channel a proportion of their earnings to business. Hence they have little regard for education which they perceive to be a waste of time. Their role models are successful businessmen, fishermen, and migrants to South Africa who, even without basic education, own standard houses and vehicles. The sampled parents/guardians might have gone through the same path in their youthful age. It is therefore not surprising that parents/guardians pay very little attention to their children's education. Hence the need to change parents/guardians' attitude towards education in Mangochi district and this requires a multi-dimensional approach.

Table 4: Main occupation of parents/guardians

	% All HHs
Farming	
Business/self employed	29.4
Casual labour (Non-Agriculture)	14.2
Fishing-related	12.2
Casual labour (Agriculture)	7.1
Remittances	4.1
Regular employee	1.5

2. Distance to the nearest primary school

Chart 1 shows that the maximum distance to the nearest primary school for the sampled parents/guardians was 4.2 Km, minimum 1 Km and the average distance was 2.5 Km. The sampling was designed to interview parents/guardians in villages at least 2 – 3 Km away from the school in order to minimize the direct school influence in the results from villages less than one Km radius from the school. FGDs with school governance committees also indicated that distance was an important factor that influences school attendance particularly for children 6 years old or thereabouts. Absenteeism was higher amongst young learners in villages farther away from the school and in other instances learners were over-age in relation to the class they were attending because they did not start attending school at the correct age of 6 due to distance.



3. Parents whose children did not attend school this term

Absenteeism from school is a problem in programme schools as presented in **Table 5** below. Overall, 64.1% of the parents/guardians interviewed reported that their children had not go to school at least for a day during the current term. There were more FHHs reporting absenteeism (68.4%) than MHHs (58.4%).

The main reason for not going to school was sickness as reported by 60.8% of the respondents. Other reasons were minor including lack of scholastic materials (12%); lack of interest (8%); and dirty clothes (8%). Although distance was not captured, FGDs with school governance committees highlighted it as one of the reasons for absenteeism especially for young learners. The school management committees therefore still have a lot of work to curb absenteeism.

Table 5: Parents whose children did not attend school this Term			
% HHs Parents/Guardians Interviewed			
	MHHs	FHHs	All HHs
Parents whose children did not attend school	58.4	68.4	64.1
Reasons for not attending school			
Sickness	60.2	61.5	60.8
Scholastic materials*notebooks, pens, etc	12.3	11.5	12.0
Lack of interest	5.4	11.5	8.0
Dirty clothes	11.0	3.8	8.0
School fund contribution	8.2	3.8	6.4
No breakfast	1.3	5.8	3.2
School uniform	1.3	1.9	1.6

4. Parents with children that dropped out of school

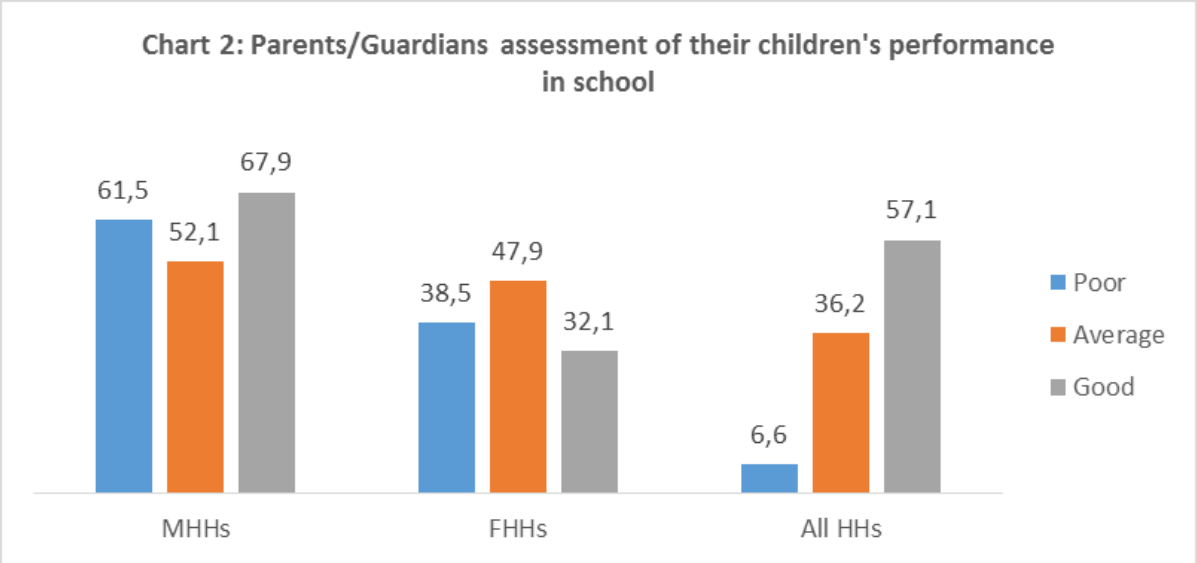
The HH Survey results in **Table 6** show that school drop-out was higher in MHHs (68.4%) compared to FHHs (31.5%). The main reasons for dropping out of school were: lack of interest (47.4% of respondents): disability (31.6%); and early marriages (15.8%).

FGDs and KIIs with Teachers highlighted the main reasons as lack of interest on part of learners as well as parents/guardians to ensure that their children remain and perform well in school. Other reasons included cases of pregnancies and early marriages, seeking employment in South Africa at a tender age; engaging in fishing while in school; long distance to school; and lack of effective support from community leaders to work jointly with teachers and school governance committees to address the issue of school drop-out.

Table 6: Parents/guardians with school drop-outs			
% Parents/Guardians Interviewed			
	MHHs	FHHs	All HHs
Parents with children who dropped out school	68.4	31.5	9.7
Reasons for dropping out of school			
Lack of interest	53.8	33.3	47.4
Disability	30.7	33.3	31.6
Early marriages	7.6	33.3	15.8
Distance to school	7.6	0	5.3

5. Parents/guardians assessment of their children's performance in school

Overall, 57.1% of the parents/guardians interviewed assessed their children's performance in school as good; followed by average (36.2%); and poor (6.6% as presented in **Chart 2**. The reasons for average or poor performance are presented in **Table 7** below.



6. Reasons for average and poor performance in school

The reasons are presented in **Table 7** below and these are: - lack of interest (26.9% of parents/guardians interviewed); absenteeism (18.2%); and sickness (17.3%). Although distance to school was reported by 66.7% of FHHs, overall it was not highly rated. It should be noted that lack of interest in learning amongst children and absenteeism are recurring in most of the responses which means that they need appropriate action to address them.

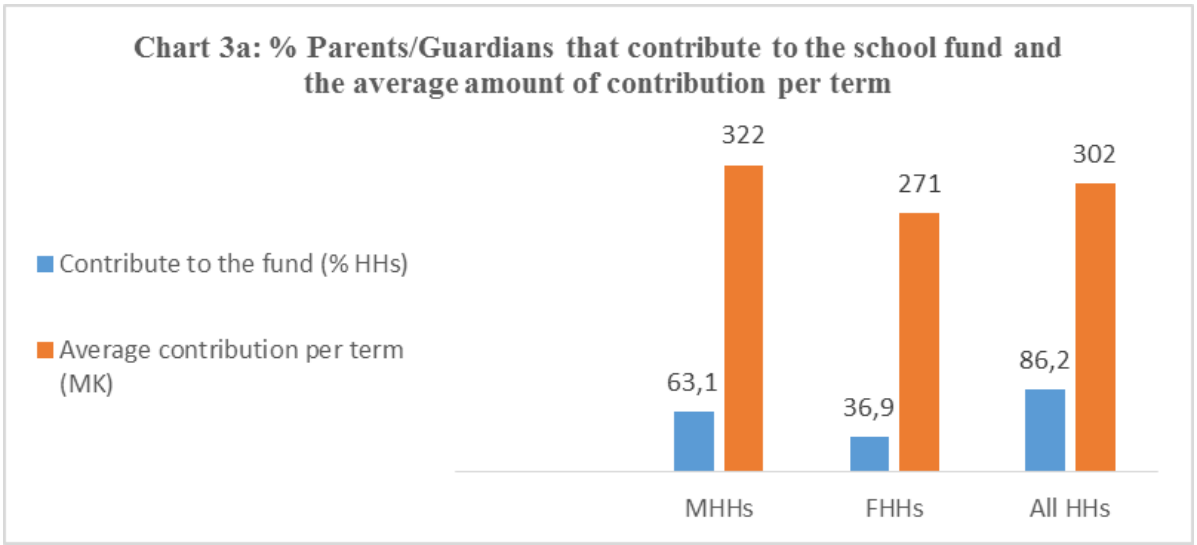
Table 7: Reasons for children's average and poor performance in school

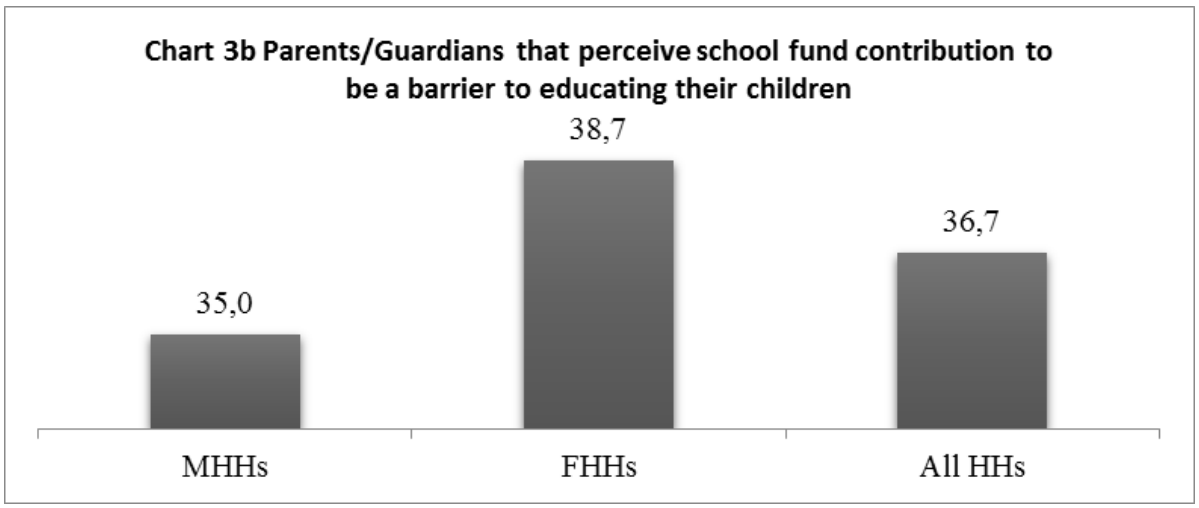
% Parents/Guardians Interviewed			
	MHHs	FHHs	All HHs
Lack of interest	20.7	48.4	26.9
Absenteeism	12.9	52.4	18.2
Sickness	1.2	50.0	17.3
They go to school without breakfast	7.8	33.3	7.8
Distance to school	3.8	66.7	7.8
Inadequate scholastic materials	5.1	0.0	3.4
Teachers lack of commitment	38.9	25.0	3.4

7. Parents/Guardians contribution to the school fund

Chart 3a shows that overall, 86.2% of the parents/guardians interviewed contribute to the fund. However within FHHs only 36.9% contribute. During KIIs with teachers it was reported that getting school fund contributions is a challenge in most schools as parents/guardians perceive the contribution as a form of 'school fees' in a free primary school education system. Other parents/guardians complain that the amount was on the higher side which they struggle to raise (average MK302 per term). **Chart 3b** shows that 36.7% of the parents/guardians interviewed perceive the school fund contribution as a barrier to children's education. This is an issue that most parents/guardians seem not to understand especially in the backdrop of low literacy levels in the district. Regular meetings between school governance committees and the community are necessary to deliver the concept of the school fund repeatedly.

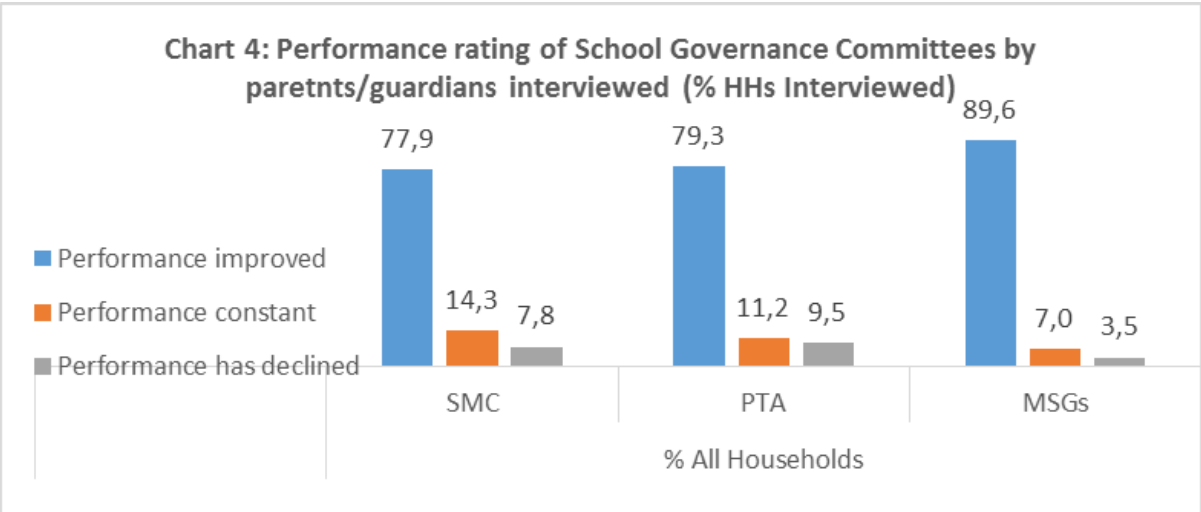
Another issue is contribution towards standardized examinations for senior primary classes. The **exams** were previously funded by ICEIDA but from this year (2018) ICEIDA is only funding classes 3 & 4 which means that parents/guardians have to contribute towards senior primary standardized exams if the exams have to be maintained. The school contribution is an issue that requires joint effort by the school governance committees and community leaders in order to garner support from the community for its good intention.





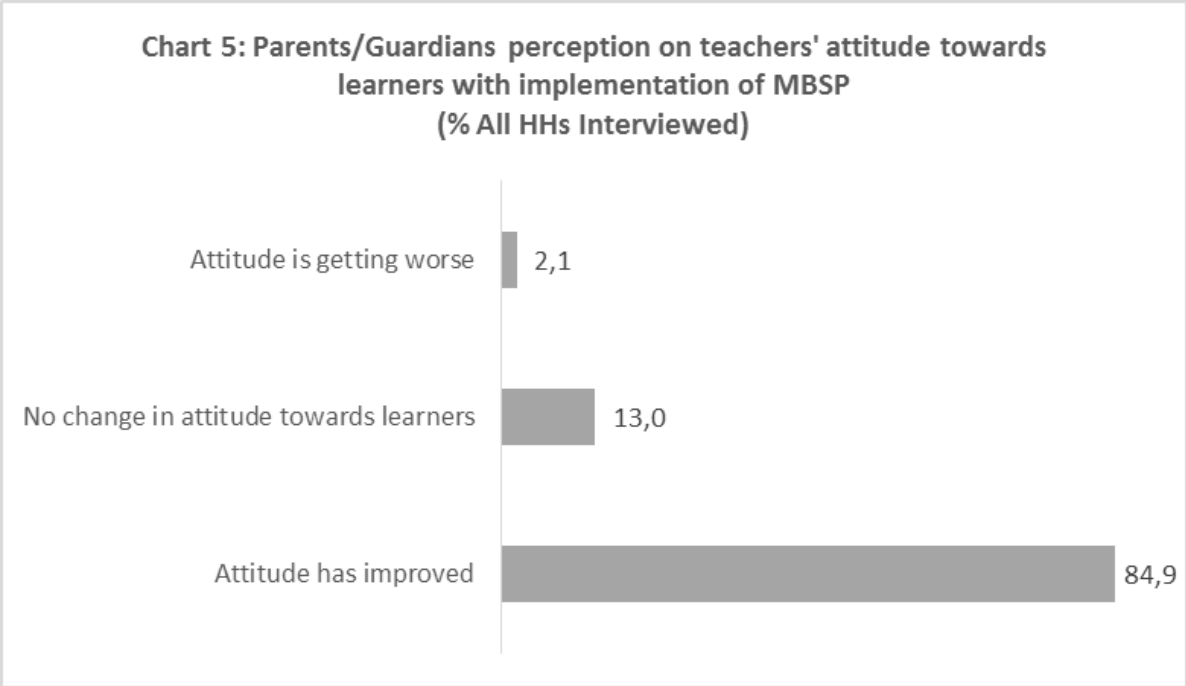
8. Parents/guardians perception on performance of School Governance Committees (SGCs)

The HH Survey results in **Chart 4** indicate high rating for improved performance for Mother Support Groups (89.6% of the HHs interviewed); followed by Parent Teacher Association (79.3%); and lastly School management Committees (77.9%). During KIIs with teachers, there were mixed perceptions on the performance of SGCs with some school teachers highly rating their committees with others casting doubt about the performance. The MSGs were highly rated in almost all the schools that were visited by the consultants mainly because of their focus and support for improving the girl child's education in various forms such encouraging girls who drop out of school to back to school; providing uniform and scholastic materials to needy learners; providing sanitary material to girls; and other forms of support. It was learnt during the visits that some committees had not been oriented to their roles and responsibilities, therefore had challenges in executing their functions. The PTA was also commended for fostering parent-teacher relations as well monitoring teacher's attitude and conduct towards learners. The SMCs were commended for their active involvement in school development e.g. mobilizing funds for maintenance, standardized examinations, etc. Generally the weaker committees are those committees that have not been trained/oriented or those with poor relations with the school teaching staff to strike a good working relationship.



9. Parents/guardians perception on teachers' attitude towards learners

Chart 5 shows that 84.9% of parents/guardians responded positively about change in teachers' attitude towards learners and only 2.1% reported the worst scenario. The approval rating is not surprising in view that most teachers attended short duration training supported by ICEIDA and facilitated by the Malawi Institute of Education (MIE) during which various skills were acquired including leadership. The MBSP also sponsored training for school governance committees in order for them to discharge their roles and responsibilities effectively. The combination of teachers' and SGCs training has resulted in improved teachers' attitude and performance.



10. FGDs and KIIs findings

- ICEIDA's introduction of standardized tests was acknowledged by teachers and school governance committees because they have helped learners to customize to real examination environment, a departure from the past where tests were written in exercise books. The standardized exams had high regard because all programme schools compete and this motivates learners to work hard and score highly. Although the tests have been discontinued in upper primary classes (Standards 5 - 8) they have subsequently been introduced in lower classes (Standard 3 – 4). Some schools have maintained the upper primary exams by seeking contributions from parents/guardians to cover printing and photocopying costs.
- The introduction of quiz amongst programme schools is another ICEIDA innovation that encourages both teachers and learners to prepare well and in the process encouraging learners to read widely in preparation for the quiz.
- The teachers' skills development programme supported by ICEIDA has empowered teachers to be more assertive and confident in teaching topics that were usually skipped prior to their participation in training. Despite not all teachers being trained, all programme schools have acquired the necessary skills that can be harnessed now or in future. The challenges seem to be: a) programme schools may lose skilled teachers due to transfers as the schools have no control over the matter; and b) some of the teachers' skills largely remain unexploited due to lack of

teaching materials such as graph paper for mathematics and materials for expressive arts e.g. materials for weaving, knitting, etc. Despite the fact that expressive art is contained in the primary school curriculum, the Ministry of Education Science and Technology (MoEST) does not provide for such materials in its budget and parents / guardians are also unable to acquire the materials. Hence expressive art may gradually vanish if strategies for supplying materials to schools are not worked out.

- However, there are also a number of issues with the education programme. The number of learners who drop out of school remains high in absolute numbers despite advances in enrolment. The main issue seems to be lack of interest from parents/guardians to ensure that their children remain and perform well in school. Cases of pregnancies and early marriages; absenteeism; trekking to South Africa at a tender age to seek employment opportunities; and engaging in fishing activities while in school are matters of real concern for the education programme. Distance to school is another factor affecting learners resulting in mismatch between age and class. There also seems to be no effective support from community leaders to work jointly with teachers and school governance committees to face the school dropout issue head-on. The role models are school drop-outs who either go and work in South Africa or turn into fishermen in their teens and acquire 'wealth' despite low academic credentials.
- **Quality of school structures/poor workmanship**

  This is another area that needs redress in future programming through improved contractor selection and effective monitoring of civil works at district and community level.
- **School governance committees**

  It was evident from FGDs with school governance committees that some of the committees remain weak, have little understanding of their roles and responsibilities, and are not innovative to initiate change especially the school management committees (SMCs) and Parent Teacher Associations (PTA). There have recently been elections where some entire committees have been dropped while some have retained a few old members. There is a definite need for capacity enhancement to enable new committee members understand their roles and responsibilities to deliver effectively. It is also important to provide refreshers to ensure that they are abreast with new approaches to managing school affairs. Most of the Mother Support Groups are very active in supporting the girl child in school and need support and motivation for them to keep the steam.

11. Recommendations

a. The issue of school drop-outs requires attention. This is not only happening in programme schools as the DEMIS data for the entire district also show a similar trend. The issue cannot be addressed locally but requires a district strategy involving all relevant stakeholders.

b. The school governance committees need additional training to empower them to contribute effectively towards improving schools' management. This is particularly important for newly elected committees.

ANNEX 9.3

HH Survey Report – Water and Sanitation Programme

Introduction

The HH Survey for the Water and Sanitation Programme was conducted around 8 water facilities (boreholes and shallow wells) in TA Chimwala where 197 water-user households were interviewed - all women as primary users of the water facilities. A two-stage random sampling procedure was employed: (i) a list of water-user households was prepared with the assistance from Water Point Management Committees; and (ii) 24 water-user households were randomly selected from the list for the interviews. Two other tools were also employed: Focus Group Discussions (FGDs) with Water Point Management Committees (WPMCs) and Key Informant Interviews (KIIs) with frontline staff namely: Water Monitoring Assistants (WMAs); Health Surveillance Assistants (HSAs) and Community Development Assistants (CDAs).

Summary of key findings

a. There is no doubt that the installation of water facilities has improved the lives of families in the programme area. Almost all communities have access to clean and safe water, congestion has been eliminated, cholera has been wiped out in the programme area, and incidence of water borne diseases has considerably diminished. Of the 197 households interviewed, 98.8% had access to clean and safe water (Chart 3).

b. Women no longer travel long distance to fetch water. The average walking time to and from a water facility is 9.8 minutes compared to 42.9 minutes before the installation of water facilities. The saved time is productively utilized for domestic chores and economic activities (Chart 4 & Table 3).

c. Water quality has been highly rated: 89.8% of the sampled households described the water quality as good (Chart 7).

d. Technical skills for water facility maintenance are now available within the communities trained through the MBSP as reported by 99.1% of the sampled households (Chart 9).

e. However, there are challenges with the water point maintenance fund in communities where water users are unwilling to contribute. There seems to be mistrust between community members and WPMCs mainly on transparency and accountability of the maintenance fund. There are no feedback mechanisms to facilitate dialogue between the WPMCs and the community hence the need for a review of the management aspect of the maintenance fund.

f. The WPMCs have no viable sustainability plans for the maintenance of water facilities with community contributions being the only source of funds. Additional resource mobilization avenues need to be explored e.g. VSLs that can be operated in a transparent and accountable manner.

g. There are issues of hygiene around the water facilities. In communities where the committees are weak or are in conflict with community members, the hygienic standards remain low as community members abstain from cleaning the water facility area. The waste pits/tanks/soak ways in most of the water facilities were observed to be overflowing which are signs of silting or blockage of the waste disposal channels. This could be a design problem that needs to be corrected. If unattended these could turn to be recipes for water borne diseases

HOUSEHOLD SURVEY RESULTS

1. General characteristics of sampled households

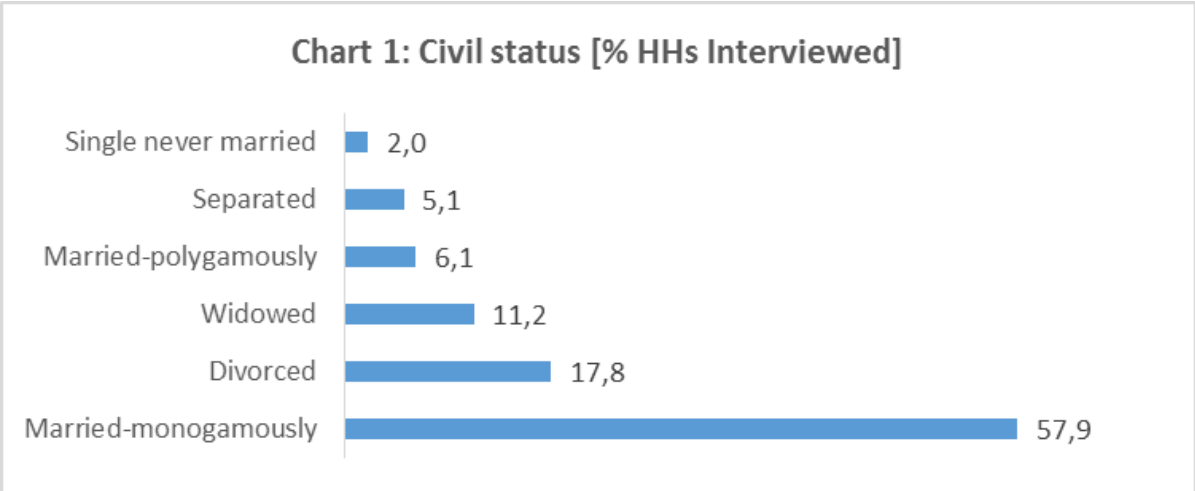
1.1 Age and family size

The information is presented in **Table 1** below. The minimum age was 18 years and the maximum age was 79 and 85 for MHHs and FHHs respectively. The average age was 37.5 years for all the HHs. The average household size was 4.8 just above the national average of 4.6[6].

Table 1: General Information on HHs Interviewed			
	MHHs	FHHs	All HHs
Total number of HHs interviewed	109	88	197
# of HHs that source water from boreholes	76	46	122
# of HHs that source water from shallow wells	33	42	75
Minimum age	18	18	18
Maximum age	79	85	85
Average age	34.7	41.0	37.5
Average household size	5.1	4.5	4.8

1.2 Marital status of sampled households

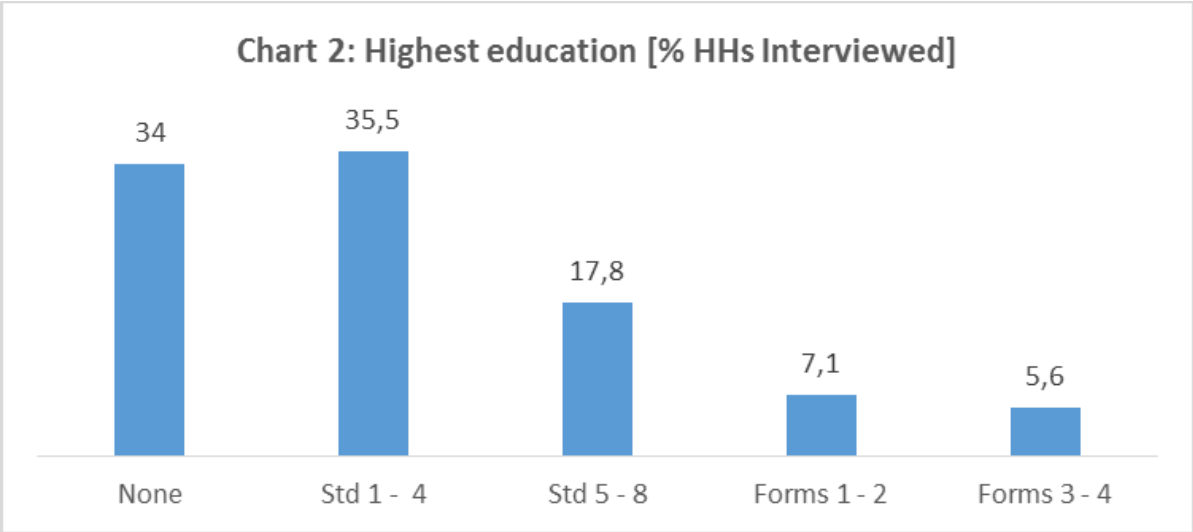
The largest proportion of sampled households (57.9%) were married monogamously with 6.1% in polygamous marriage **(Chart 1)**. Other forms of civil status were: 17.8% were divorced; 11.2% were widowed; 5.1% were separated; and 2.0% were single and never married. Overall, 36.1% of the households were female without spouses and more likely in a poor wealth category. Their vulnerability is pronounced when they struggle to contribute to the water facility maintenance fund.



[6] National Statistical Office: 2008 Population and Census

1.3 Highest education of sampled households

Overall, 34% of the sampled parents/guardians interviewed had never attended school at all (**Chart 2)**. The results show that there were more school drop-outs at junior primary school level (Standard 1 – 4) than at senior primary level (17.8%). The illiteracy rate was high, a common phenomenon in Mangochi district and to some extent this may have has implications on their ability to understand and appreciate messages on hygiene and sanitation



1.4 Main occupation of sampled households

Overall, business/self-employment is the main occupation of the women interviewed accounting for 25.9% followed by farming (21.3%), fishing-related economic activities (19.3%), and non-agriculture piece work (13.7%) – **Table 2.** This is typical of Mangochi district where business including petty trading is an important livelihoods source**.**

Table 2: Main occupation (% HHs Interviewed)

	MHHs	FHHs	All HHs
Business/self-employment	58.8	41.2	25.9
Farming	38.1	61.9	21.3
Fishing-related	76.3	23.7	19.3
Casual labour (Non-Agriculture)	48.1	51.9	13.7
Casual labour (Agriculture)	45.5	54.5	5.6
Regular employee	90.0	10.0	5.1
Other	38.9	61.1	9.1

2. HH Survey Results: Water component

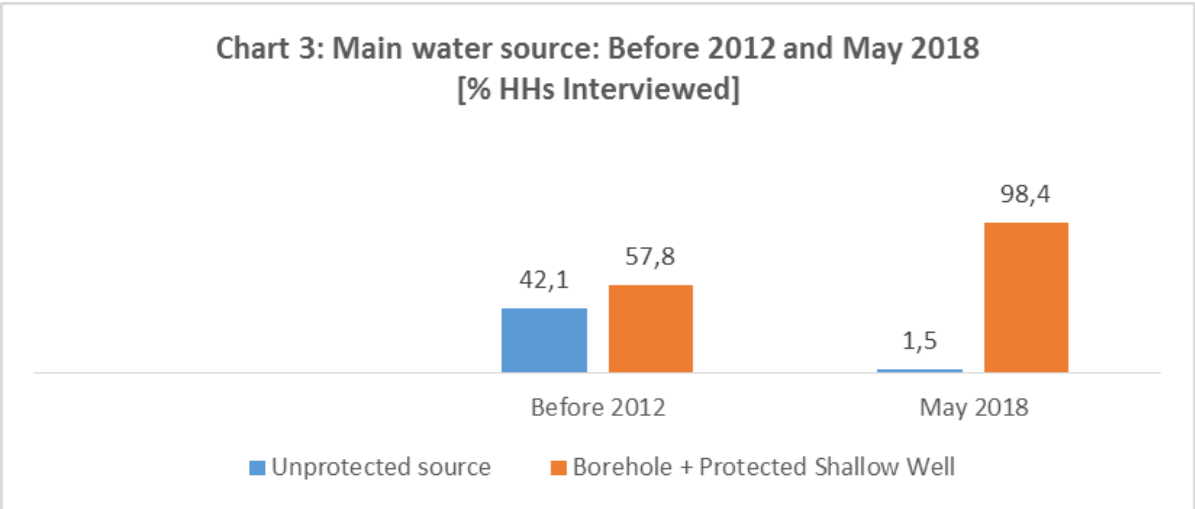
2.1 Main water sources before 2012 and with MSBP (May 2018)

Chart 3 shows that before 2012, some 57.8% sourced their water from boreholes with 42.1% from unprotected sources. With the implementation of the MBSP, some 98.4% of the households have access to clean and safe water and the proportion of sampled households using unprotected sources has drastically dropped to 1.5%. ICEIDA's investment in the water programme has been the most successful of the three programmes. FGDs with Water Point Management Committees (WPMCs) outlined a number of challenges the community in TA Chimwala experienced prior to ICEIDA's investment in the MBSP. These included:-

- Communities collected water from unprotected wells because there were few boreholes in the area and women walked long distances to the nearest borehole;
- Lake Malawi was used as a source of water for domestic use and washing clothes;
- Water borne diseases were common in the area including cholera;
- In some communities, three villages could share a borehole – there were common scenes of congestion, long queues, quarrels, and fights. This led to delays in sending children to school on time because there was no water for the children to bath in the morning; and
- Most women could wake up at 4 - 5AM to fetch water and return home around 10AM,

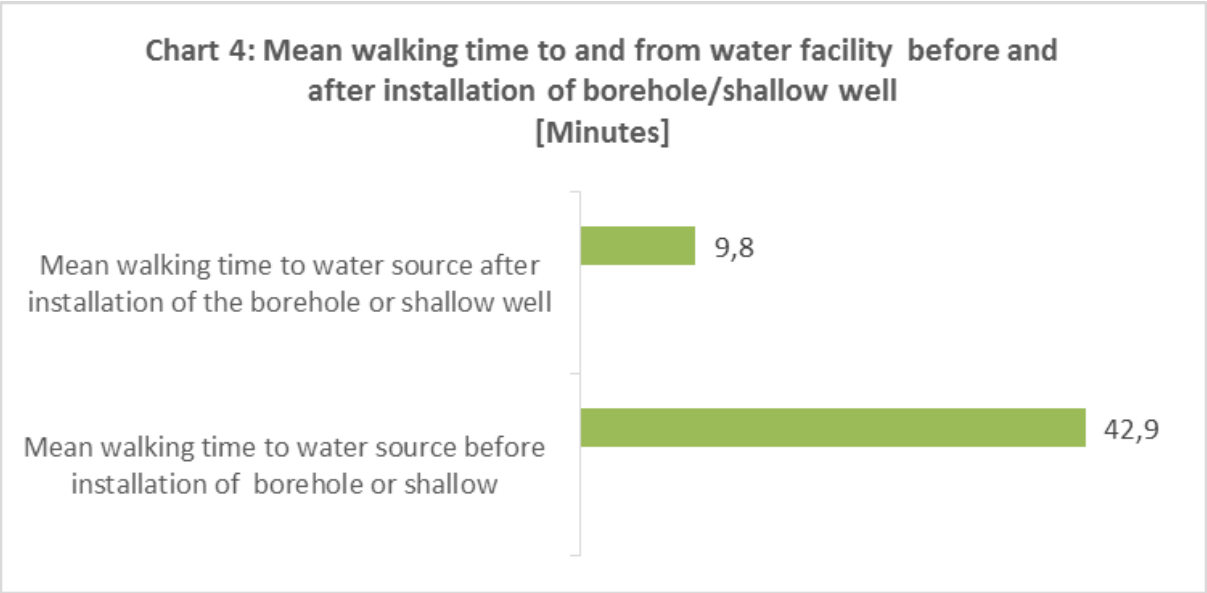
However, with the installation of boreholes and shallow wells there is a turn-around and the benefits to the communities are:-

- Since the installation of the water facility, access to clean and safe water is guaranteed.
- Water is available right in the village, no more walking long distance to fetch water.
- Water hygiene has improved, the incidence of water borne diseases has diminished.
- There is no wasted time due to long travel to water sources.



2.2 Mean walking time to and from a water facility before and with MBSP

The HH Survey results in **Chart 4** indicate that the mean walking time to a water source has **drastically** been reduced from 42.9 minutes to 9.8 minutes due to the installation and/or rehabilitation of water facilities in the target area. The walking time saved is being utilized by households in various activities as presented in **Table 3** below.



2.3 Utilization of saved walking time

With the installation of water facilities, the saved walking time is mainly used for domestic chores (68.3% of the responses), business (15.5%) and a combination of various household tasks as presented in **Table 3**. The installation of water facilities has therefore not only improved community access to clean and safe water but has also added a dimension to the economic and social spheres of the targeted population. During FGDs with one Water Point Management Committee one woman said: *'with the water facility now in our village marriages have become stable because our spouses suspected us of cheating when we spent long hours from home fetching water. Now all this is over because we are able to spend more time at home and look after our children*.'

Table 3: Utilization of walking time saved by the households

	Number of Responses			(%) of Total
	MHHs	FHHs	All HHs	Responses
More time for domestic chores	21	51	110	68.3
Use time for business	18	7	25	15.5
Farming	2	3	5	3.1
Feeding children and family	0	5	5	3.1
Piece work	2	2	4	2.5
Baby sitting and house chores	2	0	2	1.2
Farming and house chores	1	1	2	1.2
Washing and cooking	2	0	2	1.2
Feeding children and house chore	0	1	1	0.6

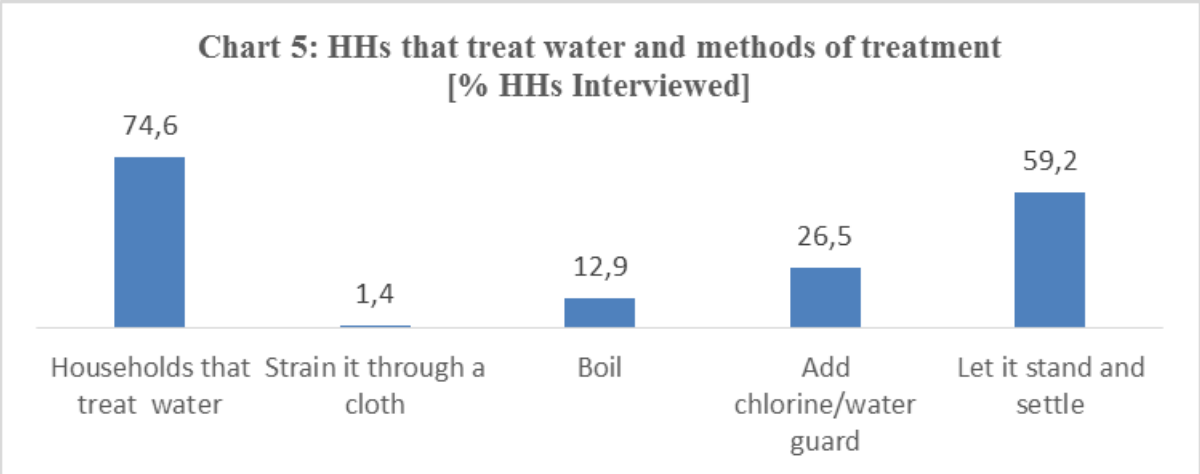
Table 3: Utilization of walking time saved by the households				
Farming and house chores	0	1	1	0.6
Manage business and house chores	1	0	1	0.6
House cleaning and baby feeding	1	0	1	0.6
Washing clothes and house chores	0	1	1	0.6
Gardening and housed chores	0	1	1	0.6
Total Responses	50	73	161	100.0

2.4 Hygiene around water facilities

Hygiene standards around water facilities vary with the level of functionality of Water Point Management Committees (MPMCs). Where MPMCs are weak or in conflict with community members, the hygienic standards are low because community members abstain from cleaning the water facility area. The task is thus left to the WPMCs. The waste pits/tanks/soak ways in most of the water facilities were observed to be overflowing which is a reflection of silting or blockage of the waste disposal channels. To some extent this is a design problem which needs to be corrected. In some boreholes/shallow wells the waste tanks are emptied and cleaned at least twice a week which is not in tandem with design specifications. The alternative is to re-construct the soak ways/tanks in order to improve the hygiene standards and prevent water borne diseases from finding a niche. .

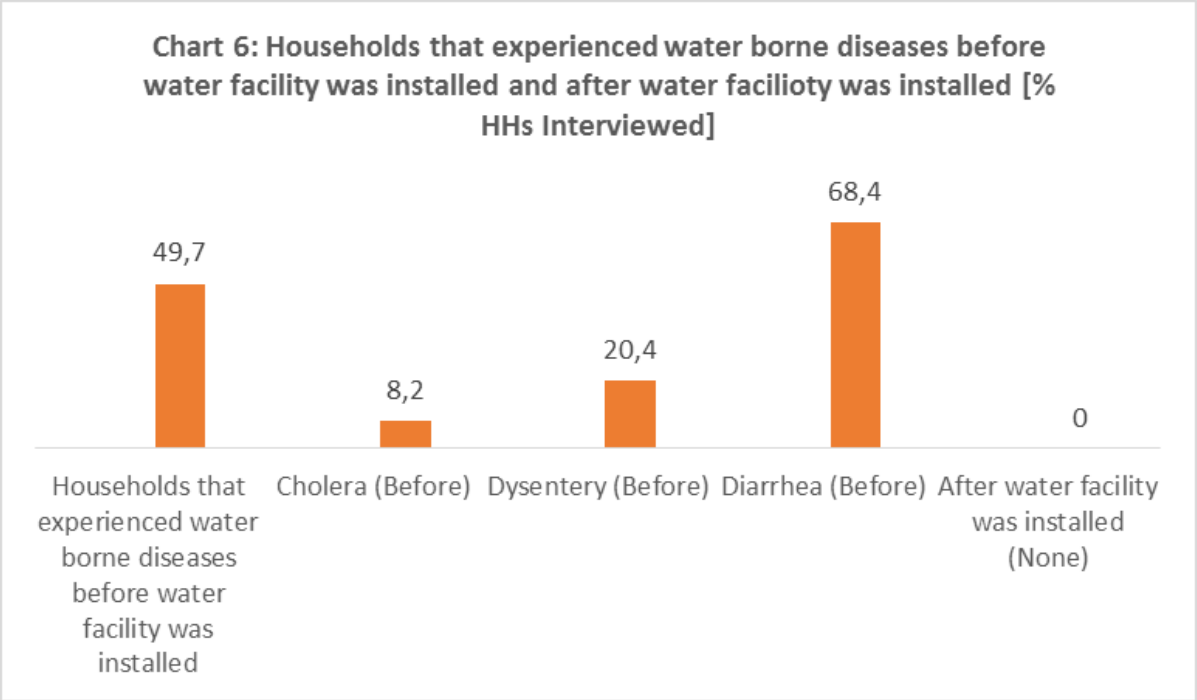
2.5 Treatment of water at household level

As a preventive measure for water borne diseases, the Health Surveillance Assistants (HSAs) and Village Health Committees (VHCs) disseminate messages on water hygiene including water treatment. HH Survey results in **Chart 5** show that 74.6% of the sampled households treat water mainly by letting it stand and settle (59.2% of HHs); adding chlorine and water guard (26.5%) mainly during the rainy season to prevent cholera and other intestinal infections; and by boiling (12.9%). The chlorine and water guard is distributed by government through HSAs and VHCs.



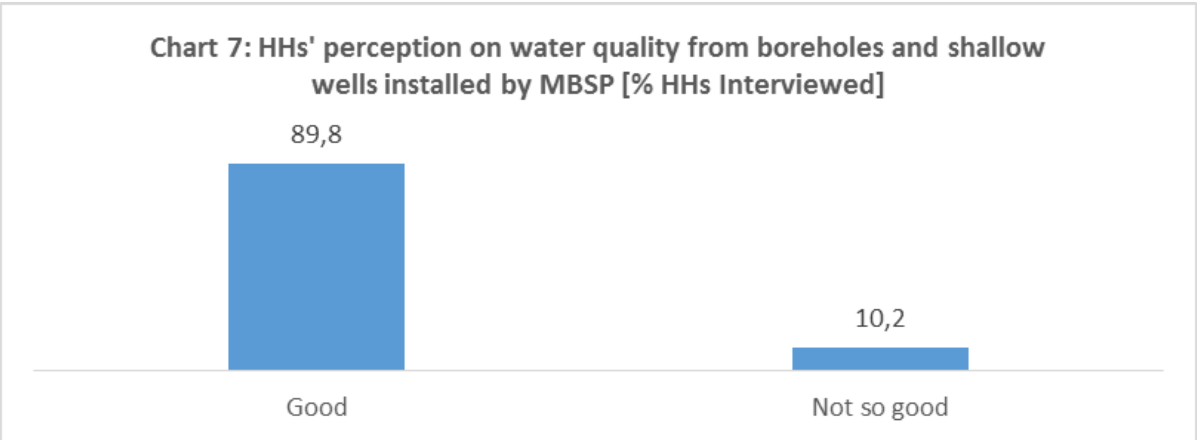
2.6 incidence of water borne diseases before and with MBSP implementation

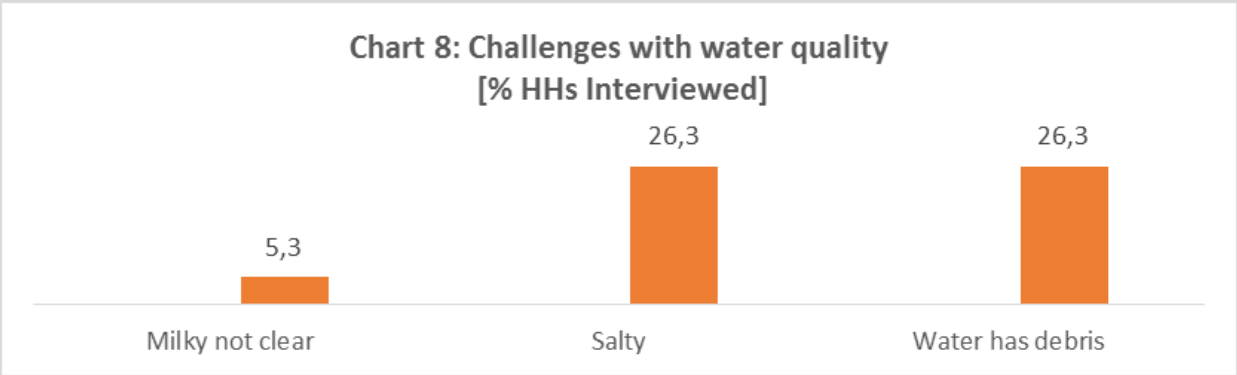
Before the installation of water facilities by the MBSP, 49.7% of the sampled households reported incidence of water borne diseases mainly diarrhoea (68.4% of HHs); dysentery (20.4%); and cholera (8.2%) - **Chart 6** below. With the installation of water facilities the communities have not experienced water borne diseases in the target area.



2.7 Community perception on water quality in MBSP installed facilities

Water quality is good as reported by 89.8% of the sampled households as presented in **Chart 7**. Only in selected communities was the quality of water a challenge in terms of debris (26.3%), salty (26.3%); and milky (5.3% of HHs) – **Chart 8** below.





2.8 Management of the water facility maintenance fund

The installation of water facilities by the MBSP in the target area means that financial resources are required for maintenance when the water facilities breakdown and this has been made clear to the communities. Each community has therefore established a water facility mainteance fund entrusted in the respective Water Point Management Committees (WPMCs).

2.8.1 Household contribution to the water facility maintenance fund

Each water-user household is supposed to contribute a specified amount at a scheduled time. However, contributions have been erratic in some water points because members do not want to pay. The main reason for the resistance to pay is lack of transparency and accountability on part of the WPMCs. The committees have failed to call for community meetings where details on contributions, expenses, and balances are supposed to be disseminated to water-users. This has raised mistrust between the WPMCs and water-users. Other reasons for non-compliance with conntribution are: poor households e.g. old FHHs fail to pay because they find it difficult to raise the money; and other community members are said to be too powerful for the WPMCs to chase.

In **Table 4** below, about 83.8% of HHs contrbute to the mainteance fund mainly on monthly basis. During FGDs with WPMCs it transpired that some members prefer to pay one-off contributions when the water facility breaksdown rather than contributing regulalrly to minimize conflicts on accountability from WPMCs. However, one-off payments like MK500 (€0.59) would be difficult for poor households to raise at once.

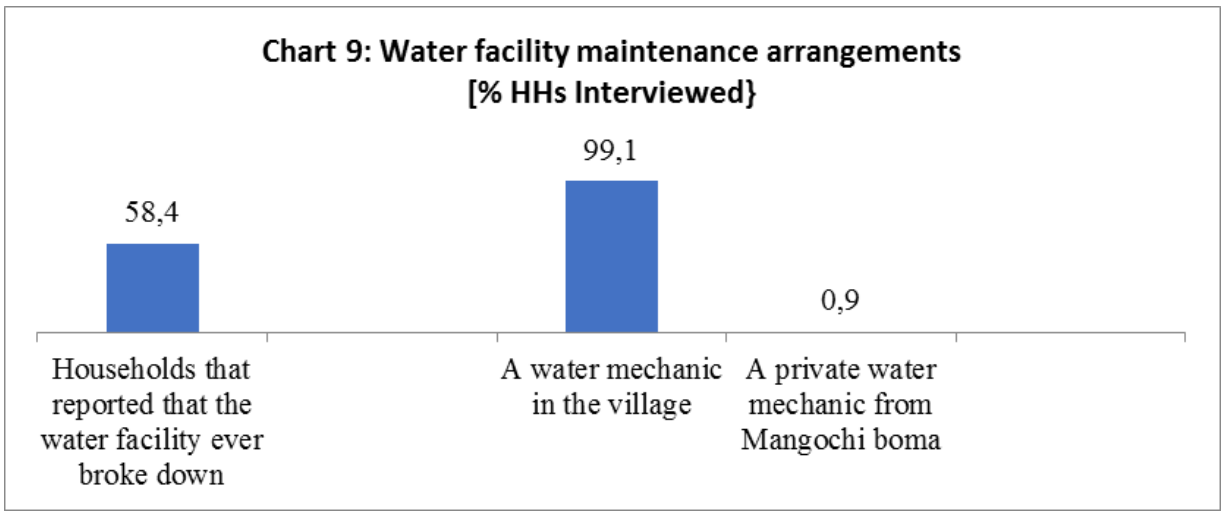
To improve transparency and accountability, the MBSP needs to provide additional training to WPMCs to introduce a cash book system to financial records i.e. income from contributions; expenditure with receipts; and book balance should be presented to the community at least once a month during specially-convined meetings. This can build trust in the WPMC and entice non-contributors to start contributing.

The other issue on the maintenance fund is its sustainability based on household contributions. The water facilities are relatively new and in good operating condition with minimum maintenance but as they age more resources will be required to maintain them. To raise additional funds, it would be ideal to establish Village Savings and Loans (VSLs) under the WPMCs and channel the profit to the water facility maitenance fund. The Community Development Assistants working in the target area are potential facilitators for VSLs.

Table 4: Household contribution to the water facility maintenance fund			
Communities with water facility maintenance fund		[%]	100
Average proportion (%) of HHs that contribute to the fund		[%]	83.8
Frequency of HH contribution to the water facility maintenance fund:			
	Monthly	[%]	93.4
	Quarterly	[%]	1.5
Amount of Household contribution to the maintenance fund		In MK	In Euro
Minimum		100	0.12
Maximum		500	0.59

2.9 Servicing/maintenance of water facilities

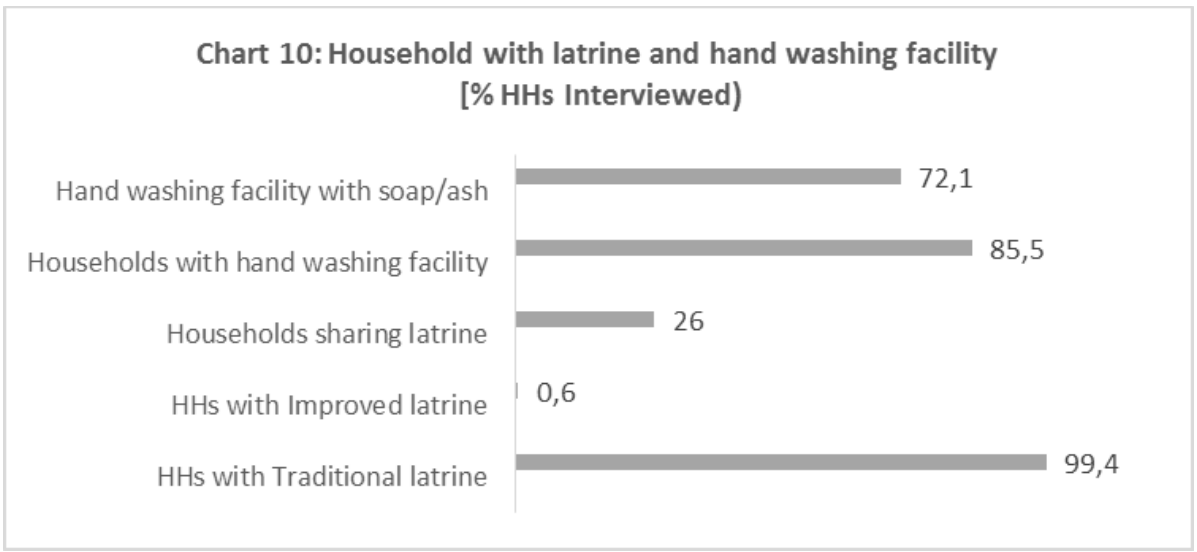
One aspect of the MBSP's capacity building at community level was to equip the communities with knowledge and technical skills in water facility maintenance. Hence the MBSP has trained a number of village mechanics who are responsible for maintaining the water facilities. **Chart 9** shows that 58.4% of the sampled households indicated that their water facility had broken down and 99.1% reported that the maitenance was done by village water mechanics trained by the MBSP. This is an apprpriate and sustainable way of keeping the water facilities running as long as there is a viable water facility maitenance fund to purchase spare parts.



3. SANITATION COMPONENT

3.1 Sanitation and hygiene in non-ODF communities

The HH Survey results in **Chart 10** show that 99.4% of the sample households have traditional latrines, some not functional due to collapse during the just-ended rainy season. Hence 26% of the respondents reported that they share latrines with neighbours while awaiting maitenance of their own during the dry season. Less than 1% of the sampled households have improved latrines – this is mainly due to high cost of construction material as subsidies on the dome slab are no longer available because the CLTS approach has been christened as the main driver for communities to own and use latrines. The HH Survey results also show that 85.5% of the sampled households had hand washing facilities with 72.1% of the facilities having soap or ash. There is some controversy surrounding hand washing facilities in non-ODF communities because of the physical location of latrines within the households' premises. The latrine and bathroom are enclosed in a grass or reed fencing such that to go to a latrine one has to pass through the bathroom where bathing water is placed. This is not the normal hand washing facility installed in ODF-declared villages which is placed outside a pit latrine and locally known as '*Mpondagea*r'. Nonetheless, the fact that water and soap/ash are available in the bathroom adjacent to the latrine is probably an indication that hand washing takes place after using the latrine.



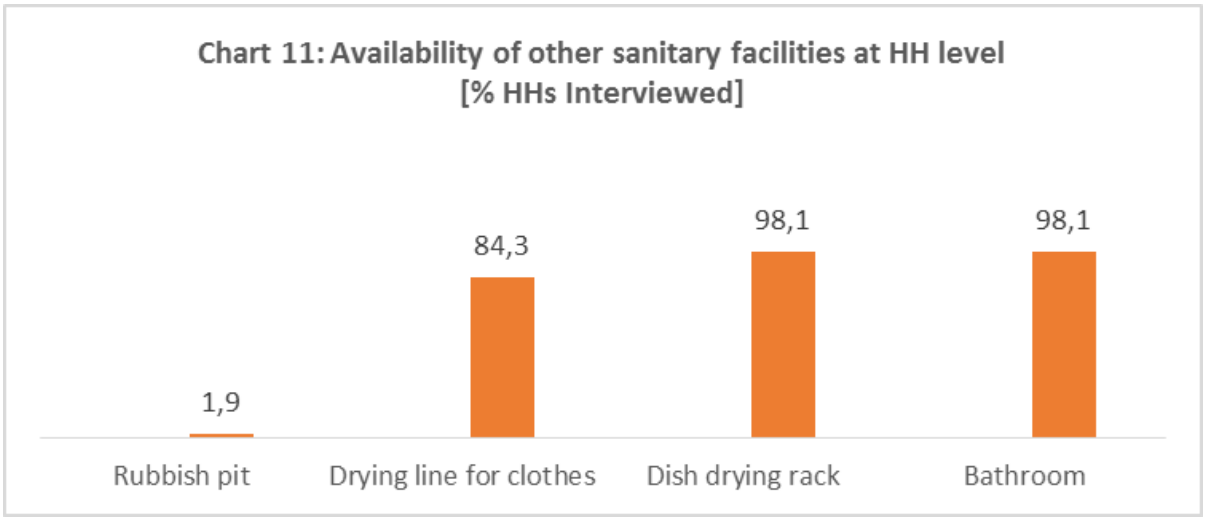
3.2 Sanitation in ODF declared communities

The Water and Sanitation Ouput Vs Achievement reports that 48 villages have been declared ODF in TA Chilipa which was formaly part of TA Chimwala. This is a good achievement as there was no ODF declared village in 2012 and the programme only achieved 11 at Mid-Term. There is a case study on ODF presented in **Annex 8**.

3.3 Prevalence of other sanitary facilities

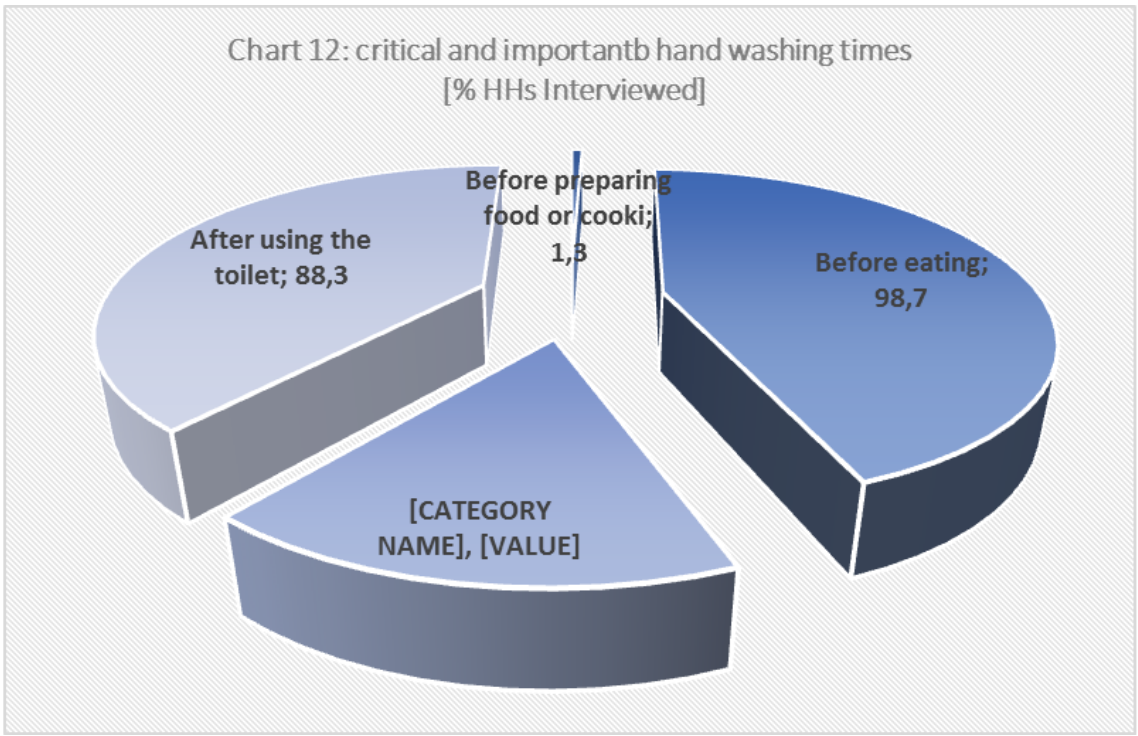
Hygiene education disseminated by HSAs and VHCs encourages community members to have other sanitary facilities beside latrines to have a healthy living. These are presented in **Chart 11**. The rubbish pit which is the third most important sanitary facility after the latrine and hand washing facility has the least adoption rate (1.9% of sampled HHs). The explanation during FGDs was that most of the rubbish pits had folded with the heavy rains and digging new pits is planned for the dry

season. For the other sanitary facilities there is high adoption with 91.8% for bathrooms and dish racks respectively, and 84.3% for drying lines for clothes. The high adoption rates reflect effective dissemination of sanitation and hygiene messages by the HSAs and VHCs.



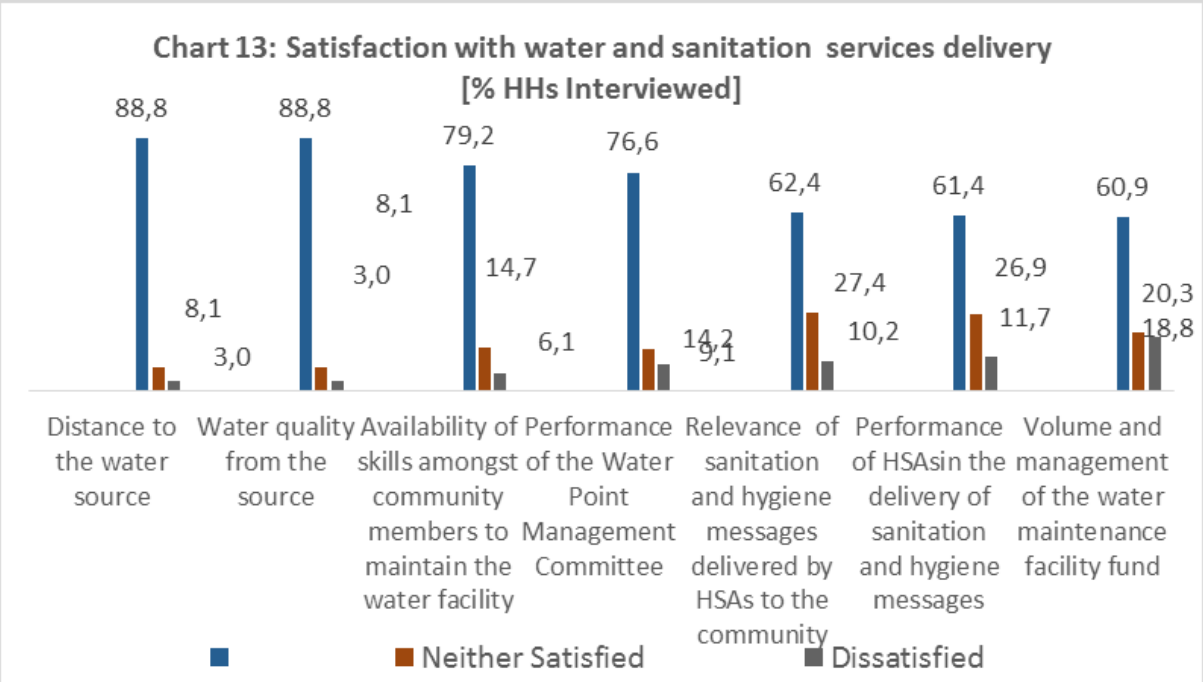
3.4 Critical hand washing times

The sanitation and hygiene education being delivered by the MBSP also emphasizes personal hygiene to prevent various infections and highly recomends hand washing at critical times as presenyed in **Chart 12**. The HH Survey results show that 98.7% of the sampled households wash hands before eating; 88.3% after using the latrine; and 37.1% after changing the baby's nappies. The proportion of households washing hands before preparing food or cooking is negligible only 1.3% of the sample. Therefor there is is need for intensive personal hygiene education especially on hand washing as a preventive action against infections.



4. Community satisfaction with the delivery of water & sanitation services delivery

The satisfaction in all services delivery is rated above 60% by the community with more satisfaction in the distance to the water facility (88.8% of sampled HHs) and water quality (88.8%) **Chart 13**. Availability of skills for water facility maitenance is also acknowledged with 79.2% of HHs as well as the performance of WPMc (76.6%). The other services delivery is only moderately rated (60.9% – 62.4% of the sampled HHs). The high rating for services delivey is an acknowledgement and appreciation of the contrbution the programme has made towards improving the living standard of the community in the targeted area especially access to clean and safe water.



5. Other attributes of the MBSP

5.1 Capacity building of WPMCs

Through the MBSP there have been a number of capacity building initiatives including training of WPMCs who have a mamoth task of overseeing the operations of the water facilities and managing the water facility maintenance fund. Based on FGDs the training exposed the WPMCs to discover and recognize their roles and responsibilities, understand water facility components and how it operates, and how to maintain the water facility through mechanics based in their own communities. In summary the WPMC training covered: -

- Clarification on the roles and responsibilities of the WPMCs;
- Trained in Village Level Operation & Maintenance (VLOM) - open the pump, check worn out parts, and repair;
- Service and maintenance of the water facility when it breaks down;
- Hygiene around the water point – regularly cleaning the water facility area;
- Collecting contributions from households that use the water facility and purchase spare parts;
- Regularly remove waste water from the waste tank;

- Landscaping around the water facility; and
- Oversee usage of the water facility and ensure that children do not misuse the water facility.

However, the strategy to facilitate the availability of spare parts in the communities did not work out as planned because the local shop owners/traders perceived water facility spare parts as slow moving items that could just tie up their capital, based on KIIs with WMAs, CDAs, and HSAs.

5.2 Capacity building of frontline extension staff (HSAs/CDAs/WMAs)

Front line staff normally coordinate their activities at community level hence the training targets all the categories together. During KIIs with frontline staff, under the MBSP they have been trained in village level operations and maintenance (VLOM) of water facilities to enable them provide technical backstopping where necessary. Besides VLOM they have also been oriented to sanitation and hygiene education and have acquired facilitation skills in the CLTS approach. This has enhanced their delivery capacity at community level.

6. Recommendations

a. Sustainability of the water facility maintenance fund – the current arrangement to solely depend on household contributions is proving to be risky in terms of community capacity to raise adequate financial resources for maintenance in case of a major breakdown. Other avenues for beefing up the water facility maintenance fund need to be explored and the VSL concept is potentially a viable mechanism for that. The CDAs as frontline extension workers are already on the ground and can be utilized to orient the WPMCs to the VSL concept.

b. Improved transparency and accountability in the management of the water facility maintenance fund – the fact that some members in the community abstain from the contribution reflects mistrust between the community and the water committees. There has been little transparency in the way the contributions are managed. An improvement would be: a) to involve local leaders in the communities where they are not actively involved; b) schedule monthly meetings for the WPMCs to interact and share information on the status of the fund and get community feedback; and c) introduce a simple cash book system whereby all transactions are recorded for water users to inspect. This would instil confidence in community members and motivate non-payers to start contributing to the fund.

c. Re-construction of waste tanks around the water facilities - the overflow in waste tanks is a potential risk for disease outbreaks if the situation is not well managed. Therefore the waste tanks need to re-done in order to maintain hygienic standards at the water points.

d. In terms of sanitation, the ODF status may be under threat as most of the latrine structures are temporary in nature and require replacement or maintenance once or twice every year. Without infrastructural support especially for dome slabs the latrine structures remain vulnerability to weather conditions. A review of the policy on the dome slab may help to promote and sustain the CLTS approach.