National Audit Office

Qualitative Research for a Value for Money Study on DFID's Work in Malawi

Final Report

24th April 2009

Prepared by

ITAD

in association with

Kadale Consultants

Acknowledgements

This study has been prepared by ITAD (UK) in association with Kadale Consultants, Malawi. The fieldwork was undertaken in the districts of Mulanje, Salima and Mzimba, and the team would like to thank the district officials, Traditional Authorities and Village Heads who helped facilitate access to the villages, non-governmental organisations and other staff. The team is particularly grateful to all those people who were willing to take part in the interviews and discussion groups, and to share their views with the team. Nonetheless, full responsibility for the text of this report rests with the authors.

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Acronyms and Abbreviations

AEDO	Agriculture Extension Development Officer
AISP	Agriculture Input Subsidy Programme
BLM	Banja La Mtsogolo
CAP	Country Assistance Plan
CHAM	Christian Hospitals Association of Malawi
DADO	District Agriculture and Development Officer
DC	District Commissioner
DEC	District Executive Committee
DEM	District Education Manager
DF	Director of Finance
DFID	Department for International Development, UK
DHO	District Health Officer
DLO	District Labour Officer
DPD	Director of Planning and Development
DSAO	District Social Affairs Officer
EHP	Essential Health Package
EHRP	Emergency Human Resources Programme
FGD	Focus Group Discussion
GoM	Government of Malawi
HSA	Health Surveillance Assistant
LSP	Local Service Provider
MA	Medical Assistant

MDG	Millennium Development Goal
MEJN	Malawi Economic Justice Network
MHEN	Malawi Health Equity Network
MK	Malawi Kwacha
NAO	National Audit Office, UK
NGO	Non Governmental Organisation
PAC	Committee of Public Accounts
PLWA	People Living With HIV/AIDS
PMTCT	Prevention of Mother-To-Child Transmission
SLA	Service Level Agreement
SSI	Semi Structured Interview
STI	Sexually Transmitted Infection
SWAp	Sector Wide Approach
TA	Traditional Authority
TB	Tuberculosis
TIP	Targeted Inputs Programme
ToR	Terms of Reference
UK	United Kingdom (of Great Britain and Northern Ireland)
VCT	Voluntary Counselling and Testing
VDC	Village Development Committee
VFM	Value for Money

1. Introduction

1.1 The National Audit Office (NAO) scrutinises public spending on behalf of Parliament in the UK. As part of its work, the NAO undertakes about sixty 'value for money' (VFM) studies per year. This work covers a wide range of issues and examines the economy, efficiency and effectiveness of public spending by Government departments and other public bodies.[1] These reports are considered by Parliament's Committee of Public Accounts (PAC), which seeks to draw lessons that can be applied to the future activity of the respective government department.

1.2 In 2009, the NAO will complete its first VFM study that considers the Department for International Development's (DFID) country-level operations as the primary unit of analysis. This purpose of this VFM study is to examine whether DFID is achieving what it set out to do in Malawi between 2003 and 2008.

1.3 This report (hereafter referred to as "the study") is an input into the main NAO VFM report that is to be published in autumn/ winter 2009. The purpose of this qualitative study is to summarize the main findings from the primary data collection undertaken in Malawi between February and March 2009. The aim is to capture the views of beneficiaries, district officials and local service providers on progress in the health and agriculture/social protection sectors over the past five years, including the challenges and constraints to service provision. The study also aims to provide insight into the lives of ordinary people and officials and in doing so, highlight some of the realities faced by people on the ground.

1.4 This study report is structured in five main parts. The first part describes how the research and analysis was conducted including the advantages and drawbacks of the evidence base (Chapter 2: Methodology). The main body of the text is then split into two chapters on findings; the first on health (Chapter 3: Findings: The Health Sector) and the second on agriculture/ social protection (Chapter 4: Findings: Agriculture and Social Protection). The final chapter then presents the main summary and conclusions of the study (Chapter 5: Summary and Conclusions).

[1] The 'value for money' criteria focuses on: (i) the *economy* (minimising the costs of resources used for an activity, with regard to the appropriate quality); (ii) the *efficiency* (the relationship between the output such as goods, services or other results, and the resources used to produce them), and; (iii) the *effectiveness* (the relationship between the intended impact and the actual impact of an activity or product).

2. Methodology

2.1 This chapter describes how the research and analysis was conducted, including the advantages and drawbacks of the methodology. For this study, the quality and rigour is especially important, particularly as this is not a "stand alone" report but will be used by the NAO to draft its own VFM report to Parliament. This section therefore provides not only a description of the methods employed, but also sets out the basis by which the evidence has been used to allow the reader to make an judgement on the extent to which more generalizable findings can be derived. This approach is followed up in the next chapter, where the presentation of the findings makes clear reference to the underlying evidence base.

2.2 The structure of this chapter is as follows. Firstly, an overview of the key questions and design of the study. Secondly, a description of the methods used for selecting the districts, locations and participants for the study. This is then followed by a summary of the data collection tools, and then finally a description of the approach used for data recording and analysis.

Overview of the research design

2.3 DFID has spent nearly £400 million in Malawi over the past five years. The objectives for its country programme are set out in two consecutive Country Assistance Plans (CAPs).[2] The major part of the NAO VFM report is to assess DFID's achievements against the objectives set out in the CAPs, including reasons for success or under-performance. In broad terms, the VFM study seeks to answer three main questions:[3]

- Is DFID achieving what it set out to at the *national level*? Here the study will focus on progress against national targets such as the Millennium Development Goals (MDGs) and DFID's country assistance plans.
- Is DFID achieving what it set out to at sector level in two *case study sectors* (health and agriculture/ social protection)?
- Is DFID achieving what it set out to achieve at the *project level*? The study will examine a sample of DFID projects, including those in or contributing to the two case study sectors.

2.4 As mentioned earlier, this study is an input into the main VFM report. This study only focuses on the two case studies sectors (health and agriculture/social protection), and the DFID-funded programmes within these sectors. The interventions funded by DFID in these sectors can be summarised as follows:

[2] The CAP 2003-2006, and the draft CAP 2007-2011.

[3] Page 1 of the Terms of Reference, Annex D.

- *Agriculture and social protection:* Over the years, DFID has supported a series of programmes that have distributed fertilizer and seeds, or helped subsidize these agricultural inputs. The latest such support is to Malawi's national Agricultural Input Subsidy Programme (AISP). This is a Government of Malawi (GoM) programme that aims to increase access to cheaper fertiliser and seed for roughly 50 percent of farmers in Malawi. DFID is also supporting the GoM to develop a new national social protection policy and programme to tackle chronic poverty and vulnerability.
- *Health:* DFID is a significant contributor to health in Malawi, and a development partner in the Health Sector Wide Approach (SWAp), including the Essential Health Package (EHP) that addresses human resources, drugs and medical supplies, infrastructure, medical equipment, district-level delivery and central support to service delivery. DFID also supports the complementary Emergency Human Resources Programme (EHRP), which seeks to address the acute lack of health professionals in the sector.

2.5 Making the link between DFID-funded interventions and the experiences of local people is however highly challenging. There are several reasons for this: Firstly, DFID-Malawi has moved further upstream over the years; away from individual projects that may show good results in one particular location, and more towards addressing the underlying structural and institutional concerns that affect people across the whole nation. For instance, DFID's support to the health SWAp seeks to improve the health system, and address some of the structural problems that undermine service delivery (such as a lack of health professionals). As such, the chain of links between DFID's support (advisory, technical, financial) on the one hand, and the eventual changes in people's lives on the other, is highly complex and at times weak in terms of direct attribution. Secondly, DFID increasingly cooperates with other donors and supports the programmes of the GoM. For example, support to the GoM's subsidy for inorganic fertiliser under the AISP in 2006. Therefore rather than many donors supporting many similar projects, there are benefits in donors working together to both reduce transaction costs and increase the effectiveness of development aid.[4] As a consequence of this approach however, it is often very difficult (and even undesirable) to isolate the contribution of any one individual donor and attribute such contributions to specific results.

2.6 The approach of this study therefore leans more towards *understanding the contribution* of DFID support to changes in service provision and the lives of people, rather than necessarily providing affirmative evidence of attribution.[5] The study seeks to

[4] DFID is a signatory of the Paris Declaration 2005, an international agreement that seeks to increase efforts to better harmonise, align and manage aid more effectively.

[5] Contribution means *to help to achieve something*, whereas attribution is a direct effect, i.e. that *something caused by something else*.

do this in two main ways: firstly, by capturing and assessing perceptions about progress in a particular sector or range of services (i.e. changes which are not necessarily attributed to DFID funding); and secondly, by asking questions about specific areas or programmes that DFID has supported. In health and agriculture particularly,[6] some of these programmes lend themselves to asking tangible questions at lower levels (the district level, and below). For example on the implementation of the input subsidy programme (on the distribution of coupons, or availability of fertiliser), or on the health sector (e.g. the availability of medicines, access to doctors, the quality of healthcare).

2.7 To summarise, the main objectives of this study are:[7]

- To examine *overall progress in the two sectors* (health and agriculture/social protection)
- To examine the *delivery of services by the government*, given DFID's support to the government of Malawi through General Budget Support, and also specific government programmes
- To capture *perceptions of corruption* in the delivery of services
- To focus on *specific areas that DFID has supported*, for example the Emergency Human Resources Programme in the health sector, and the Agricultural Input Subsidy Programme in the agriculture sector
- To collate and analyse *perceptions of problems and successes* in the implementation of projects or programmes in these sectors, and their experiences of the results.

Sampling and selection methods

2.8 The study employs qualitative techniques (semi-structured interviews, focus group discussions) in 3 locations in each of the 3 selected districts/ regions (9 locations total). Overall, 36 FGDs were conducted, plus 18 SSIs with district officials and a further 54 SSIs with local service providers. See table, below.

Table 1. Summary of interviews and focus group discussions, by region

	FGDs: Beneficiaries	SSIs: District Officials	SSIs: Local Service Providers
South (Mulanje)	12	6	19
Central (Salima)	12	6	18
North (Mzimba)	12	6	17
Total	**36**	**18**	**54**

[6] Social protection is not included here, as DFID programmes supporting social protection are relatively recent and small-scale, and thus were unlikely (and indeed did not) feature in the sampled areas.
[7] Based on the Terms of Reference (Annex D, page 2) and summarised in the ITAD-Kadale technical proposal (page 7).

2.9 While the selection of districts, locations and participants is not meant to constitute a statistically representative sample, it was nonetheless important that districts were selected with broadly "representative" characteristics, and were likely to provide interviewee experiences and perceptions that are prevalent across Malawi as a whole. The approach to selection is set out in the sections that follow.

District selection

2.10 In selecting one district per region (north, central, south), six main criteria were considered. These are:[8]

- *Remoteness:* At least one of the districts being relatively remote.
- *Budgetary allocations:* Health per capita allocations vary between districts. For example, the Malawi Health Equity Network (MHEN) gives per capita allocations of health budgets by district (page 26 of the MHEN Budget Analysis of 2007/8 Health Budget).
- *Agro-ecological conditions and type of agriculture practiced:* Because of the focus on agriculture/ social protection of this study, it is important to capture the variation in agro-ecological conditions. However, only major variations in agricultural practices should be captured, i.e. very unusual districts were not to be chosen.
- *Politics:* Highly politicised districts to be avoided. However, if politics plays a part in service delivery, variations in how this affects different districts were to be captured.
- *Poverty:* Malawi Poverty and Vulnerability Assessment gives poverty levels for the districts (page 37 of the MHEN Budget Analysis of 2007/8 Health Budget).
- *Quality of services/ programmes in chosen sectors:* There is some data on the quality of services/ programmes, i.e. data from Malawi Economic Justice Network (MEJN) Service Delivery Satisfaction Survey 2006, and data available in DFID project documentation on health e.g. doctors per head of population.

2.11 The final three districts were purposively selected from a shortlist of nine districts (see Annex 4 for details). DFID Malawi were consulted and consented to the selection. The objective of the selection process was to obtain a reasonable diversity between the three districts, but omitting the most extreme 'outlier' districts that are clearly unique compared to the rest of Malawi – and ideally a range of above and below 'average' districts that could provide more interesting comparisons. It became necessary, for the purpose of this study, to select districts on the basis of a *combination* of districts in order to reflect the range of health and agricultural issues in Malawi and across the three regions. Therefore the initial selection grouped the districts into regional combinations that were considered to do justice to the range of issues being considered. This included

[8] NAO notes on "District Selection Criteria", 23rd December 2008.

one lakeshore district (to highlight differences in agriculture/ ecology) and one relatively remote district (to highlight issues concerning people's access to services).

2.12 The final selection was: *Mulanje* (southern region), *Salima* (central region) and *Mzimba* (northern region). Mulanje district has the highest poverty incidence and highest ratio of population to doctor, while Salima represents the countries average district by these criteria. Salima also exhibits a mix of fishing and agricultural cash crops in addition to lakeside tourism activities, while Mulanje is predominantly tea estates and other cash crops. Furthermore, the Mulanje/ Mzimba combination covers a wide variety of crops, farm size and farming practices – especially when compared to other options such as Ntchisi/ Mzimba, which has a similar agricultural base (dominated by maize production). Mzimba is also relatively more remote than the other two selected districts and although the ratio of population to doctors is low, poor infrastructure means there is still difficulty in accessing health services. Admittedly, Mzimba was not as remote as some other districts, yet it was considered as *suitably* remote for the purpose of this study; the district capital is over 200km to the north of Lilongwe, and the size of the district means there are plenty of remote peripheral areas within the district itself (i.e. infrastructure to the outlying parts of the district is generally basic).

Selecting locations

2.13 In each of the districts, 3 locations were selected with one at least 10km from a tarmac road, and one at least 20 km from a tarmac road, plus one other. This was done on the basis that the current research shows that villagers are more diverse (especially in terms of access to services) when selected according to the distance from a tarmac road.

2.14 A pilot was first conducted, and this only served to emphasise the importance of selecting areas *before* the meeting with the District Commissioner (DC) or Director of Planning and Development (DPD) – so that the team could resist any attempt by district officials to influence the selection of locations.

2.15 With regards to location selection, locations were first chosen to ensure coverage of the geographical spread and agro-ecological diversity of the district. For the former requirement this entailed taking stock of the size/ shape of the district and choosing three representative areas. As Mulanje is a roughly circular district with Mulanje massif dominating the eastern side, it was decided to choose areas to the north, west and south of the massif. As Salima and Mzimba are both long and narrow districts it was decided to take a north-central-south approach (as was the case for the overall selection of the districts in Malawi). The next step was to select villages on the basis of agro-ecological conditions as well as the 'distance from tarmac road' criteria. The villages identified are listed below (in the order that they were visited):

MULANJE:

1. **(North) TA Nkanda – KAMBENJE Village (20km from tarmac road):** Located to the north of the Mulanje massif, TA Nkanda is a mix of grasslands and rain fed

cultivation typical of the northern area of Mulanje district. Kambenje village was the first village arrived at after 20km of driving on the only passable earth road leading around the massif into this northern area.

2. **(South) TA Mabuka – BONDO Village (10km from tarmac road):** TA Mabuka has the highest concentration of teas estates in Mulanje district. The area surrounding the southern base of the massif also hosts an abundant mix of rain fed cultivation and woodland. We took the first earth road that leads towards the southern face of the massif and travelled 10km to arrive at Bondo village.

3. **(West) TA Nthiramanja – NTHIRAMANJA Village (5km from tarmac road):** The west of Mulanje district is predominantly rain fed cultivation. Nthiramanja is the first village arrived on an earth road off of the main tarmac road leading west out of the district.

SALIMA:

1. **(North) TA Mwanza - MAKIONI Village (15km from tarmac road):** This inland area contains the highest concentration of woodlands in the district in addition to rain fed cultivation. It also contains the longest earth road that is passable at this time of year therefore we decided to locate the 20km-from-tarmac-road village in this area. Unfortunately it was only possible to travel 15km down this road before reaching an impassable river. The village headman at this destination, Makioni, confirmed that it would be possible to call in villagers from the more remote villages over the river on the designated FGD day. As there were no other options for 20km from a tarmac road we decided to settle for this arrangement.

2. **(South) TA Ndindi – RABSON Village (5km from tarmac road):** This is a lake shore area, representative of the majority of rain fed cultivation in the south of the district. We took the first earth road after the southern trading centre of Chipoka and stopped at the first village reached after 5km.

3. **(Central) TA Kaluunda – CHIUTIRA Village (10km from tarmac road):** This is a lake shore area that exhibits grasslands, wetland cultivation, dimba cultivation, forest reserves and marshes. We took one of the two main earth roads into this area and stopped at the first village reached after 10km. The village is on the lake shore just after Lifuwu trading centre.

MZIMBA:

1. **(Central) TA Kampingo Sibande – KASOTI Village (5km from tarmac road):** This area is on a high plateau relative to the rest of the district and is classified as 'open canopy woodland of hills' on a biotic community map of the district (Mzimba Socio-Economic Profile). As the roads in this area are poor at this time of year we chose the first village that we reached after 5km off the tarmac road from Chikangawa trading centre.

2. **(North) TA Mtwalo – BALUBA CHIRWA Village (20km from tarmac road):** Classified 'open canopy woodland of plateaux' in the SEP, this area represents the majority mixed and rain fed cultivation in the north. It also represented the main area which contained villages 20km from a tarmac road. (There are two tarmac roads running N-S through Mzimba and the district boundaries are rarely more than 20km away from these roads – therefore it was necessary to choose a village between the two roads that was 20km from both.) From the main city in the north, Mzuzu, we travelled north on the M1 until we could turn-off onto an earth road that took us 20km to a village in the plains area.

3. **(South) TA Mabulabo – DANIEL JERE Village (10km from tarmac road):** Mabulabo TA is a representative area of the south of the Mzimba where there is predominantly rain fed/mixed cultivation. As we had already chosen our 20km and 5km village we took the first earth road into this area and selected the first village we reached after 10km.

Data collection tools

2.16 The main tools for the data collection were Focus Group Discussions (FGDs) and Semi Structured Interviews (SSIs), with the work divided into three packages according to the type of respondent:

- Package A: FGDs with local people/ beneficiaries
- Package B: SSIs with district level officials
- Package C: SSIs with local service providers

2.17 These tools were first piloted in a rural area in the district of Blantyre, from 21-22 January 2009. The first day was spent at the *district level*, undertaking semi-structured interviews (SSIs) with district officials and service providers. The second day took place at the *village level*, undertaking the Focus Group Discussions (FGDs). The pilot was used to primarily test and finalise the topic guides, as well as to help normalise the team's methods and develop a consistent approach to the study. The pilot in particular addressed the following issues:[9] (i) revisions to topic guides; (ii) the selection of district officials and service providers; (iii) the selection of locations within districts; (iv) the negotiation of access to participants and introducing the study to Village Heads; (v) the selection of participants for the FGDs; (vi) the conduct of facilitators in undertaking the FGDs and SSIs; (vii) data recording; and (viii) the approach to the analysis.

FGDs with beneficiaries (Package A)

2.18 As communities are not homogenous, the process of selecting participants for the study is particularly important to capture a cross-section of views from the community. Gender was considered to be a key factor in shaping differences in opinion; particularly

[9] See: "Planning report for NAO-ITAD / DFID Evaluation", 27th January 2009.

for health issues (e.g. pregnancy, child rearing, malnutrition), plus many farming tasks are split along gender lines (e.g. working the fields, growing cash crops versus vegetable gardening, selling at the market). The FGDs were therefore divided into groups for "women in agriculture", "men in agriculture",[10] "women in health", and "men in health".

2.19 Other factors such as age and poverty status were also considered, and this was mainly achieved during the FGDs as the poorest, elderly and disabled were often present. Dividing discussions groups into wealth categories was seen as too cumbersome for the purposes of this study (e.g. using techniques such as wealth ranking). Instead the views of the poorest, disadvantaged and vulnerable were captured by targeting some questions at these participants during the discussions.

2.20 One of the other challenges of selecting participants for the FGDs is including people who are either less interested or less dominant. The risk is that if only those who are interested attend, the results may be biased towards the more powerful, able and articulate. To minimise this, two steps in the selection process were undertaken:

- *Finding a pool of participants:* The field supervisor first met the Village Head (or Group Village Head) in advance the visit by the field team. This was to explain the purpose of the fieldwork, and how the team wished to proceed. The field supervisor then asked the Village Head to invite participants, with a particular emphasis on including the poorest/ oldest/ youth/ disabled and vulnerable.[11]
- *Recruiting participants:* From the people who were present on the day of the FGDs, the facilitators selected ten people for each FGD. The facilitators selected the participants who fitted the criteria, drawing out people for male and female FGDs in the morning ("men on agriculture", "women on health"). From the remainder they selected those who would attend the afternoon FGDs ("men on health", "women on agriculture"). The groups were limited to five to ten people, though in most villages others gathered around to listen in, and these people were also recorded on the participant lists.

[10] The term "in agriculture" is used broadly here as the topic checklists for the FGDs also covered aspects of the natural resource base (soil, forestry, etc) and social protection (reaching the most vulnerable, cash-for-work programmes, etc). See Annex 5 for details.

[11] During the pilot it was found that by just relaying the message through district officials resulted in too many villagers turning up, with most being members of the Village Development Committee (VDC). The methodology for the main fieldwork was therefore modified to reduce potential selection bias. Firstly the field supervisor met the Village Head in advance, followed by an official letter to the Traditional Authority or Village Head, and then the team visit. This process was used to both clarify the studies purpose and help ensure that the Village Head selected a range of participants. The team also insisted on the right to select randomly from the villagers according to the requirements of the study.

SSIs with district officials (Package B)

2.21 SSIs were conducted with a selection of district officials located at the district office, or *boma*. As is customary, an initial meeting was first conducted with the District Commissioner (DC) or another senior figure, to explain the task of the field team. After this, meetings were held with the following key individuals: the Director of Planning and Development (DPD), District Agricultural Development Officer (DADO), District Health Officer (DHO), the Director of Finance (DF), District Social Affairs Officer (DSAO) and District Labour Officer (DLO). Where opportunities arose, or when of the aforementioned officials was unavailable, interviews were also undertaken with other 'key informants'; those people that have a particular insight or knowledge about the topic to be discussed (such as historical knowledge, or particular technical insights). A full list of interviewees is provided in Annex 3.

2.22 An introductory script was used to ensure that a consistent approach was undertaken by all facilitators. This script explained the purpose of the study, that their views would be treated as confidential, as well as introducing the approach to data recording.

SSIs with local service providers (Package C)

2.23 The SSIs with local service providers were conducted in a similar manner to those undertaken with the district officials. The list of possible interviewees however varied far more between districts. The bulk of the names of local service providers was elicited from two main sources: (i) Interviews with district officials, during which they mentioned particular service providers operating in the area (especially in health and agriculture/ social protection); and, (ii) In the meeting with the Village Head (or Group Village Head) prior to starting the FGDs.

2.24 The selection of local service providers relied heavily on local knowledge. Often this was achieved using a "snowball sampling" method, whereby interviews with particular professionals led to other possible names for interview. A particular emphasis was placed on purposively selecting *key* informants, rather than attempting to cover a seemingly endless list of interviewees involved in health (doctors, nurses, clinic administrators, pharmacists, midwives, health extension workers, health surveillance assistants, etc) or agriculture/ social protection (extension workers and advisers, subsidy administrators, village heads, ADMARC staff, traders, etc).

Topic guides

2.25 The actual topic guides used by the study are presented in Annex 5. In general, all the topic guides followed a consistent structure. This is summarised below:

Section A: Outcomes	A1: Current status in the sector
	A2: Overall changes compared to 5 years ago
	A3: Unpacking the answers to A1 and A2
Section B: Reasons for changes	
Section C: Delivery of services	C1: Range of services provided
	C2: Use and benefit from services
	C3: Adequacy of services
Section D: Wider outcomes	D1: Impact of services/ programmes on poverty
	D2: Other significant causes for changes in poverty

Data recording and analysis

2.26 All SSIs and FGDs were audio recorded, with full written transcripts of the SSIs and detailed notes from the FGDs – the latter because of difficulties with sound recording (people spoke quietly, were distant from the microphone, or there were other noises such as rain falling on corrugated iron roofs). Also, the FGDs were conducted in Chichewa (and hence the audio recordings are in Chichewa, but with the notes transcribed into English). The SSIs were conducted in English. At each SSI and FGD, the facilitators mentioned the voice recorder and the need for it – there were no objections to its use (except in one case)[12] and all interviews and discussions appeared to flow freely.

2.27 In order to ensure consistency and familiarity with the subjects, the facilitators were paired with the same note-taker. The note-taker was responsible for switching on/ off the recording equipment, checking sound quality and labelling all tape recordings. The note-taker also took comprehensive notes during the FGDs, helping to free up the facilitator to concentrate on the topics under discussion. For the SSIs it was originally thought that the audio recording device would be sufficient, without the need for a note-taker to be present. In practice, note-takers found that in order to grasp the flow of conversation, they would still have to listen to the whole interview anyway and take notes before transcribing. As such, note-takers were also present during the SSIs to take detailed notes. At the end of the discussions, the note-taker would also write down any observations, such as the group dynamics or circumstances that might affect the quality and interpretation of the information collected. Each FGD/ SSI was allocated a code/ file name to identify the transcript and audio recording. For example: "*Mu-A2-Agric(M)*" for "Mu" (Mulanje), "A" (FGDs with beneficiaries), "2" (Village 2), and "Agric(M)" (Males

[12] One district official objected on the basis of a previous bad experience of being quoted out of context, so no data recording exists for this interview.

in agriculture/ social protection). These references were included in earlier versions of this report for ease of reference and transparency. They have however been removed for the final report to protect the identity of participants and the confidentiality of the discussions.

2.28 In order to ensure the accuracy of content and the correct transcription of technical terms and acronyms, the facilitators worked closely with the data recorders on the FGD transcripts and edited the transcripts before submission to the dataset. All of the SSI transcripts were crosschecked for accuracy by a third person who listened to the recording and corrected the first draft transcripts for missing words or sections so that they accurately reflected the discussion, verbatim. A final check was undertaken of every transcript for punctuation and formatting. A data collection sheet was used to record each person that handled the transcript – the original recorder, the cross-checker and the final editor. The facilitators were not involved in the production of SSI transcripts (unless they were cross-checking).

Method of analysis

2.29 The process of data analysis commenced as part of the data collection rather than, as often the case, being viewed as a separate task to be completed at the end of the assignment. The method of analysis followed a number of key steps:

- Firstly, *during* the FGDs and SSIs, the facilitators were briefed to listen for vague or inconsistent comments and probe for further understanding where necessary.
- In the *evenings*, the field team met briefly to discuss the main themes arising from that day. This was a fairly straightforward process, using questions like: What seemed to be the key themes of the today's discussions? What was surprising? How did the discussions compare with the previous day? Are there any common ideas or findings that emerge?
- Then, *after* returning from the field, the field teams organised a de-brief meeting to draw out and record emerging themes. At these meetings, notes were made of key findings, as well as differences between health and agriculture/ social protection, between socio-economic groups (male/ female; young/ old; better-off/ poorest), between locations (distance from tarmac road), and between districts.

2.30 The result of this process is a set of summaries that highlight the emerging themes from each of the three districts. The idea behind this process is to capture the tacit knowledge of the field team, who between them have listened to *all* the discussions and interviews. These summaries provide a useful basis for identifying the overall 'storyline' that link the main findings, as well as a starting point for 'coding' the data to draw out paragraphs and sections related to a particular theme.

2.31 For purpose of the main NAO VFM report, it is also important that this study demonstrates the rigour of the evidence base and presents the main findings in a transparent manner. As such, it is essential that the analysis be not solely based on such

district summaries, which may be (unintentionally) selective. Therefore, whilst the nature of the research does not lend itself to quantitative findings, the analysis has been undertaken in a systematic way to demonstrate the prevalence of opinions, views and experiences amongst the different respondents:

- For each question, the answers were coded (using MAXQDA)[13] to draw out the *'big picture'* issues that can be summarised in frequency tables. So for example, question A2 asks about changes over the past 5 years. These qualitative answers were coded in broad terms, such as on a scale from "improving" through to "worsening", and then summarised in a frequency table.
- Then, in cases where the frequency of particular answers is high, these have been *further disaggregated* by gender (male, female), district (Mulanje, Salima, Mzimba) and distance from a tarmac road. This is particularly useful for questions such as C2 where the list of the barriers to using services can be quite long; i.e. the first frequency table gives the range of answers (from lack of medicines, through to distance to the health centre), and this second disaggregated table provides a more in-depth analysis of the more frequently occurring issues.
- Then, for each of the main issues, the *qualitative information* was extracted in the form of summary tables – allowing shorter sections or answers to be compared across the different transcripts. This provided the basis for a further analysis of common themes, insightful comments or outliers – as well as the source material for quotations.
- Finally, *quotations* were extracted, and particularly those that help illustrate a key finding or that were particularly insightful. These can be referenced back to the original transcript.

2.32 The advantage of undertaking the process in this way is that it is possible to present the findings in a very transparent manner; i.e. so that words such as "a few", "several", "many" or "most" can be supported with figures or percentages. So for example, it is possible to say with confidence phrases like, "*a few district officials (2 out of 18) said…*", or "*most women (8 out of 9 FGDs) thought that…*". The figures are not statistically robust, and we are not interested in the figures per se. They do however inform the reader about whether a particular issue is a problem in just one location, or whether it is more prevalent. This is important to prevent exceptional circumstances (or the opinions of one individual) being misinterpreted as widespread or a common issue. The following chapters present the results of this analysis in this way.

[13] Software for the analysis of qualitative data.

3. Findings on the health sector

3.1 This section summarises the findings from the FGDs on health (women/ men), the SSIs with district officials, particularly the District Health Officers (DHOs), as well as SSIs with local service providers and others (including health workers, Traditional Authorities and Village Heads). The section is structured in three main parts: (i) Health outcomes, including perceptions of disease incidence and health challenges; (ii) Perceptions about changes in health status, including reasons for these changes; and, (iii) The delivery of services, covering access and adequacy of provision.

A. Health status

3.2 In general, villagers view the current state of health in their area as not particularly good.[14] A whole range of issues were cited, with respondents often intertwining the most common *diseases* (cholera, diarrhoea, malaria, dysentery, skin infections, HIV/AIDS) with the *perceived causes* (hunger, dysfunctional boreholes, poorly constructed latrines, poor hygiene practices) and the *challenges of obtaining treatment* (long distances to health centres, not enough medical staff, poorly qualified medical assistants, medicines running out, insufficient beds, etc). This section separates out this complex reality, and does so by focusing on two main aspects: (i) the current health status in terms of perceptions of disease incidence, (ii) the challenges people face in terms of health.

Disease incidence

3.3 Villagers were prompted about a range of diseases and whether they thought these were commonly occurring or otherwise. While this does not provide a statistically representative picture of the current health status, it does provide some insights into the issues that concern ordinary people. Overall, the discussions revealed that HIV/AIDS and malaria were considered widespread; understanding of reproductive health seems to have generally improved in recent years but there are still problems gaining access to family planning methods; the perceived incidence of malnutrition appears to vary from place-to-place; tuberculosis is mostly viewed in terms of being present yet treatable; and schistosomiasis (bilharzias) is seen as generally rare – though more common in Salima and Mulanje.

3.4 **HIV/AIDS and other Sexually Transmitted Infections (STIs):** All the village discussion groups mentioned that HIV/AIDS is present in their areas, with several saying that the incidence is high (5 out of 18 FGDs). Some stated that people are more open about the disease than previously, with one person explaining that their community is now open enough to mention the causes of death at funerals, i.e. with those who had died of AIDS being announced as such. In a few discussions however,

[14] 9 out of 18 FGDs gave negative responses when asked about how they perceive the current status of health in their area, plus a further 6 FGDs gave a mixture of negative and positive comments. Only 3 FGDs gave a generally positive response.

people said that people still fear being stigmatised if they are found to be positive (3 out of 18 FGDs). For example, "*Those who can reveal their HIV positive status are stigmatized in various ways. These people are mocked and this makes people not to be interested in coming in the open and going for VCT to know their very own status. So I can say things are moving but there are hiccups. We have a CBO [community based organisation] where people meet to talk and teach each other about HIV/AIDS. Some are there who have exposed themselves and revealed their status and others are sick there but don't have any aid*".

3.5 While awareness of HIV/AIDS appeared to be high amongst the communities visited, there was little mention of other STIs (e.g. gonorrhoea and syphilis). Only 6 FGDs (out of 18) mentioned other STIs, and the majority of these (5) said that it was difficult to know about these problems as they are not discussed: "*On STIs, there might be there but it's difficult for us to know as it is a secret between husband and wife*".

3.6 **Malaria:** People generally viewed malaria as a continuing "problem" (10 out of 18 FGDs), although some view the situation as "okay" or are beginning to feel more protected (5 out of 18 FGDs). Of those that perceive malaria as an on-going problem, most attributed it to difficulties in getting hold of mosquito nets (7 FGDs), while others saw the issue as one of not knowing how to treat nets (1), ineffective medicines (1), or the long distances needed to get treatment from the hospital (1). As one person said, "*It is really a problem as in the past, there were PSI [Population Services International] who were selling mosquito nets but they are not there anymore. There were Anglican people who just collected names here but there's no progress. We had hoped that by this time we would have nets but nothing so far. We just sleep, we wrap blankets up to the head so when it is hot at night, we find our heads out of blankets. So malaria is a big problem*".

3.7 It was noted that mosquito nets seem to be prioritised more towards pregnant women or mothers with young children (5 FGDs): "*We have malaria frequently because we don't have nets. They give nets to those who have babies or to those who are pregnant, if we the old people go there (to the health centre) they tell us that there are no malaria drugs, go and buy drugs from the shop, so we come back from the health centre with nothing and we don't have money to buy drugs*". Some groups in society therefore find it difficult to get hold of nets: "*It's a problem especially for the elderly and the poor who can't afford to buy nets which are so expensive, and also a problem to those families who don't have under five babies*" .

3.8 **Reproductive health[15]:** Views on family planning were split. Firstly, many felt that understanding about the need for services, the range of services and access to methods of choice had improved (10 out of 18 FGDs): "*We get reproductive health education even from church, volunteers and most men and women are now taking part in family planning activities"*. And secondly, others felt that there continued to be problems gaining access to methods or that they don't practice them (8 out of 18 FGDs). Among the former

[15] This section focuses on family planning aspects of reproductive health, since STIs were discussed in the previous section

group, the views were fairly evenly split between women (6) and men (4). There were geographical differences however, with more positive views being held in the southern and central regions (5/6 groups in Mulanje (5 FGDs) and 4/6 groups in Salima), than in the northern district of Mzimba (1/6 groups).

3.9 Among those who choose not to use or have problems gaining access to family planning methods (8 FGDs), misconceptions and rumours persist. For example there are claims that women who use family planning methods have swellings in the abdomen; these scare young mothers who end up not using contraception and instead have children every year. When people experience complications or difficulties, word seems to spread quickly. As one person explained, "*Here in the village if we hear that something is bad, then we all believe that it is indeed bad*". Examples of this include:

> *"Many women are facing problems with family planning methods they used; some used pills, and some used injection methods. But on injection method, many women are encountering problems. To some this method seems to be compatible but had problems when they do their monthly cycle lost a lot of blood with some things that we couldn't understand. This is forcing many women to quit this method and they are now adopting condom methods. On pills, many faced a problem of abdominal complications and at other times the nurses were telling our women that the 'family planning methods are not good and they were advocating them only because by virtue of their employment, they are demanded to do so".*

3.10 Cultural factors and religious teachings also affect access to and utilisation of services. For instance, "*We believe that to have a lot of children is a good thing and this makes family planning methods not to be followed properly*". Or, "*People are taught all the methods but what people find to be good to them it's that of injection. But then, there are other people who do family planning basing on what their religion says and not the health instructions. Like I have already said that some of us are Moslems and the Quran tells us that every woman should breast-feed a baby up until three years. If she breast feeds the baby for two years, then in the third year it's when she will be thinking of having another baby. That is what most of us are using".*

3.11 People also noted specific problems in accessing a range of reproductive health options:

> *"…family planning methods that are available are not enough as there are only injection and pills method. The BLM [Banja La Mtsogolo] come once a month but they also don't bring all the methods. When they came last week, they didn't have a …and most women went back without taking any of the methods".*

3.12 In terms of safe motherhood, most respondents said that expectant mothers delivered at the health facility or hospital (9 out of 12 FGDs),[16] with only a few mentioning that women generally delivered en route (2 FGDs) or at home (1 FGD). A common sentiment was that most women do not deliver in the homes now: "*When we go*

[16] There are 18 FGDs in total but the others did not discuss the issues (6 FGDs), hence the total is 12.

to antenatal clinics, we are asked to come and deliver at the health centre and not at the Traditional Birth Attendants. Once the labour starts, we tell people to escort us to the health centre".

3.13 **Malnutrition and nutritional deficiencies:** Just over half of the groups (10 out of 18 FGDs) said that malnutrition and nutrition deficiency is common, especially among children (9 FGDs); with more groups of women than men citing it as an issue (6 out of the 9 FGDs). As one villager explains, "*Malnutrition and nutrition deficiency are there in our village, this is because of food scarcity. We eat once sometimes or not even eating for the whole day. This causes children to become malnourished… When one is given drugs at the health centre, he or she is supposed to eat first before taking the drugs. We are told to have porridge first before taking drugs but we have problems as there is no food here*". There are also some instances where there are not enough food supplements to meet demand: "*What saddens us is that there can be 10 malnourished children at the health centre but sometimes it's only four of those children who are able to get food supplements, but the kids are equally malnourished and we see food supplements being supplied and this is so sad to us. Food supplements that come to the health centre include Soya, cabbage, beans but it's only a few who can benefit. Women come and complain to us that they did go to the health centre but we have been sent back with nothing"*.

3.14 Of those that saw malnutrition as either not a problem or no longer a problem (8 out of 18 FGDs), the change is mostly (in 7 cases) attributed to improved access to food supplements from the health centre: "*previously there were a lot of malnourished children but now the number are reducing as children are getting "likuni phala" [a type of porridge] from the health centre*".[17] In addition to *likuni phala*, people also mention receiving soya flour and *chiponde* (a nutritional peanut butter). It thus seems that in some areas, food supplement programmes are making a difference. As one district official in Mulanje observed, "*in terms of food security we are making good strides but so far as malnutrition, cases in the district have gone down. Maybe we expect them to rise, maybe with this lean period, but generally there are positive strides being made. Even in our Nutrition Rehabilitation Unit (NRU) the number there has decreased*". Other health workers also made the link to nutritional programmes, for example:

> *"We have nutritional clinic for those with malnutrition, there are some with Oedema [fluid retention], and they are supposed to receive chiponde so we refer them to the nearest health centre instead of receiving here"*.
>
> *"Again on supplementary feeding programmes, we see that the malnutrition programme has improved even though it's seasonal, the cases have gone up, but not as it used to be in the past"*.

[17] Few other reasons for the improved situation were given, with one mention of better education on nutrition, and another of 'children being diagnosed more quickly'.

3.15 There are slight regional differences, with malnutrition being viewed as less of a problem in Mzimba (4/6 FGDs) and in Mulanje (3/6 FGDs), than in Salima (1/6FGD). As the District Labour Officer (DLO) in Mzimba explains, "*We have them [cases of malnutrition] but not as many because this time Mzimba has more food than other districts because we can see people coming here from other districts to buy maize here from south or central; here we are better off. Malnutrition cases are there but not as serious. When you go to the hospital we have wards for malnutrition children but the children are not as many*".

3.16 **Tuberculosis (TB):** In general people view TB as either not common (3 out 18 FGDs), or something that can be dealt with by referring to a health centre or hospital (11 out of 18 FGDs). Awareness in many of the groups appears high, with several groups explaining how they identify TB and when to go for testing (7 FGDs). For instance, "*In the past, most of us could just cough and kept on coughing without knowing why we are coughing. But now with the HSAs who visit us and show various videos on TB, how it starts and tells us to go to the health centre if we cough for more than three weeks. So we go and if one vomits blood, we rush him or her to the health centre. At the hospital we are given medication and we are cured*". And as another person adds, "*…on TB, we should not cheat each other here that TB is a big problem in our area because they have set up Sputum Collection Centres in our health centres unlike in the past when we used to go to Mulanje district hospital. it was difficult for one to get results and to start TB treatment but now we are able to get results from our health centres*". Of the few groups that saw TB as a continuing problem (3 out 18 FGDs), they cited that people don't want to reveal themselves and go to the hospital to get medication (2 FGDs), or that they have not been told about TB (1 FGD).

3.17 **Schistosomiasis (bilharzia):** People generally view schistosomiasis as uncommon (10 out of 17 FGDs), especially in Mzimba (all 6 FGDs). Of the others, some view it as very common or something that just exists, while the others see it as simply a treatable disease that occurs (7 FGDs). Of these, most are in Salima (4 FGDs), which is a lakeshore location, while the others in Mulanje, see its prevalence as more common during the rainy season. The generally held view is, "*Bilharzia is there, both children and adults get affected but the problem is that people do not want to come out in the open and go to the health centre to get medication. Drugs are also available at the health centre*".

Remarks:[18]

- The perceptions of local people are consistent with what might be expected; i.e. malaria and HIV/AIDS being viewed as the most prevalent, and with (perhaps) the greatest impact on the lives of ordinary people; plus, malnutrition viewed as much more location-specific, dependent on food harvests and the supply of supplements.

[18] The "Remarks" sections are the author's own conclusions, as distinct from the main body of this report which summarises the key findings from the qualitative data.

- Recent policy changes concerning the role of TBAs also appear to be widely known; with greater numbers of women seeking facility based maternal health care.
- The National TB Programme also appears to have been successful in ensuring that both key messages concerning TB and new sputum collection mechanisms are well known.
- It appears that some areas have benefited from greater availability of Family Planning, possibly related to the expansion of Banja La Mtsogolo's community and tent outreach initiatives, which provide key reproductive health services in under-served rural communities. This programme is in alignment with the Health SWAp and is part of the DFID package of support to the health sector.
- People are clear about some of the gaps in services for key disease areas, for example: (i) while people are now generally more open to HIV/AIDS testing, some who are tested positive are still stigmatised; (ii) while pregnant women and children have better access to bed-nets, access remains a problem for the poor and elderly; (iii) while food supplements from health centres make a difference to malnutrition in some areas, it is not consistently applied in every area; (iv) while there is improved understanding about reproductive health, there are still problems with access to family planning methods - something that continues to be hampered by cultural beliefs and misconceptions.

Health challenges

3.18 People face many health challenges in their daily lives, with 30 different challenges being identified by respondents; the 9 most frequent are shown in Table 2. Villagers highlight both challenges of health provision (e.g. lack or inadequacy of facilities, lack of health transportation, lack of adequate drugs, long distances, lack of staff) as well as making links to the broader context (e.g. hygiene practices, water scarcity, unsafe water, lack of transport and a lack of food). District officials and local service providers tend to focus more on the challenges within the health system rather than the broader context. Table 2 shows the challenges highlighted by type of respondent

Table 2. Most frequently cited health challenges

Challenge	Community Focus Groups	District officials	Local service providers
1. Lack of hygiene (bodily and in the home)	16	0	0
2. Scarce and unsafe water	13	0	0
3. Limited health care facilities	12	9	13
4. Insufficient food	8	0	0
5. Health centres far from communities	7	1	0
6. No ambulance/ lack of transport to health centre	6	1	11
7. Shortage of staff at health centres	5	5	11
8. Mosquito bites/Malaria	5	0	0
9. Mosquito nets not given to all	5	0	0

Source: Section A (health outcomes) for packages A, B and C.

3.19 The section that follows focuses on the broader contextual issues of hygiene, water supply and the lack of food. The challenges of healthcare provision (limited healthcare facilities, distances and transportation to health centres, and the shortage of staff) are discussed in detail under "Section C: Delivery of services".

3.20 **Lack of hygiene:** A lack of hygiene was the most frequently cited challenge for people's health status in their area (16 out of 18 FGDs). This was mostly linked to sanitation (toilets, bathrooms),[19] though also to food hygiene, the disposal of refuse, and general cleanliness (e.g. sweeping around homes, cutting down grasses to keep mosquitoes at bay, cleaning the buckets used for drawing water and covering them). For example:

> *"Sometimes when you sleep where you cook your food, you can risk diseases. A person needs to have everything like a toilet, kitchen and refuse pit. However, you can have everything like toilet, refuse pit, but if you don't take care of your body, then you can fall sick as well".*

> *"There is not much attention to people's houses [hygiene] as people construct toilets but they are not all strong as the area is sandy. Every household has a toilet but they are not very strong to withstand the rains. There are talks about construction of concrete toilets but that is not implemented – HSAs tell the chief that some NGOs will help in toilet construction but that doesn't come to pass".*

> *"For example, most of us here are Moslems who use water quite a lot on almost everything we are doing. When going to the toilet, we have to take a cup of water, after using the toilet, we use a toilet paper thereafter we use water and then we wash our hands to touch some other things. But there are other people who when they go to the toilet, they only use a toilet paper and don't wash their hands and then they touch food. Sometimes our friends who sell cooked foods like doughnuts, scones; it happens that they just touch the food with bare hands. This*

[19] 8 out of the 16 FGDs that mention hygiene as an issue.

threatens peoples health".

3.21 **Scarcity and unsafe water:** A lack of functioning boreholes or the long distances needed to fetch water was also a commonly cited reason for the health problems in the areas visited (13 out 18 FGDs). As one person put it, "*What is needed most in our area is water, we don't have good water as most of our already few boreholes are not functioning. You know water is life and without water, our health is not okay. We drink water from unprotected wells and rivers*". While the sample is too small to be representative, it seems that this is not specific to one particular locality or geographic region.[20] It does however appear to be more of an issue in Salima (all 6 FGDs). Examples from Salima include:

"Most of the times its water, for example in our village [Bwadzi] we drink water from unprotected wells and from the river. We don't have a borehole, so it's the water we drink from these places that give us diseases".

"Like we said, we drink water from the rivers. This water comes from far where we don't know, some [people] might be bathing in the same river. With this, our health can't be good".

"*The water we are drinking is not good, we drink from rivers and when we become sick, we just die on the way to the health centre as it is very far… we are told to boil water and put in chlorine but it doesn't work. Water is life".*

"The area has a lot of water as it is close to the lake, but the water is not safe to drink. The whole village has four boreholes of which two are not functioning".

3.22 Nonetheless, several district officials in Salima perceive the situation as having improved (mainly due to NGO activities), although borehole coverage and maintenance remain an issue. As the DADO explained, "*Salima is one of the districts that has more boreholes. I have noted that NGOs are coming here for sanitation and water management. You can walk around not more than a kilometre and you can find that there is a borehole, but most of the boreholes are not working because some have been broken down by the villages themselves because of the ignorance*".[21] And in terms of coverage, "*Water quality I would think as a district we are much better off because there has been a number of interventions coming from the NGO community particularly WaterAid… they have worked in the district for a number of years. Of course they have not touched all the TAs {Traditional Authorities] .We have 10 TAs in Salima and we have worked in about four if not five TAs*". And similarly, "*Because most villages around I know WaterAid now they are persuading TA Mwanza to improve the number of boreholes in the TA. I think that's the one who has fewer boreholes scattering the villages around but the rest of the area most of them have boreholes for clean water".*

[20] This issue was cited in all the districts: in all 6 of the health FGDs in Salima, plus 4 out of 6 in Mzimba, and 3 out of 6 in Mulanje district.

[21] Broken boreholes was also mentioned by one Village Head in Salima, though the blame for a lack of repairs was attributed to the government.

In Mulanje and Mzimba, district officials also mentioned concerns about water supply, with people drinking from unprotected sources. As one Director of Planning and Development (DPD) explained, "*Access to water, yes as a district, we have more water in the mountain but you discover that people are still drinking from the rivers, the springs, whatever unprotected wells; it's a challenge… if we drink from unprotected wells that means diarrhoea, and we can have more places for breeding mosquitoes. People will suffer*". Similarly, "*at least this time people have quality water however other places are still drinking from the rivers but for three-quarters, you can go around and you can find people are drinking safe water*".

3.23 **Insufficient food:** Several (8 out of 18 FGDs) mentioned that food was insufficient and that this affected people's health: "*Sometimes diseases come in a person's body because of lack of food. If the person doesn't eat balanced food, they are prone to diseases"*. Or, "*the health people tell us to eat balanced food. So if the food is not balanced, opportunistic diseases come in*". On one occasion, a FGD mentioned a link to child malnutrition, "*the problem is here, if I can have a child and I see that my child is malnourished; if I go to the hospital the medical personnel there may find that child not fit to be on food supplements but when I look at my child I feel that the child needs food supplements. So there are other kids who are approved by medical personnel to receive food supplements. So the question we have is that why is it that my child is not given supplements while this other child is given when all the kids are malnourished?*".

Remarks:

- The evidence supports the view that people not only link health outcomes to the quality of healthcare provision, but actually give greater importance to other factors: to hygiene practices, to the lack of boreholes (scarce and unsafe water), and to the lack of food (long hunger seasons, malnutrition).
- This suggests that to make progress on health outcomes (e.g. the MDGs), it is essential to ensure that, amongst the development partners and government, there is sufficient support to other 'sectors' like sanitation and water supply, as well as food security.

B. Changes in health outcomes

3.24 This section explores the changes in health outcomes compared to 5 years ago, as well as the reasons given by respondents for these changes. The section provides a mostly positive view, and seeks to understand the reasons for this improving situation.

Overall changes compared to 5 years ago

3.25 Respondents were asked whether they felt the health situation had improved compared to 5 years ago. Based on the answers from villagers, district officials and local service providers, the vast majority have seen an improvement over the past 5 years (40 responses out of 48, or 83%). For villagers the perception was still generally positive, but less pronounced (i.e. 11 out of 18 FGDs, or 61%) – with no particular differences between male and female focus groups, nor between the different districts. The FGDs in villagers

around 5km from a tarmac road seemed to be less positive (2 out of 6 FGD citing improvements), than those around 10km (4 out of 6) or the more remote villages (5 out of 6 FGDs).

Table 3. Overall changes in the health situation compared to 5 years ago[22]

Changes in health status	Community Focus Groups	District officials	Local service providers	TOTAL
Improved	11	8	21	40
About the same[23]	4	1	0	5
Worse	3	0	0	3
TOTAL	**18**	**9**	**21**	**48**

Source: Question A2 (changes compared to 5 years ago) for packages A, B and C.

3.26 As one District Health Officer summarised, "*As myself, because I have been in the health system for close to 13 years, I have to be frank, the outcomes are better, they are better, they are improving but as I have said, you can not just improve within five years, but this what is improving now, will have a greater impact in the future*".

Reasons for reported outcomes

3.27 Respondents cited a range of reasons for the observed changes in health outcomes (22 in total). The most frequently cited explanations include improved understanding of how to prevent infections, the better supply of medicines, and people seeking help earlier (see table, below).

Table 4. Reasons for reported changes

Reasons	Community Focus Groups	District officials	Local service providers	TOTAL
1. Better understanding of infection prevention	4	0	4	8
2. Better drug supply	2	1	2	5
3. People seeking help earlier	2	1	1	4
4. NGO aid	2	0	1	3
5. More resources coming to sector from SWAp	0	2	1	3
6. More medical staff	0	1	2	3
7. Increased accessibility of health facilities	1	1	0	2
8. Better understanding of family planning	1	0	1	2
9. Cooperative community	0	0	2	2
10. Free distribution of mosquito nets	0	1	1	2

[22] Note: the total number of responses (n = 48) excludes 4 unclear answers plus 6 transcripts from Package B and C where the questions was either not asked because it was seen as inappropriate, or the response was more general (for example a SSI with the Director of Finance).

[23] This category includes a mixture of answers, some of which state that the health situation is the same, with others that mix aspects that are improving alongside those that are worsening.

Source: Question B (reasons for outcomes) for packages A, B and C.

3.28 The following quotes provide examples of how people attribute improved outcomes to better understanding and people seeking help earlier (items 1 and 3, above):

> *"TB cases seem to be going down because every one knows the importance of going to the hospital to get the medication..."*

> *"Some of the things have changed in the area because of the health education the HSAs are offering in the villages and at the health centre".*

> *"The state of health is seen to be improving in the area because the HSAs are trying to do a lot in teaching the community on various hygiene issues like construction of good toilets and bathrooms, cleaning of hands when coming from the toilet and before touching food – even children are also following these instructions now, covering the food to protect it from germs".*

3.29 Of those FGDs that mentioned that the situation was about the same or worse, the sample is too small to identify any clear pattern. People mentioned a range of answers from location-specific cases (e.g. because of past reliance on the forest department to transport people to the health centre) to deaths from HIV/AIDS, a lack of protection from malaria and unsafe drinking water.

Remarks:

- It is notable that people generally perceive the health situation as improving, even if some villagers are less positive that those who work in the sector (such as DHOs, HSAs, medical assistants, nurses, midwifes, etc.).
- While the observation of overall improvement is fairly consistent, this cuts across a wide range of health outcomes and the reasons given are multifaceted. Given the relatively small sample, it is inappropriate to draw substantive conclusions concerning attribution. Only that increased understanding (knowledge, awareness), better supplies of drugs, and greater resources (SWAp funds, staffing and NGOs) are seen as contributory factors.

C. Delivery of services

3.30 This section explores in detail the delivery of health services, and the perceptions of villagers, district officials and local service providers. DFID contributes to the Health SWAp, which supports the implementation of the Essential Health Package (EHP) and the Emergency Human Resource Programme (EHRP) which focuses on training, recruitment and retention of staff. The aim of this support is to improve access to, and quality and effectiveness of, essential health services. This includes developing the health system by increasing numbers of trained and skilled personnel; improving the availability of drugs and essential medical equipment; infrastructure development; and

improving routine operations.[24] DFID also provides support to the Malawi National Response to HIV and AIDS, with the aim of scaling up universal access to prevention, treatment and impact mitigation.

3.31 This section explores the changes in service delivery, including: (i) key constraints to access, in terms of costs, distances, timeliness, targeting, etc; (ii) the adequacy of service delivery, including staffing, facilities and medicine supplies; (iii) the provision of health services by Non-Governmental Organisations (NGOs); and, (iv) the adequacy of HIV/AIDS services.

Access to health services[25]

3.32 Respondents were asked a number of questions about access to health services. Most villagers saw the main constraints to accessing services as indirect costs (mainly for transportation), distances to health centres, and the timeliness of services (mostly long waiting times). There are other examples, such as previous bad experiences (e.g. with harsh or rude staff), although this does not appear to be a major constraint. Concerns about restricted entitlements, corruption or unfairness, were not mentioned by most people. The key findings for each factor are summarised below:

3.33 **Direct and indirect costs:** The vast majority of villagers identified indirect costs as a barrier (15 out of 18 FGDs). As one person explained, "*the hospital is for free, but the transportation to the hospital is what is expensive as people have to hire a bicycle, especially those who don't have one*". This differed from the views of local service providers and district officials who generally saw cost as less of an issue (12 SSIs and 4 SSIs, respectively).[26] Villagers identified a range of indirect costs, particularly the cost of transport to the health centre, the additional costs of transport when referred to a hospital, but also the costs of telephone airtime, for volunteer allowances and administrative fees to release dead bodies. Elsewhere during the FGDs people also mentioned other indirect costs although these were not necessarily perceived as barriers.[27] For example, health care at private/ NGO hospitals, especially for groups of people that fall outside the Service Level Agreement (SLA) locations; the purchase of health passports; the costs of medicines when told to buy them from a grocery store or private clinic because the health centre had run out; and the cost of paraffin for lighting when the health facility lacked electricity.

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[24] Based on the outputs presented in the logical framework for, "Support to the Sector Wide Approach including Essential Health Package and Emergency Human Resources Programme".

[25] The evidence in this section is mostly based on responses to question C2a (constraints to access) unless stated otherwise.

[26] It is not clear from the transcripts why this difference might occur, although it might reasonably be supposed that as the costs are borne by the villagers, it is understandably more of a concern to them. Also many villagers are amongst the poorest in the country (with few income sources), whereas these costs might not be see as so high by health workers (who have a regular wage).

[27] This is based on responses to question C3a (adequacy of services) where people were prompted on cost.

3.34 As mentioned above, the most commonly cited cost barrier is that of transportation to a health centre (10 out of 18 FGDs); something that was substantiated by the views of local service providers (9 SSIs) and district officials (4 SSIs). In one village, the discussion group mentioned that while the health centre was free, some people come from very far and have to walk long distances. They used to have a bicycle ambulance but this was taken back as it was claimed that they were close to the hospital. Other villagers explained their concerns as follows:

> *"Some people fail to come here because transport is very expensive to come here. It is very difficult for a patient to source money for transport… As we have said, there is a health post at Kanjuchi but there is no road there and a road passes through Khosolo. But this entire place is called Khwalakwala. There is no road and our friends are very far from the health centre. They can't even think of carrying a patient on a homemade stretcher and climb all the hills to walk to the health centre. Even the HSAs can't reach the areas as bicycles can't go there as well"*.

> *"On transport, we wish if the health centre were close to us because as you see, some of us are old people. To find someone with a bicycle to take you to the health centre, you have to pay MK 200.00 when going and MK 200.00 when coming back... The mobile Lifeline clinic is a paying service; we have to pay MK 50.00. So where do we get it here in the village? Most of us are sick in the villages because we can't find the charged MK 50.00"*.

> *"People from far areas have a problem as they have to spend some money on hiring a bicycle to the health centre. Some who are very ill can't manage to sit on the dumper [a name given to bicycles for hire] so they have to find an ox-cart. Once at the health centre, they are asked to buy a health passport at MK 50.00 which most of them do not have"*.

3.35 Not many respondents mentioned the actual costs of transportation, but those that did said that they ranged from MK400 to MK500 (about £1.40 to £1.80)[28] for a return journey by bicycle. While such costs might not prevent visits to health centres, they are certainly not perceived as trivial – especially when compared to other monetary costs borne by poor households in rural Malawi.[29]

3.36 Amongst district officials and service providers, transportation was also mentioned by some (13 SSIs). Distances and cost of transport are a particular concern for those that have to make repeat visits. As one District Health Officer explained, "*I will give an example of ART services. Initially as ART services started, they were only available at the district hospital… If anybody in any corner of the district wanted to have that service it meant he [or she] must travel all the way from which ever point to come here. We got quite a lot of complaints and comments and we even see some patients could fail to come for their scheduled date citing maybe the issue of transport, the issue of distance… so that this is a challenge*". For

[28] Based on an average exchange rate of MK 280 for 2008 (HM Customs).

[29] For example, subsidized maize was sold at around MK800 (£3), and one person mentioned selling his year's crop of 3 bags of groundnuts and 2 bags of beans for MK4,500 (£16).

others, it makes it difficult for them to come back on another day. For example, "*For example yesterday we had a woman who came from up the hills there walking on foot and alone. It was raining in the morning and she arrived here around 10am and she met the nurse who is offering such services. She was told to go back home and come the other day. She had to complain that she is coming from very far. So she met a health surveillance assistant who is responsible for the area where this woman comes from. The HSA had to talk to the nurse to tell her that she can't manage to come the next day as she has walked a long distance. So most women are sent back home without assistance on family planning methods*".

3.37 The general lack of personal means of transportation (such as a bicycle) is exacerbated because ambulance services do not operate in some areas.[30] In a few cases, the system of referral was mentioned as it sometimes increased the distances that people had to travel: "*… the referral systems is affecting the health system since if we had an ambulance close, referrals could be easier and emergencies could be sent to Mulanje district hospital*". For instance, people in one area said that the problem occurs when the relief medical assistants at the health facility cannot be found or they haven't been deployed; people then have to find money to travel to the nearest hospitals. It also occurs when the seriousness of the illness is considered to be beyond the capabilities of the health centre: "*Serious cases of illness are usually referred to Mulanje district hospital but the health centre doesn't have an ambulance. This brings a lot of transportation problems as the area is very far from the district hospital*".

3.38 The consequences can be serious, with people sometimes ending up worse off than when the left: "*But the problem we have here is the ambulance, when travel to Mzimba, the patient arrives there more serious than before, because of the distance – there is no stationery ambulance at the health centre"*. Even where Service Level Agreements (SLAs) are in place, there are instances where problems with transportation: *"… here we are having a Service Level of Agreement (SLA) with Ekwendeni Mission Hospital, but they are just picking pregnant women to Ekwendeni whenever they have some complications with maternity cases… but with the other cases we are having problems where by patients need to find his or her own transport to go to Ekwendeni… carrying the patient from the area is also expensive as they need to hire a car… I remember we had some bush ambulances we were getting in 2000, but as of now they are not functioning so it's a problem*". Likewise, "*since Mzimba District Hospital is very far, we refer patients to Mzuzu Central Hospital, so the cost is very high for them to travel from here to Mzuzu, so the travel cost is high. Others are referred to Ekwendeni Mission Hospital which is near, there is indeed an agreement between government and CHAM where they are managing obstetric cases on free of charge basis but for these other cases, people tend to pay - so that is a problem that we are facing*".

[30] Villagers also highlighted this issue when they discussed the various health challenges they face (Question A1a). See Table 2. Lack of transport (including a lack of ambulances) was mentioned by 6 out of 18 FGDs.

3.39 **Distance to health facilities:** Most villagers cite distance as a constraint (13 out of 18 FGDs) – a view supported by many service providers (12 out of 17 SSIs).[31] In one case, villagers cite a distance of 20 km to the nearest health centre, while for others it is a journey of 2 hours or more by foot. This, combined with transportation costs and a lack of personal transport (see above), makes it a major challenge for many communities. Indeed, when asked about the main health challenges in their area, the distance to the nearest health facility featured prominently (see Table 2).[32] "*It is a problem, for example, our friends from Nandolo area. It becomes a problem for them to walk [descending the mountains] with the sick to the hospital. There is a long distance and there are a lot of big mountains*".

3.40 Sometimes it is said that this has fatal consequences, with one group of villagers in Salima mentioning that with no health centre near to their village, and with the nearest health centre taking about 2 hours, many old people fail to reach the centre at all. As one person added, "*I have to comment on the problem of the health centre, to our friends who are pregnant; sometimes they deliver on the way to the health centre due to distance. At times they die in due course as a result of such problems. The health centre is really far from here*". In another village, there were similar concerns about the distances needed to travel to health centres:

> *"We in the community took part in the construction of the health structure by moulding bricks, getting sand, but the government claimed that the distance from here [Nthiramanja] to Chonde is short, but its not. If so it happens that when a person faints with cholera, sometimes they die on the way to Chonde health centre or sometimes pregnant women deliver on the way to Chonde because of the distance that is there. So we need the structure here to offer these other small services because Chonde is far and most of the times patients die on the way to Chonde health centre"*.

> *"On the part of pregnant women, sometimes they have problems which can be handled right here but they are referred to Mzimba which is very far. We have been talking about this is the past, this district has to be divided into two so that we are a district here as well as most people die on the way to Mzimba hospital when they are pregnant. This happens because the distances are very long"*.

3.41 **Timeliness of the medical services:** Timeliness was perceived as a barrier to access for most villagers (13 out of 18 FGDs), with only two FGDs stating that it was not a problem, a further two that it was sometimes a problem, and one unclear response. There were three main aspects to timeliness that were cited: (i) congestion or long

[31] Statistical evidence also shows that people travel long distances to health centres. According to Malawi Core Welfare Indicators Survey, 2002, the vast majority of people travel more than 60 minutes to the nearest health centre (64.1% in the North, 56.5% in the Central region, 58.6% in the South).

[32] Based on responses to question A1a (health challenges): 7 out of 18 FGDs cite the distance to the health centre as a major challenge.

waiting hours, (ii) the late opening of the facility, and (iii) the set opening hours.[33] With regards to the long waiting hours, some villagers observed that medical staff might be overworked. For example:

> *"When we go to the hospital, we don't get timely services because of congestion of people at the health centre. There is one medical assistant and he comes around 08:00 AM to the health centre and he finds may be over one hundred people waiting for him. To help/ serve all those people, it becomes impossible and some go back"*.

> *"Sometimes when we go at night, the medical personnel will say he is tired and we have to wait until its morning the next day. They become tired because it happens that he can come to help one, by the time he goes to sleep, someone is coming again. So he has a lot of work that he can't manage to do it alone"*.

3.42 Few district officials however commented on timeliness, with those few that did (3 SSIs) seeing it as only a slight issue or improving, or that certain services were offered 24 hours while others were not – something that may be misunderstood by villagers. Of the frontline staff interviewed (HSAs, medical assistants and nurses/ midwifes), most did not view timeliness as a problem or barrier to access (14 out of 21 SSIs). Some (6 SSIs) however identified overwork as a major issue – citing the work as a "24 hour" job. As one HSA put it, "*Time? It's any time, starting from 07:30 AM up to 16:30 PM and whenever we have emergencies we try to work on Saturday and Sundays*".

3.43 **Previous bad experiences (reputation):** In most discussions people gave examples of bad experiences (9 out of 15 FGDs), although in general this was not clearly seen as a constraint. Bad experiences were mostly referred to in terms of "sometimes it happens", often with specific examples from an individual's personal experience – such as due to the harsh attitudes of some medical staff (sometimes due to tiredness), or patients being sent back without treatment. Most of the district officials or local service providers did not however view this as a problem (13 out of 23 SSIs), with those that did mainly seeing it in term of "sometimes" they get complaints (7 our of 23 SSIs). Only in Salima was it cited as a particular issue – relating to a bitter experience with a hospital in a poor condition, and reported cases of pregnant women being poorly treated in wards (nurses being rude or abrupt).

3.44 **Restricted entitlements (poor targeting):** Of those that discussed this issue, few cited concerns with segregation or poor targeting (2 FGDs). There was some concern that occasionally people are given the incorrect medicines: "*Sometimes the medical personnel will say that aspirin is not suitable for children/ babies but sometime if we go there, we are given the same prohibited aspirin to give to children. If you ask, they tell you "that's the only drug we have, how do we help you?*". Amongst the local service providers, the vast majority

[33] "Congestion or long waiting hours" was mentioned by 7 FGDs, "the late opening of the facility" by 4 FGDs, and "the hours of opening" by 3 FGDs. Of these, 1 FGD mentioned cited both of the last two issues; hence the total is 13 FGDs.

say that targeting is not an issue (18 out of 20 SSIs). Where targeting is perceived as a concern, this is seen as a consequence of indirect costs. For example, "*Indirect in the sense that most disabled are poor people… if somebody is disabled and is living 10km away from the health facility they need to be pushed, and it's at night there is no-one to push her they can call an ambulance which might not come when is required to do so. I still feel because of distances between health facilities most of our poor people and disabled, the elderly… and sometimes the orphans, these I think they are quite marginalized. So there is still a challenge*".

3.45 **Misappropriation or unfairness:** Nearly all villagers saw corruption or the unfair treatment of people as not an issue in their areas (15 out of 18 FGDs). As one disabled person explained, "*When I go to the hospital, I am received very well and when I find long queues of people, the medical personnel take me out of the queue so that I get served quickly and I get served quickly and in good time unlike my friends who are not disabled like me*". Only a few FGDs (3) cited issues of segregation (see above).

Adequacy of service provision

3.46 This section considers the quality of service provision, in terms of personnel, facilities and equipment, the availability of medicines and other factors. In general, most villagers felt that staffing, health facilities and equipment are inadequate, yet district officials and local service providers present a less negative picture. Villagers are concerned mainly about the high demand placed on services (as evidenced by the long waiting queues, staff overworking), with concerns about equipment seemingly less severe, with most being localised examples (such as one facility not having a blood pressure machine). In terms of drug supplies, villagers express concern that when medicines run out they are not replenished quickly, yet many of the frontline medical staff no longer have problems with such supplies - an indication that the situation has improved.

3.47 **Staffing:** When asked about staffing, nearly all villagers said that staffing was inadequate particularly as regards numbers of staff (12 out of 17 FGDs).[34]. For example, "*Staff at our health centre is inadequate. You sometimes go to the hospital and it's the cleaner that helps you when the medical assistant is busy with some other things. So to us, we see that staff is problem at our health centre*". This was mainly linked to overworked staff, though in some cases also to too large or an increasing population. As one villager put it, "*Yes they have given us the health center but the staff at the health center are inadequate. That's why they over work. When we go at night, maybe around 7pm with a patient – an emergency case - the medical assistant will say 'Can't you give me sometime to rest please'. At the same time the*

[34] Based on responses to question C3a (adequacy of services). Note: When the focus groups were asked about key health challenges in their area (question A1a), a "lack of staff" was mentioned by 5 FGDs and ranked 7th out of many other challenges (see Table 2). When respondents were asked specifically about the adequacy of staffing (question C3a), 12 FGDs mentioned concerns about the number of staff – typically citing that there were not enough staff which is why they are overworked. This seems to indicate that while there are concerns about staffing, other challenges are perceived as a greater problem.

patient is crying with pain. We also shout at him and tell him he is arrogant, 'why did you come here, you are such an arrogant person'. In that way we find we are at a difference. The medical assistant is tired but at the same time our patient is crying". Another villager explained, "*Today on Thursday, there is ART clinic there and there are only two medical people who handle this. So whenever they are tired, they can speak anything they wish and this drives people away from going to the health center. All this is a result of staff shortage*".

3.48 Some people also mentioned a lack of qualified medical assistants, as well as concerns about the attitudes and behaviour of staff – but this does not appear to be a generalizable theme.[35] In one example, people were concerned that they only had relief medical assistants, who come and go after just a short while. This was seen as a particular problem for pregnant women who, as a consequence, are usually referred to the nearest hospital. Others felt that they are not well cared for at the health centre, or that they were even afraid because of the way medical staff receive them:

> *"Like for example, pregnant mothers. We have a nurse who if you are to see her, you can deliver properly but she inserts her hand into the birth canal claiming that she is cleaning it, but then she leaves cotton in there, this makes people to be referred to Salima district hospital for removal of the cotton. We are not happy with this one nurse here! We don't want her, she has caused a lot of problems. When we meet the other nurse, she doesn't do what this one nurse does to us. This nurse is always harsh and sometimes she scratches the birth canal. Most of us are afraid to go to the health centre for delivery and we opt to deliver right at home"*.

3.49 Yet, amongst local service providers the reality appears to be less of a concern, with views more evenly split between local service providers that find staffing as inadequate (13 out of 25 SSIs) and those that do not (12 out of 25 SSIs). Few district officials highlighted staffing as an issue (3 SSIs only). The reasons for this difference is not evident from the range of answers, though several cite recent increases in Health Surveillance Assistants (HSAs), and others say that while the overall staffing is adequate, there were some posts that are understaffed.

3.50 For those service providers that identified staffing problems, a whole host of reasons were cited. These ranged from large catchment areas, not enough staff at the facility when others have to do community visits (and conversely not enough staff to do outreach clinics), difficulties providing all services due to frequent emergencies (e.g. dealing with women who are in labour), and problems filling posts (e.g. enough HSAs, but not for the rest of the cadre). As one nurse explained, "*Even though they say that according to the requirements for a health centre we are enough here, but as I have said the services are increasing every day for us to do. So to us who are doing the job, we see that there is a shortage; that's why we fail to go to outreach clinics in the community as there are services to be*

[35] Based on responses to question A1a (health status).

done right here and there are services to do in the outreach clinics – all to be done by the same staff. So we see that we are not adequate".

3.51 There is also some indication that Health Surveillance Assistants (HSAs) are being received positively. Of the few villagers that saw the overall health status as positive (3 out of 18 FGDs),[36] all of them link improved health status in the area to the work of HSAs - who are able to teach people about the construction and use of latrines, refuse pits and the cleaning of hands, as well as helping people to gain access to medicines and mosquito nets from the health centres.

3.52 **Facilities and equipment:** When asked about the health facilities, all the focus groups said that they are inadequate (18 FGDs). This however conceals a broad range of concerns. Of those that mentioned specific concerns with the physical infrastructure (8 out of 18 FGDs), there is no overriding theme: a lack of electricity resulting in people having to take their own lamps, paraffin and matches; for maternity, patients being asked to bring basins and other materials which used to be available in the past; a lack of rooms for patient attendants, with people waiting under trees for services; a lack of beds, with one example of a patient with a sick child sleeping on the bare floor.

3.53 Others mentioned inadequacies with the equipment to test or treat certain diseases (4 out of 18 FGDs). Examples of equipment that people found was either not there or not working, include: blood pressure machines, testing equipment for malaria, facilities to treat toothache or extract teeth. A few local service providers mentioned equipment like thermometers, blood pressure machines and having to use old scissors and forceps, but otherwise there was little concern with the healthcare equipment.

3.54 People also highlighted concerns when asked more generally about health challenges in their area (12 out of 18 FGDs).[37] Again, this captures a complex mixture of both a limited number of facilities per population, as well as limitations within the facilities that do exist (e.g. stocks of medicines running out, patients having to sleep on the floor, not enough rooms for patients). In five of the FGDs there is explicit mention that there are not enough facilities to serve the population. For example, "*The other thing is that the health centre was built some time back when the population was very small but now the population is very high and even if you can go now, you will find that there is a heavy congestion there. The government should have expanded the health centre and also increase the number of qualified staff here. Patients sleep on the floor and most of the times we are told to procure drugs on our own from the shops*". In some areas, overcrowding can put a severe strain on existing facilities. In Salima, one group mentioned that, "*There is only one room for holding patients while waiting for referral to the district hospital with only two beds; both men and women are nursed in this same room. It becomes a problem especially when some are opening bowels and others are vomiting in the same room. There is a project where staff houses*

[36] Based on responses to question A1a (health status).

[37] Based on responses to question A1a (health challenges). See also Table 2.

are being expanded and community is not happy with this development instead of considering rooms for holding patients – people are really sad with this".

3.55 **Availability of medicines:** Villagers' perception about the availability of medicines presents a complex picture. Firstly, when asked about the main health challenges in their area, a "lack of drugs" was mentioned within concerns about "limited health care facilities" (7 out of 18 FGDs, 39%).[38] When asked specifically about the adequacy of services, such problems were mentioned much more frequently (12 out of 16 FGDs, 75%),[39] and indeed only a quarter of the FGDs stated that drugs were generally available (4 out of 16 FGDs). This perhaps indicates that while a shortage of medicines is a concern, there are other more pressing challenges from a villagers' perspective, such as poor hygiene practices and scarcity of clean water (see Table 2).

3.56 In terms of a lack of medicines (12 out of 16 FGDs), the main concern was with stocks running out, medicines not being quickly replenished, as well as a lack of medicines for all types of diseases. In Mzimba it was said, *"… when drugs run out of stock, it takes time before they are replenished. The medical assistant tells us to buy from shops such drugs as panado and aspirin*". Similarly during a discussion in Mulanje, people mentioned that the demands on stocks were outstripping supplies: "*My opinion is that health services in our area are not good because here at Nthiramanja we rely on Chonde health centre which services a lot of areas. For example our friends from Chiradzulu come there and those from Thyolo also go there. It so happens that some people go back home without getting any help because of overpopulation at the hospital. Within a short period of time, we find that drugs have run out. So we can say that health services are not good*". A few respondents even stated that stock-outs occurred most of the time: "*Most of the times, we are told to buy drugs from shops. Drugs come from very far and it takes time to restock when they have run out of stock here at our health centre. Drugs for some diseases are not available always and we are referred to Mzimba hospital*".

3.57 Amongst frontline staff (HSAs, medical assistants and nurses/ midwifes), views are split between those who do not face issues with medical supplies (11 out of 19 SSIs) and those that do (8 out of 19 SSIs). This seems to be more of a concern in Salima (6 FGDs) and Mzimba (2 FGDs). For instance, "*The supplies are erratic. There are no gloves now such that the suspect cases I talked about, we were touching them with bare hands and not using gloves. Chlorine is also very erratic, the whole health centre being given only 5 kg of HTH which is only enough for two villages only*". Likewise, "*At times we face shortages; we receive low quantities, other months satisfactory, and the other month just very low drugs received to this health facility… I don't know what is happening*". And lastly, "*Maybe they can come with five boxes of gloves for the whole month. Just imagine how busy the maternity is; you can't use five boxes the whole month, what about the whole year… we are having problems to render these services due to poor supply of items or drugs*".

[38] Based on responses to question A1a (health challenges); grouped under "limited health care facilities".
[39] Based on responses to question C3b (adequacy of services).

3.58 On the availability of medicines, some district officials are able to explain the difficulties they face and recent improvements they have seen:

"Its central medical stores, (region), they supply when they want to supply, they don't tell you when they will supply… you only get to know when they deliver. Then you have to start going through the very long process of trying to procure… so when they don't have, then we all suffer because they still try to stop us from procuring outside… they play delaying tactics".

"The budget has improved but the cost is still on the higher side... so when you marry what you require at district level versus what you have to spend I would say it's not always that we manage to square the bills… These days you get items out of stock not because it is not available within Malawi but its maybe because you have failed to purchase because of buying power".

I would say the drugs and supplies they fluctuate in availability but at least you get assured that one of the days at least this supply will be with us as opposed to previous two years... The past, maybe the past year or so, we were still dancing with availability of supplies like testing kits for HIV/AIDS. It was a big issue; you could not get them anywhere else… while today, maybe longest that you could stay without a particular HIV testing kit could be, maybe three months. Within three months the problem would be sorted out".

3.59 The situation appears to be improving. When asked about improvements in health outcomes, a few villagers and other respondents linked this to better supplies of medicines (see Table 4).[40] In 2 FGDs, people said that the improved health status was due to better access to medicines, and that when put to proper use, they got better from various illnesses. In Mulanje, a health worker also said that the supply of medicines has improved:

"In the past years, the problem we had would have been drugs would maybe run out 10 days before the other drugs come in. Maybe due to the change, because at first we were getting the drugs from the district pharmacy but currently we are getting them right away from central medical stores. So I think that has been a good part of it".

"Drug supply, I can say at least we don't run short of drugs like in the past we used to stay without no aspirin, no panado but as of now, at least we have essential drugs, most of the time we have them. If we are in short of drugs, that means the central medical stores didn't supply. As much as possible we try to order from the district hospital and they supply us, like just yesterday we didn't have local anaesthesia for adults so we had to order from the district, they have given us".

NGO healthcare provision

[40] Based on responses to question B (reasons for changes in health outcomes).

3.60 People generally feel that the Christian Hospitals Association of Malawi (CHAM) or other NGO facilities are better than those of the government (14 out of 17 FGDs), but that they have to pay a lot of money for such services. There is however a concern by some villagers that the medicines are more effective from these facilities than those received from the government health centres (8 FGDs):

> *"At CHAM… their medication is very effective so that when you fall sick again, you should come back to them. Whereas here at government facility, you find that you complain of headache, you are given drugs for other diseases and not for headache. I don't know how these things work.*
>
> *"… sometimes you can go to a government facility, you get drugs but you don't quickly recover but if you go to a mission hospital and take their drugs in the morning, come afternoon hours, you find that you are already recovering and you are able to eat food if you were unable. We don't know why it is like this with a government facility".*
>
> *"There are differences even in the type of drugs that are at government facility and at CHAM facility; those at CHAM are very powerful as people feel far much better soon after taking such drugs".*
>
> *"However some feel that at the government facility, the only treatment they are given is LA [Lumefantrine-Artemether – for malaria], and are told to buy aspirin or any other drugs for themselves".*

3.61 This may be changing, with at least one DHO seeing the gap closing between the government and CHAM services: "*I think government has beaten CHAM because now we actually have more people staying in so there are more services provided, more experienced people still staying in government so we get a lot of knowledge bank, we get to learn from them a lot of things because of I think because of the SWAp thing. We actually have people now wanting to leave CHAM to come into government so I think we can say that we are better now… initially CHAM was the place to go*".

HIV/AIDS service delivery

3.62 Most villagers that mentioned that Voluntary Counselling and Testing (VCT) services are available at the health centre (13 FGDs). As one nurse explained, "*We have this VCT room… as a nurse I use it to counsel some women on HIV/AIDS counselling and testing so that they can be able to know their status. At the same time the aim of preventing that baby, expectant baby, to be born free from HIV/AIDS. So as a nurse I use to try to give women education each and every day to pregnant women*". Similarly, "*Most people who have been tested and confirmed to be HIV positive are getting ARTs [anti-retroviral therapy] from the health centre. VCT services are offered twice a week at the health centre. Pregnant mothers are asked to undergo PMTCT [prevention of mother to child transmission] services at the health centre*". Yet even with these testing services, health workers experience difficulties:

> *"We have VCT here and we also have ART services but the problem we have is that if a client has been found to be HIV positive, he/she is supposed to go for CD4 count check. This service*

is done at Salima District Hospital and if you tell a villager to go to Salima, it doesn't work as it is very far from here and transport is a problem. We were told just to take blood, but to me I saw that it's a failure because we wait for the day an ambulance happens to come here if there is a patient that has to be referred, sometimes the blood becomes flawed right here. Now we just tell them to go to Salima, we talked with our colleagues in Salima and they told us that the machine for checking CD4 count is very big and can't be moved now and again. So that's where we see that we have a problem on CD4 count but on ART, everything is perfect as we have enough drugs".

3.63 There is however one concern about access to ART. While most people said that it is possible to access ART (11 out of 18 FGDs),[41] many said that they are unable to do so at their nearest health centre (12 out of 18 FGDs).[42] This seems to be corroborated by the views of local service providers, where many said that they did not offer ART services (11 out of 21 SSIs) while others did (10 SSIs). In many cases, this means that people living with HIV/AIDS (PLWA) have to go to the district hospital or another health centre, which can require a long and relatively costly journey. For example, "*This service [for HIV/AIDs] is not improving since a person is sick and has to travel to Nkhamenya just to get drugs. It is a long distance and that is our complaint. Nkhamenya is very far from here… to travel to that place, there is need for transport; it is about 10 km and we pay MWK 200.00 when going and MWK 200.00 when coming back*". There was also a concern that children will not get ARTs:

"I have seen that HIV/AIDS got worse in our area here because of the cultural beliefs before they were prohibited. There were beliefs, which helped in spreading AIDS, but things have changed in the last five years and if people are contracting the virus, then there should be some other ways…we are worried about children who get the virus from their parents on how they will get ARVs. We are told that people in other areas don't have that much problem in getting ARVs as we have here".

3.64 One district official however explained that while progress has been made, the rollout of ART services is still on-going: "*We started as a district providing ART as a starting point. But now we have health centres providing ART, I think by the end of this year, all our health facilities will be able to provide PMTCT. At least about 80% or our facilities will be able to provide VCT and… we are thinking of opening four new static centres for ART where we want to be providing ART in health centres*".

Remarks:

- Distance and transportation costs are seen as major constraints to accessing health care, and more so for the poor and elderly. This is made worse when patients are referred from a health centre to a hospital for treatment. Plus, often ambulance

[41] Based on responses to question A3 (diseases, HIV/AIDS).

[42] Based on responses to question C3b (service provision for HIV/AIDS).

services are not available, or are reserved for certain cases.

- Healthcare facilities are perceived by many villagers as inadequate, with insufficient numbers of staff to deal with the demand placed upon them (e.g. long waiting times, overworked staff). While there are some examples of poorly qualified staff or improper behaviour, this does not appear to be an overriding concern.
- In general, villagers perceive the physical infrastructure and equipment at health centres as inadequate, but district officials and staff do not cite this as a major concern. The range of examples given (from a lack of rooms and beds, to no electricity or blood pressure machines) is very diverse, though it is not evident from the discussions whether this is due to different locally-specific instances or a more systematic failure.
- NGO and particularly CHAM provision, is seen as generally more effective that government services, though the gap may be closing. Villagers however express a specific concern that government medicines are less effective, perhaps indicating problems with the dispensing and availability of medicines.
- While the supply of medicines may have improved in some instances, most villagers and about half of the health workers asked, still seem to have problems with stocks running out. Some district officials still see the availability and distribution of medicines as unpredictable.
- For HIV/AIDs there appears to be good provision of VCT services. People however experience problems with access to ARTs from their health centre. This can result in the need to travel to the district hospital; an indirect cost (even barrier) for some; although it must be recognised that the ART programme is still in the process of being rolled out to health centres, so coverage is likely to improve. It also appears that PMTCT services are beginning to be implemented through more health centres.

D. Contributory factors

3.65 While there are a whole host of contributory factors to changes in health service provision and outcomes, this section focuses on the perceived contribution of the Health SWAp (including the EHRP), and the decentralization process.

The Health SWAp and EHRP

3.66 Respondents were not asked specifically about the Health SWAp, though most district officials (15 out of 18) and a few local service providers (2 out of 26) mentioned it as a contributory factor. Several district officials attributed improvements in health outcomes to the additional resources brought in by the SWAp (and occasionally with a specific reference to it supporting the EHP). For instance: *"… this animal called SWAp, it has attracted so many personnel into the health system. In addition, more resources are coming to the district in the SWAp form. In that way at least we are able to prioritize which areas we have to intervene. I look at the SWAp mechanism, it has assisted the health sector to… work on the*

challenges and see how best they can improve; now we are making positive strides". Similarly, a DHO, after talking about the trebling of budget allocations and increased staff numbers, attributed the main reasons for an improving health situation to the SWAp over the past 4 to 5 years: "*I believe we are different from most of the sectors. It looks very different and I think at district level it's the health sector that is seen to be getting a big chunk of money if we compare with other sectors in the [district] assembly. So I attribute that to SWAp basket of funding*". The difference that the extra resources through SWAp funding and processes and the EHRP can make is explained in detail by one particular DHO:

> *"The biggest problem which was there and which SWAp is managing [addressing]; initially in our health centres, most of our health centres were closed because we didn't have the staff, but as of now,* ***all our health centres are operational****. So the only problem is inadequacy of skilled personnel because, per health centre you are supposed to have two medical assistants and two nurses. You will find that in the health centres that are operational, maybe there will be only one nurse, may be one medical assistant despite that huge population. But to us, or to me, it is still an improvement because we are talking of a situation whereby the health centres were not able to open, but at least now the community is being served…"*
>
> *"Then there is also* ***training/ recruitment of health surveillance assistants****; take it in Mulanje, we have 22 health facilities against a population of about 550,000. With those 22, it means we cannot reach every community but with the coming of SWAp, we have recruited more health surveillance assistants who are right in the community. I know you might think of the impact because these people are not trained in a very long medical training, but we are talking of people who should be able to recognize problems in the community, who should be able to give at least a certain amount of information on health in the community. So that on its own has an impact…"*
>
> *"And if you look at* ***general infrastructure****, you find that one of our challenges which we need used to meet is where most of the health facilities don't have utilities like electricity, water and communication, but with that using of SWAp money we are able to rehabilitate most of our health facilities; like last year we managed to put solar energy and water at a health facility which has had no water for close to 15 years".*
>
> *"And again, if we talk in terms of drugs, I have talked of* ***availability of drugs****, at least it's not a problem… I know people, we might not have all the drugs we need but we should try to compare; what percentage you had the past 5 years and what percentage you have of out-of-stock drugs as of now. You can actually see that there is a good improvement, at least most essential drugs are available and we are not just talking of available at district hospital, but we are talking of even in the peripheral facilities it's the same".*

Decentralisation

3.67 District officials also perceive improvements due to decentralization, both in terms of cross-sectoral decision making, and the ability to take decisions quickly at the district level:

"So with developing of our decentralization, we still meet at the district assembly where I have a problem with water, I have to take and tap expertise from water department, the same I have to do with agriculture whether its education; we work as a team… all sectors. We have to meet and we might work independently when we are doing the district implementation".

"Yes, right now with the SWAp and decentralization, we are able to make decisions right away at the district. If there is cholera, we don't have to wait for the ministry, we start reacting straight away. For example, there was a situation here where people had eaten a rabid animal, rabid cow; we could wait for them or any ministry because we have our resources it was set for our usage, lets go there and deal with the situation and when the ministry came to know it, it was we were already on the ground, so all these have come because of SWAp otherwise previously that couldn't be".

Remarks:

- While it is difficult to attribute some changes in health outcomes directly to the health SWAp due to the lack of a clear baseline, it is clear that some district officials perceive improvements in health service provision (as a result of the increased resources, through SWAp and EHRP). In particular, district officials see improvements in staffing, training of HSAs, health infrastructure and the supply of medicines.
- Health service users also see some changes, particularly in the availability of HIV services. These have been facilitated through pooled funds to the National AIDS Commission, a proportion of which have then been passed on to support Ministry of Health HIV/AIDS activities at district level.
- In some cases the improvement of services targeted to specific groups can be observed in the findings by communities noting that the non-target group are not accessing the same service – if the target group were not accessing the service, others would not note its absence. For example, pregnant women and under fives accessing mosquito nets and maternal health services being delivered free of charge at CHAM facilities
- The inclusion of NGO healthcare providers, particularly CHAM and BLM, in the SWAp appears to have increased access to maternal health and reproductive services respectively.
- Decentralisation has increased the efficiency of the use of SWAp funds at district level. The district health officers appear to have access to the resources they require to rehabilitate health centres that they know need improvement.

4. Findings: agriculture and social protection

4.1 This chapter summarises the findings from the FGDs on agriculture/ social protection (women/ men), the SSIs with district officials (and particularly DADOs), as well as SSIs with local service providers and others (including ADMARC staff and Village Heads). The chapter is structured in three main parts. Firstly, the key challenges faced by farmers. Secondly, the main changes in agricultural outcomes, including reasons for these changes. And lastly, comments on the delivery of services with a particular focus on the AISP, plus covering social protection and broader impacts on poverty.

A. Agricultural status

4.2 This section summarises people's views on the broader agricultural context, focusing on aspects of soil quality, natural resources, incomes from agriculture (engagement in the market economy), and food security (especially for the vulnerable). Views are fairly evenly split on the environment (soil quality, natural resources); with about the half of all respondents seeing the situation as improving and the rest having persistent problems. Regional differences are also important with deforestation being considered as more of a problem in Mzimba, and tree planting more active in Mulanje. The selling of a wide range of crops is also important for most villagers, though often choosing to sell small quantities to meet particular needs. Markets are seen as particularly problematic, with many people complaining of low prices such as when vendors come to the village to purchase crops. And finally, the general food security situation is seen as having improved in the past years, though for some families it remains a challenge.

The broader context

4.3 **Soil quality:** About of half of villagers said that they either don't have problems with soil degradation or that the soil conditions are getting better (7 out of 14 FGDs). While problems still persist in many cases, the improving situation was put down to a variety of methods including: training on how to construct drainage systems, the construction of contour ridges, the planting of *vertiva* grass, and the replanting of trees. The views of district officials and local service providers generally corroborate the view that soil quality is either not an issue or improving for about half of the locations (12 out of 22 SSIs).

4.4 Other villagers said they had high levels of soil erosion, or that the situation was getting worse (5 FGDs). This was put down to poor soil management, such as not using crop rotations (due to limited land area), not applying manure or inorganic fertilizers, a lack of trees, and heavy rains. Many officials and service providers (10 out of 22 SSIs) also saw soil quality and erosion as a problem in their respective area. There were also concerns with a reluctance of some farmers to take up soil conservation technologies. As one agricultural extension worker explained, "*Here most of the areas are sloping so there is always some erosion even if we teach them to construct bands, farmers are reluctant… they think*

it's a very big task. When you bring such messages, you find that attendance is reducing; they think that you are bringing them more work for them to do in their fields". Similarly, "*In the boundaries of this forest a lot of people are planting trees, but in the villages there isn't such things happening. I have never seen any new trees grown; therefore erosion is taking place in such areas*".

Natural resources: Several of the villagers express concern about deforestation and the cutting down of trees (6 FGDs), with a particular concern with charcoal burning and flue-cured tobacco in Mzimba (4 and 2 FGDs, respectively). Plus, deforestation appears to be more severe in Mzimba district where very few references are made to tree planting whatsoever, and several district officials expressed concern with the continuing deforestation (5 SSIs). Again charcoal production and flue-cured tobacco are seen as the major contributory factors, though beer brewing and shifting cultivation practices are also cited. As one district official explained in Mzimba, "*I see that like for example the burning of charcoal its still a problem… that is in terms of natural trees, indigenous trees… so many people now who are interested to grow flue cured because of the returns, the high prices they are getting the high prices*".

4.5 Elsewhere most villagers say that trees are being replanted (10 out of 16 FGDs), particularly in Mulanje (5 FGDs). Examples are given of replanting indigenous trees, the establishment of tree-planting clubs, support for replanting along the riverbanks (Concern, GTZ) and the setting-up of a village nursery for tree seedlings. As one DLO explained in Mulanje district, "*Great efforts have been made and are still being made because we have got Mulanje mountain conservation. Of course it is only strictly for the mountain but the knowledge that people acquire from the association, from that organization, has improved the planting of trees in the mountain and beyond, below the mountain. So people do have forests, those who have got land have got woodlots within their communities. So definitely there is an improvement*". While these activities are said to be taking place, it is not clear from this limited evidence, whether this is sufficient to address the loss of forest cover.

4.6 **Incomes from agriculture:** A wide range of crops are mentioned in the discussions, although these are often sold in small quantities to meet a particular need: "*I had 3 bags of groundnuts and 2 bags of beans. I realized almost MK 4,500 [£16]. This helped me to buy some iron sheets for my house*".[43] The examples were often specific to the agriculture of the region. In Mzimba for instance, people said they sold sweet potatoes, beans, cassava, maize, tobacco, Irish potatoes, soya beans, groundnuts and vegetables like tomatoes – though not all in the same village. It is also apparent that some villages may have been exceptional, rather than broadly representative – with one location it was said that three-quarters of the village had irrigation enabling them to grow winter crops, including maize, sweet potatoes and vegetables like tomatoes for sale. In Salima, cotton, groundnuts and rice were mentioned. One farmer mentioned that the government is mostly interested in tobacco and maize farming, and has little interest in rice – hence

[43] Based on an average exchange rate of MK 280 for 2008 (HM Customs).

agricultural support was more limited. In Mulanje, vegetables like lettuce and cabbage, groundnuts, pigeon peas, tea, pineapples, bananas and maize were mentioned.

4.7 **Markets (for selling crops)** seem to be a problem for many farmers, with villagers complaining of low prices (7 out of 16 FGDs). People mention problems with both their access to larger markets (due to long distances, and vendors coming to buy produce), as well as being forced to sell when prices are low (due to a lack of storage facilities, or more pressing needs). For instance, "*We sell various crops, beans, cassava, maize, tobacco; but we sell at lower prices because to go to Chikangawa or Mzimba it is a long distance. We sell to vendors at lower prices. What can we do since we want money. We are used to that*". Other examples include:

> *"We don't have access to bigger markets, vendors have to come to us and buy from us at lower prices".*
>
> *"We have markets but they are at distant places. Vendors come and buy crops from our fields. We are not happy because vendors buy at cheaper price. They can buy pineapples at K10 and sell it at K60 or K70".*
>
> *"There are not enough agricultural markets and moreover prices are too low… The problem is during the rainy season, we buy maize at a higher price but during the harvesting time, we sell at K5".*

4.8 And, this sometimes has consequences on other aspects of people's lives, such as: "*We have pineapples but prices are not good enough. We are failing to have more money from agriculture. Therefore, we are failing to take care of our expenses like paying school fees for our children*". Or as one Village Head explained, "*… a garden cultivated by me and my wife, we are able to produce maybe 10 bags of rice; we exchange five bags of rice with maize (food for our children) and we sell the remaining 5 bags in order to find money for children's school uniforms. That's how we find money, but its not enough to us since its only five bags, even if we sell the rice at a high price*". Even where there are attempts to assist with producing crops for sale, markets can be difficult to find. For example, during one village discussion people mentioned that NGOs had assisted with distributing seeds but that, "*after we harvest, the NGOs may come back to say we have not yet found better markets for your crops. This erodes enthusiasm*".

4.9 **Markets (for buying food):** In terms of consumer markets (particularly for food/ maize), some people highlighted differences in the prices between private vendors and ADMARC. "*If you compare with these people vendors and the like, they sell at very high prices while at ADMARC there has a fixed price. So people at least buy at a reasonable price than from the vendors. Vendors just dream; today they sell it at MK 600 tomorrow at MK 700, while at ADMARC its fixed price*". Other examples include:

> *"Food is available in ADMARC markets of course; its not always there but may be if the food stipulated in ADMARC it takes about 3 to 4 days before the new stock. Apart from these, we also have that maize that is being sold by the private traders. The only problem is the price is*

exorbitant it's on the higher side because at the ADMARC is going at K52. And at the private traders is going to K85 to K95, so that only farmers with the economic muscle are able to access the maize".

"Areas that are increasing poverty are where some of the vendors are able to store the maize so that they should sell it higher price after buying at lower prices from farmer. As of now, ADMARC sells at K52 and vendors are selling at K85".

"People are getting from vendors at K85 and at ADMARC we are selling at lower price. Vendors resell crops at higher prices. Therefore, it is not good to allow vendors buy maize".

4.10 Amongst a limited sample, views were fairly mixed between whether ADMARC was well stocked for maize or frequently ran out. So for example, some mentioned that ADMARC provided a useful reserve:

"I think there is a big change despite the harsh weather but at least we have been able to feed ourselves. At least this time if you move around and go to ADMARC you won't find long queues looking for maize. At least we have adequate stores especially this year we had fears that due to heavy turn of rains last year we would have problems in terms of food. But at least we feel that this time I think we are able to feed ourselves and can even sell some outside the district".

"In the past years we used to see some Swahili (vendors) buying maize in the villages but as of now such scenarios are not happening. This has helped people to have more maize for food and even some ADMARCs are still selling maize. There isn't long queues… Very often private traders externalize maize whereas if we sell maize to ADMARC, it will remain in the country and we can buy from them in times of maize scarcity. In Mzimba we have a lot of maize this year compared to the previous years".

"ADMARC is a government institution. People will have more maize and as a result we sell it to ADMARC, therefore during the hunger period people will be able to buy from ADMARC at lower price. ADMRC acts like a food reserve to people as they can sell to in time of plenty and buy from it in time of deficit".

4.11 There was also some mention of stocks running out at ADMARCs in some locations. So for instance: "*Most of the time ADMARC does not receive adequate maize for sale to the villagers. Maize is sold to villagers in small quantities, which is very often not enough for large families. I try my best to sell small quantities so that everyone should have an opportunity to buy maize".* And similarly, "*ADMARC has not helped us because a stock of maize can come today but if we go there tomorrow we will find that the vendors have bought all the maize*".

4.12 **Markets (for seed).** There was not much mention about seed availability and market access. In one interview, there was mention of the need for linking seed traders to extension activities, to help ensure that farmers knew how to make the most of the varieties they were purchasing. So, as one respondent that had been in the district for eight years explained: "*what I have seen in Mzimba is that people know how to buy fertilizer*

but the main problem is the use of the fertilizer and the hybrid seeds; they do not know how to use these farm inputs correctly. I should start with hybrid seeds… what happens here in Mzimba district is that people do just buy because hybrid seeds have been subsidized… They are used to planting local maize seeds in early November with the first rains, therefore, they just come and buy subsidized seeds because they want to satisfy the needs of the government. At one time… I told the suppliers of the hybrid seeds that they should deploy Agriculture extension workers to each and every area to impart good information on how to use their hybrid seeds correctly. The challenges with these suppliers are that they just want us to sell their inputs. Therefore, this is also the contributing factor that hinders the improvement of agriculture. The suppliers need to inform buyers of their seed on how best to use them".

4.13 In another interview, it was explained how seed varieties were sometimes unavailable and that this undermined the coupon system of the AISP:"*One challenge under subsidy program is that some farmers got flexible coupons and these were to be used to buy maize seed, groundnut, beans, soya and the like. Unfortunately these other inputs were not available… Even the previous year, the coupon was there but it was not fully utilized because we had some farmers who wanted to have these seeds… groundnut, beans, soya but these were not available*".

4.14 **Food security:** Most villagers saw the food security situation as having improved in terms of fewer hunger months (10 out of 13 FGDs).[44] For example, "*We are food secure from May to December but for the past year it was only April to July*". Or, "*We have food within March-December, in the past we used to have food from March to July. Therefore, there is better improvement. We are able to keep food for quite longer time…*". And though people might not be fully food secure, the situation is better than before: "*we are not fully food secure, because we have maize after harvest April to December. As of now things are better, we are able to eat comparing with the past years*".

4.15 People cope with the challenge of food insecurity through a range of strategies, such as piecework (*ganyu*), selling firework, gathering wild food, exchange/ bartering, and growing winter crops:

> *"I planted Seedco (Lion) hybrid seed. On 1 acre I harvested 30 bags of maize because of fertilizer subsidy but in the past I used to harvest 5 or 6 bags because it was difficult for me to buy fertilizer. I source money through doing some piecework like moulding bricks and selling firewood"*.
>
> *"In the past during the Bakili regime, we were eating jungle fruits and roots. As of now with the access of fertiliser subsidy, we are able to share the maize within our community. We are seeing some surplus of maize here and there, although some of us didn't have access to the fertilizer"*.

[44] Many villagers actually spoke about increased maize productivity, rather than food security per se. The implication was that with more maize then the number of hunger months was reduced.

"I have four plots of rice. I harvested only four bags and then I exchanged it with two bags of maize. I cannot use the maize for almost a year. It not enough because the rice production is so small. If it could have been that I harvest more rice therefore, I could have had more maize since I exchange with people who grow maize".

"In our area, after harvest we use our maize in May up to August or October. We do not have enough fields to cultivate because our land holding size is between 0.5 – 1 acre per household. However, people are used to growing winter crops (maize) called Nseula. We also have tea but we only harvest for three months and that is the time we get income".

4.16 The interviews with district officials and local service providers also support the view that food security has improved in recent years (7 SSIs). Several cite indications that people are less likely to resort to coping strategies such as looking for piecework (*ganyu*) in exchange for food, eating wild roots, and eating maize while its still in the field (green maize); with more people seen selling surplus maize. For example:

"Yeah that's quite obvious that we are now more [food secure] than five years ago. I think the instances where we have a situation where people were eating wild roots, these have not been reported in the recent past – which means that food security has now improved…".

"In the past around this time we would hardly see people selling maize but now if we move around even the people in the rural areas, you find that some weighing scales have been hung somewhere and people are selling maize, which is an indication that people had grown enough last year".

"We have not seen people going about in other people's home looking for piecework in exchange with food. It seems people have food in the village, though we can't say everyone has food but a good number of people have food".

"When we harvest our rice, we exchange with maize. If we produce 10 bags of rice, we exchange 5 bags of rice with maize which we will eat only for three months since we are many in our families… So we eat this maize from June, July and August then the maize is finished and if we sell the remaining 5 bags of rice, the money doesn't take long to get exhausted. You buy school uniform for children, a piece of cloth (Chitenje) for my wife, I also buy a shirt for my self, the money is gone…".

4.17 Some district officials (3 SSIs) make the point that while the apparent food security situation is better, both at a district level and for most households, there many families that continue to struggle: "*It is still a challenge [food security]. But overall you find that in the district you might have enough maize. But it's the question of now who has got that maize and who has not… So we are likely to have some families who still have some food shortages during certain time of the year, like this time of the year. But overall when they do, if they have money and they want to buy, they can easily access maize within the community. Unlike what was the case in the past where even when people had money it was a bit difficult".*

Remarks:

- While soil conservation and tree planting *activities* are occurring, protecting the environment in terms of soil quality, reducing erosion and planting trees remains a considerable challenge in many areas. It is not clear from the interviews the extent to which the environment is affecting people's daily lives, although clearly the high demand for inorganic fertilizer is an indication that soils are poor.
- Markets do not appear to be working particularly well for the smallholder farmer, with many complaining of low prices. This seems to be partly because surplus production is limited, but also because markets are distant (being replaced by vendors visiting the villages).
- Food security has improved recently, but for many it is equated to simply better maize production. While maize production may be better than in the past years, it still remains highly dependent on weather patterns. As such, many villagers remain vulnerable and highly dependent on weather patterns and access to fertilizer.

Challenges in agriculture/social protection

4.18 This section explores the current status of agriculture in terms of the everyday challenges that people face. Indeed villagers cite a huge range of challenges (40 different types in total), ranging from a lack of farm inputs (fertilizer, seeds) and erratic rainfall, to long distances to markets, a lack of land, unknown diseases and animals eating their crops (e.g. hippopotami). The most frequently cited challenges are: (i) an insufficient number of coupons (used to obtain subsidised fertilizer/ seeds); (ii) other difficulties obtaining farm inputs such as price or availability; (iii) erratic weather patterns, particularly rainfall; and, (iv) discrimination (possibly corruption), which is mostly linked to the coupon system. See table, below.

Table 5. Most frequently cited agricultural challenges

Challenge	Community Focus Groups	District officials	Local service providers	TOTAL
1. Not enough coupons	13	0	10	**23**
2. Lack of farm inputs	5	3	10	**18**
3. Rainfall	6	2	6	**14**
4. Corruption/discrimination/exploitation	5	0	5	**10**
5. Soil degradation	5	0	4	**9**
6. Hunger/food insecurity	0	4	5	**9**
7. Timing of input programme	5	2	1	**8**
8. Farm inputs expensive	1	1	4	**6**
9. Long distance to nearest agro market	4	0	1	**5**

Source: Section A (agriculture outcomes - challenges) for packages A, B and C.

4.19 Clearly for many people, there is concern about gaining access to coupons (mentioned by 13 FGDs). While many simply stated that there were not enough coupons distributed through the AISP, others were able to provide figures to support their concerns. In one village it was said that only 5 out of 120 households obtained coupons, plus some AEDOs mentioned that there were not enough coupons in 9 or 10 villages , or that only 45% of beneficiaries received coupons .

> *"The program is quite good but the problem is the inadequacy of the coupons provided to farmers. It is good when responsible people of the coupons come and register people but the problem when they want to distribute the coupons some names are deleted out from the coupons register and this negatively affects may farmers. This has affected a lot of people, almost 50 households of the village…"*.

> *"Fertilizer is being sold using coupons and these coupons are not enough for every body. They are given only to poor people and it happens that that poor person can take that coupon and sell it to buy maize. But what is needed is to remove this system of coupons so that everybody should have an equal chance of buying cheap fertilizer; in that way we will have food. So the challenge on maize that is there is the subsidized fertilizer that is not available to everybody"*.

4.20 The shortage of coupons is also closely linked to other factors that are mentioned by villagers, including discrimination/ corruption (5 FGDs, 5 SSIs) and the timing of these inputs (5 FGDs, 3 SSIs); cited as the forth and seventh items in Table 5. These aspects are discussed in more detail under "Section C: Delivery of Services".

4.21 There also appears to be a more general difficulty in gaining access to farm inputs (cited as the second item in Table 5), particularly fertilizer and seeds but also herbicides and pesticides (5 FGDs, 13 SSIs). For many it is simply that, "*it is difficult for farmers to buy fertilizer because it is very expensive*", but also because some suppliers experience stock shortages (such as for fertilizer stocks, and seeds for soya, groundnuts and beans).

4.22 Smallholder farmers also say that they experience problems with the rains, including the rains arriving late, erratic rainfall or the premature ending of the rainy season (cited as third item in Table 5).[45] In people's minds this is sometimes linked to climate change. For many people, this year appears better than the past three or so years:

> *"Here we expect rains to be in December. For the past three or four years there is a tremendous change of rainfall. When they are expecting to receive rains is when they don't receive rains. Therefore, they can buy the seeds and plant but without rainfall. Hence, the seeds can rot in the soil, without germination. Therefore, they may come and buy some more seeds of which they are wasting money"*.

[45] As most smallholder agriculture is rain-fed (i.e. dependent on the rains rather than irrigation) this can sometimes have catastrophic consequences for households and the nation more broadly.

"Changes in climate – too much rainfall sometimes it affect hybrid production since it matures fast compared with other local production".

"Another challenge is the poor climate, rainfall ceases earlier before the crops matures. It is only this year that we have seen that rainfall is still falling".

"Some other problems of hunger are coming because there were rainfall problems; may be there were dry spells for a long time, this contributed to low yield. And here again the rivers in this area don't have enough water and people fail to grow crops three times a year".

4.23 Finally, villagers mention a whole host of other difficulties and challenges with farming in their areas. While many are only mentioned once or twice, these include:

- Increased soil degradation, such as due to cultivation of the riverbanks
- Long distances required to buy inputs from traders or shops
- People undertaking piecework, having less time to work their own fields
- Vendors selling inputs at a high price, or buying crops at a low price
- People who have HIV/AIDS, or poor health, are unable to work the land
- A lack of land, with fields sometimes infested with weeds
- Crops being attacked by unknown diseases (e.g. groundnuts)
- Inaccessible markets, i.e. distant markets places
- Vendors using inaccurate scales when purchasing crops

Remarks:

- Access to farm inputs (fertilizer and seed) are seen as by far the major constraints to smallholder farming – and hence why difficulties getting hold of subsidized fertilizer (through the coupons) ranks so highly. That DFID has supported several programmes to increase the availability of inputs, does appear to have directly targeted the primary (perceived) needs of farmers.
- Other aspects also rank highly however, including erratic weather patterns and soil degradation, plus hunger/ food insecurity, high input prices and dysfunctional markets. This seems to imply the need for complementary support in other areas, such as adaptation to climate change, protection for the most food insecure, and addressing the value chain and input/ output markets.

B. Changes in agricultural outcomes

4.24 This section explores the perceived changes in agriculture (whether the situation is improving or not), and the reasons given for these changes. The section provides a mixed perspective, and seeks to understand the reasons for such a range of views.

Overall changes compared to 5 years ago

4.25 In general, some villagers view the current state of agriculture as improving (8 out of 18 FGDs), though many still see it as a mixed (7 FGDs) or worsening situation (3 FGDs). Indeed, many of those that cite positive responses about agricultural situation also highlight difficulties. Yet, district officials (DADOs, DPDs, etc) and local service providers (mostly extension workers, NGO staff, ADMARC Market Officers) generally perceive the changes as mostly positive over the past 5 years (26 out of 33 SSIs). See table, below.

Table 6. Overall changes in the agricultural situation compared to 5 years ago[46]

Changes in agriculture status	Community Focus Groups	District officials	Local service providers	TOTAL
Improving	8	13	13	34
Improving, but some problems[47]	7	2	3	12
Static, or getting worse	3	0	2	5
TOTAL	**18**	**15**	**18**	**51**

Source: Question A2 (changes compared to 5 years ago) for packages A, B and C.

Reasons for reported changes[48]

4.26 Villagers cite a whole range of factors for general improvements, ranging from subsidized coupons, rainfall and advice from extension workers, to the use of manure, the drawing of water for irrigation and better protection from thieves. Other factors mentioned include farmer's hard work, diversification of crops and cash-for-work schemes.[49] Fertiliser subsidy coupons and extension workers are cited as the main reason by those who perceived improvements – yet conversely, it is also seen as the main reason for a worsening situation. See table, below.

Table 7. Main reasons given for reported changes

Reasons	Community Focus Groups
For an improving situation:	
1. Fertiliser subsidy	8
2. Better advice/leadership	4
3. Agriculture Extension Development Officers (AEDOs)	4
4. Better rainfall	3
5. Use of manure	2
For a worsening situation:	
1. Lack of coupons	4
2. AEDOs not delivering	3

Source: Question B (reasons for outcomes) for package A. All other responses occurred only once.

[46] Based on responses to question A1 (agricultural status) and A2 (changes compared to 5 years ago).

[47] This category includes a mixture of responses, including those where respondents say that agriculture is improving (when asked about the general status, A1) but then provide less positive responses later on (when asked to compare with 5 years ago, A2).

[48] This section is based on responses to question B (reasons) unless otherwise stated.

[49] Based on responses to question A1b (changes over the past 5 years).

4.27 As mentioned above, of those that cite unequivocal improvements, people make the strongest link to coupons for subsidized fertilizer (8 FGDs).[50] A typical response was, "*Generally, we are improving in agriculture because of the fertilizer subsidy, although some of us did not benefit from the fertilizer*". Or, "*The current state of agriculture is improving despite various challenges. It is improving because of better rainfall and subsidized fertilizer. People used to have only maize only for four months after the harvest but now they are having six months after the harvest. Children were affected by malnutrition because of the scarcity food, but now such cases have been reduced*". Several district officials and others staff see rainfall and access to inputs together as having improved production in recent years:

> *"I think there were fewer people who were benefiting from the targeted inputs…. But from what I have seen, a good number of people are able access the inputs [under AISP]. And of course, it's still it's not everybody because when you go round you find there are some fields which you see that have not been applying fertilizer. But to some extent… the food situation has been improving taking into consideration that other factors are equal in the sense that if the rainfall comes normally… But if there is a drought somewhere, that still will have an affect… But in general I think there a positive improvement".*

> *"It has improved very much. When I came here in 2004, I found that some farmers were buying commercial fertilizer but not many. But upon the introduction of the AISP in 2005, I have seen so many farmers coming for instructions on how to apply fertilizer. I have been telling them that UREA is the fertilizer that we apply when the maize is knee high. This is an indication that farmers in the past were not using the fertilizer".*

4.28 Villagers also cite better leadership (4 FGDs), and advice from AEDOs as helping to improve the agricultural situation (4 FGDs). For instance, "*The general observation is that agriculture… is improving because of the good leadership, near the agriculture the EPA [Extension Planning Area] and the fertilizer subsidy program. As such, we have many crops which we are growing within our village*".

4.29 Rainfall is also cited as an important factor (3 FGDs). Rainfall is seen as being generally better this season, especially when compared to more erratic rains in previous years. For instance, "*This year we have had better weather and rainfall so we believe that we will have more yields comparing with the past years. For those who worked hard and had farm inputs like fertilizer, they will have more yields. But for those who didn't work hard and fell sick, things will be bad for them. Last year rainfall ceased earlier and this contributed to low crop production* ". And, "*I think there is a big change despite the harsh weather but at least we have been able to feed ourselves; at least this time if you move around and go to ADMARC you won't find long queues looking for maize. At least we have adequate stores especially this year. We had fears that due to a heavy turn of rains last year we would have problems in terms of food but at*

[50] At the time of interviewing (February, March), farmers had not yet harvested the year's maize although they generally considered the situation to be better than past years. Based on both responses to question A1b (changes over the past 5 years) and question B (reasons for these changes).

least we feel that this time I think we are able to feed ourselves and can even sell some outside the district".

4.30 For those that saw the situation being static or getting worse, this was mainly put down to not being able to access fertilizer – either because it was too expensive or because not everyone benefited from the coupon system: "*We have poor soils and full of terrains, because of fertilizer coupons we are able to receive fertilizer. We are 30 households in total but only three-quarters got access to the fertilizer coupons, and a quarter did not have access. Therefore, it causes disagreements"*. And likewise, "*We received only 5 coupons out of 63 households. We were told to share the coupons upon buying the fertilizer. For five bags we shared 2kgs for UREA and CAN and this wasn't enough for village. Therefore, it likely that the production is going to be poor*". The sharing of fertilizer was reportedly common in most villages, with people citing inadequate coupons and that village headmen wanted every household in the village to benefit from the coupons.

4.31 Several villagers recognized the fact that AEDOs were not adequate in their area and therefore serving their designated areas was a tall order (3 FGDs). Examples given include: "*We just hear from people that at Makioni, there are some AEDOs but we have never seen them. In the past years we used to see more AEDOs; they were visiting us and our fields. We are still using a traditional way of farming*". Similarly another group of villagers explained that the AEDO is not delivering a good level of service, and although the AEDO established a sample field 400m away, they are not interested in going because, "*she is going to tell we what can not afford, like commercial fertilizer*".

4.32 A few other factors were also mentioned to explain a worsening situation. These included poor rainfall, limited take-up of irrigation practices, insufficient time to work on fields because of doing piecework, hippopotami eating crops, a lack of fertilizer, and hybrid maize that was more easily attacked by pests and diseases.

Remarks:

- The AISP appears to have been the major factor in improving agriculture (maize) production in recent years. The positive comparisons of the agricultural production with the past five years however, need to be considered in context. As some farmers and officials mention, rainfall is a major factor, and in previous years poor rains have resulted in severe shortages. As soils are often very poor, access to inorganic fertilizer can also make a dramatic difference to production in a single season.
- There is a mixed picture in terms of whether agriculture extension has contributed to an improving situation, or indeed whether the worsening situation is due in part to extension not delivering.

C. Delivery of services

4.33 This section explores in depth the various factors that affect the delivery of agricultural services, based on the perceptions of villagers, district officials and local service providers. Over the past five years, DFID has supported various schemes to provide farming inputs, including subsidized fertilizer and seeds. Malawi has a long history of subsidising fertilizer, and DFID has in the past supported the Malawi Targeted Inputs Programme (TIP 2003), the Inputs for Assets programme (2003), Support to 2004/2005 Special Agricultural Programme, and support for the Government's growth-enhancing Agricultural Inputs Subsidy (AISP, 2006). Under its current strategy, DFID is also looking to support farming input and maize markets under the GoM's Agricultural Inputs and Maize Markets programme, 2007-11.

4.34 Under AISP, the government allocated a significant proportion of the national budget to subsidized fertilizer, with the aim of reaching at least 1.5 million smallholder households (half of Malawi's population) with vouchers (coupons) that entitle them to access fertilizer at less than one third of its average retail price.[51] The aim was to increase maize production, for consumption and sale, and by doing so reduce the number of households at risk of not being able to meet their nutritional requirements.

4.35 This section explores service delivery in the agricultural sector, and particularly subsidised fertilizer under AISP. The section is structured in two main parts. Firstly, it covers agricultural services in general, including public/ private and NGO provision. Then, the second and longer section focuses on the AISP, and especially concerns with targeting and the implementation of this programme.

Agricultural service delivery

4.36 This section explores the broader concerns about agricultural services, such as through extension, the private sector and NGO provision. Most FGDs commented on aspects of direct relevance to the AISP, which are covered later. Instead this section draws on mainly the concerns of district officials and local service providers. Agricultural services are generally seen as meeting people's needs to some extent, with concern expressed particularly about the number of extension workers to serve the population, their skills and the location of suppliers.

Adequacy of services

4.37 In general, respondents said that agricultural services are meeting people's needs *to some extent* (18 out of 24 SSIs). Services were seen as inadequate in terms of too few extension officers to cover large areas (with a lack of resources for fuel and allowances) as well as a lack of services in terms of irrigation, soil conservation (manure, agroforestry), protection from animals and the planting of trees. Inadequate supplies of

[51] Logical framework for DFID support to GoM's Growth-Enhancing Agricultural Inputs Subsidy, 2006.

inputs (due to agro dealers) and the high demand placed on extension services was also mentioned by those who felt that services were not meeting the demand (3 FGDs).

Table 8. Perceptions of agricultural services meeting people's needs

	District officials	Local service providers	TOTAL
Yes - meeting people's needs	1	2	3
Yes – to some extent	6	12	18
No – not meeting people's needs	0	3	3
TOTAL	**7**	**17**	**24**

Source: Question C (unmet needs) for packages B and C.

4.38 The main factors that people used to explain inadequacies in service provision were: (i) not enough extension workers; (ii) not enough skilled extension workers; (iii) problems with the location of suppliers, and; (iv) concerns with the availability of inputs due to the cost of commercial fertilizer.

4.39 **Staffing:** Many respondents (14 SSIs) expressed concern that there were not enough AEDOs, and those that were in post had to cover a large area. This was occasionally (2 out of 14 SSIs) linked to a lack of transport (motorbikes) to cover the long distances. For example, one agricultural extension worked explained, "*Here at Chikangawa we have 4 AEDOS. For example myself, I am AEDO for livestock. I am responsible for whole area and three AEDOs for farming; we cater for almost 5,000 households*". Similarly, "*The services are not enough. Farmers here are many and our services are not enough to give to all the farmers. We are just two of discharging extension services. We are working with 4 sections with over 3,000 farming families. To monitor them all using a bike [bicycle] is not a piece of cake. It takes very long time to meet each of them and some times they finish growing seasons before we can advise them. The demand of AEDOs is so high especially in irrigation schemes and we cannot manage to cycle long distances. It needs a lot of concentration like when designing, and with any slight mistake farmers come and ask you the way forward which may demand your presence at the site. Therefore, we need motorcycles so that we can assist almost 10 clubs within a minimum time*".

4.40 Another common complaint was a lack of skilled extension workers, either to bring new technologies or update existing skills such as on pests and diseases or artificial insemination (8 SSIs). For some, motivation was seen a problem amongst governments staff, "*Motivation is of course there but maybe people they go to workshops… salaries are not all that motivating in civil service that is why you see sometimes we lose members of staff moving to non-governmental organisations*".

4.41 **Location of suppliers:** Some respondents (10 SSIs) mentioned problems with not enough suppliers of inputs, or that the suppliers ran out for some inputs. For instance, "*We are not many [suppliers] we are only one and we don't have farm inputs like pesticides and sprayers. There are some farmers who use sprayers for tomato treatment with pesticides. We do not have most of the pesticides. However, most of the times we have actellic*". Sometimes,

people experienced long queues to obtain fertilizer, even sleeping overnight on occasions: "*The places we are buying our inputs are not enough. For seeds, pesticides, insecticides at least it is working because we have agro dealers, but for fertilizer they are not enough because people can sleep at a depot for 2 days without accessing fertilizer*". Yet, there were also many who thought that there was not really a problem with input supplies, with no clear pattern to do with location (7 SSIs).

4.42 **Cost of inputs:** In general respondents said that the subsidized fertilizer was affordable for most farmers, but that commercial fertilizer was just too expensive for the average smallholder (8 SSIs). As explained by an extension worker, "*During the 2008/09 season, it was not easy for the farmers to buy and have such inputs because fertilizer was adjusted from K3500 to K8000. It was so expensive to the local farmer*".

4.43 **Private/ public sectors:** In a comparison of the private and public (ADMARC) suppliers, opinions are divided. The general perception is that the ADMARC suppliers are better because they are cheaper, but the private sector will often have better supplies despite being more expensive. As one farmer summarised, "*It is easy to have inputs from a private trader/retailer but they are expensive. However, at ADMARC inputs are cheaper but the availability is poor*".

Remarks:

- These are the views of district officials and local service providers who generally see agricultural services as meeting the needs of smallholder farmers, at least to some extent. A lack of staff (and skilled staff) for extension services and the location of suppliers are seen as the major constraints.
- Villagers however were much more focused on the issues around access to subsidized fertilizer, and the AISP in particular. These are covered in detail in the following section.

Agricultural Input Subsidy Programme

4.44 The AISP is the current centrepiece of support to the agriculture sector – as witnessed by many of the discussions which, when asked about broadly about agricultural challenges, highlighted the lack of coupons for subsidized fertilizer (see Table 5). This section focuses on targeting and implementation aspects of the programme in terms of: (i) comparisons with past programmes, and particularly the TIPs and starter pack; (ii) the targeting of inputs especially for the poorest; and, (iii) implementation constraints around registration, the timeliness of coupons, distances to input suppliers and corruption/ unfairness.

AISP, TIPs and the Starter Pack

4.45 In many cases, villagers, district officials and local service providers made comparisons with past programmes, such as the TIP and the Starter Pack. For the majority, the AISP was seen as better, with only a few citing the TIP as better (see table below).

Table 9. Comparisons between AISP, TIPs and the Starter Pack programmes

Districts	Community Focus Groups	District officials	Local service providers	TOTAL
AISP perceived as better:				
- Mzimba	2	2	7	11
- Salima	1	0	3	4
- Mulanje	4	1	6	11
All districts	**7**	**3**	**16**	**26**
AISP perceived as worse:				
- All districts	**3**	**1**	**0**	**4**

Source: Lexical search across all questions (Packages A, B and C).

4.46 For those that thought the AISP was better, most made the comparison with the Starter Pack scheme (n = 15, made up of 5 FGDs and 10 SSIs). The most commonly cited reason for the AISP being better was that under the Starter Pack scheme the quantities of fertiliser were too small. So for example, "If *we compare to the Starter Pack, this subsidy [the AISP] has improved because the Starter Pack was just like peanuts… but now with this one, it's like 'ikumamuthandiza muthu kuti apeze thumba' [translation: it is helping someone to get a bag, meaning to get a step up in life]... so that if he harvests maize he will be able to care for his family. While the Starter Pack was just one week; they would just benefit a week. I think it has really improved*". Others also cited comparisons with the quantity of fertiliser received:

> *"With starter pack we used to receive 10kg of fertilizer, therefore it wasn't enough for application in the field. AISP is better because a 50kg bag can be used for a larger area".*

> **"***Fertilizer subsidy [the AISP] is assisting because you are assured of a full bag of fertilizer if you buy. Starter pack was bad because the harvest was low, but AISP is better because with two bags of 50kg fertilizer, one can apply to a larger area than the Starter Pack which was*

only 10 kg".

"With the Starter Pack, fertilizer or seeds were not enough. Suppose if one is to cultivate a large area, you were only given maybe 5 kg or 10 kg of fertilizer which will not be enough for your field. This means if you apply that fertilizer, you will still need some more fertilizer to top up, whereas with subsidy fertilizer [the AISP], if you are given two or more bags, you apply on a big land and you harvest a lot of crops".

4.47 For a few others the main benefit of the AISP was the greater transparency compared with the Starter Pack scheme (3 FGDs). So for instance, "*Things are better now because coupon beneficiaries are identified during open forum and we receive it [the coupons] in an open forum upon calling names. It was different with the Starter Pack*".

4.48 For most of the others that cited AISP as better,[52] the comparison was made with TIP (n = 9, made up of 1 FGD and 8 SSIs). The main reason give was that AISP enabled farmers to get access to more fertiliser, and so farmers were able to apply this to a larger land area, and produce more maize to last them through the hunger season. As someone from the private sector explained, "*It has improved much. AISP is providing a bag of 50kg fertilizer but TIP is a small bag of 5 kg. With a 50kg bag a farmer may be able to apply to an acre of maize, but for TIP it was so difficult to do so*". Also, "*TIP was a difficult programme because farmers were receiving 10 kgs or 5kgs of fertilizer. It was not enough, but coming to fertilizer subsidy [AISP], farmers are buying a bag at K800.00 per 50kg which they can apply on half hectare. Everywhere we can access, and we can access it in time*". And finally, "*With TIP a farmer could only have a small plot, but with AISP, at least a farmer has to do something to find money to buy fertilizer. Whereas with TIP a farmer will just sit back and wait for the inputs*".

4.49 Amongst the villagers, perceptions about the AISP being better were less clear, with 3 out of 10 FGDs (30%) seeing the TIP as a better scheme. The reason cited was most commonly because "everyone" was able to access the scheme:[53] "*TIP was better because we were all able to access fertilizer although it was in the small kgs and we applied in small field… at least we had something from the field. AISP is bad because coupons are not enough, and once the coupons are shared out it is just like the TIP*". And similarly:

"TIP was better comparing to AISP. In TIP everyone had access to the fertilizer; we were able to apply the fertilizer at small portion but AISP is bad because, to access the programme we need to have more coupons and it is quite difficult to be registered".

"TIP was better because everyone of us was benefiting almost 5 to 10kg and AISP is not better because 5 people are sharing one bag. Therefore, AISP need to be universal so that everyone should access".

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[52] Only two (out of 26) respondents cited that the AISP was better but did not make a direct reference to the TIP or Starter Pack programmes.

[53] This might seem surprising, as the TIP was a more targeted intervention (as the name suggests). It seems however that due to shortages of coupons in some areas, the AISP has to in effect become even more targeted (i.e. due to the scarcity of coupons and the large numbers of potential beneficiaries).

4.50 One other comment by a DEM mentioned that at least under the Starter Pack, distribution and access was better for some communities. This was because the pack was delivered closer to where the people lived (i.e. more similar to humanitarian aid distributions). Yet, as AISP utilises some commercial suppliers, the distance for some villagers can be quite large (see also paragraph 4.62). So for example, "*in the past when we were looking at Starter Pack, people were just distributing … you would register and then they would get the actual pack. They would just go out there and deliver…. But this time, since it is done at a more or less commercial level, people have to travel. While in the past people were going and the commodity was going where people were, and people were just told to assemble at a certain point and then a truck would come. They would offload and then people would just be given the packs. But this time… it's a bit challenging*".

Targeting

4.51 This section explores issues of targeting, and particularly who gains access to the subsidised fertilizer and who does not. Most discussions (11 out of 18 FGDs) mentioned that the coupons were "not enough", and this makes targeting difficult. For example, "*Some are accessing, some not. Here we had 197 coupons yet we are almost 800 households. Therefore, others are not accessing*". It seems that many villagers experienced lots of people registering by when it came to actually receiving the coupons the numbers were far less than at first thought: "*We just register the names but agriculture people do reduce the number for example we registered 70 people in this village but only 19 people had to receive the coupons. We used to call people on the open forum and we were calling them their names*". As one Market Officer from ADMARC summarised, "*The programme [AISP] is quite good, but the problem is the inadequacy of the coupons provision to farmers. It is good when responsible people of the coupons come and register people but the problem when they want to distribute the coupons some names are deleted out from the coupons register and this negatively affects many farmers. This has affected a lot of people almost 50 households of the village; we could see that during the time of selling fertilizer only 10 households out of 50 households are able to buy [using] the coupons*".

4.52 This puts considerable pressure on Village Heads and other leaders as they seek to resolve disputes about who receives the coupons and who does not – with villagers sometimes suspecting that the leaders have hidden some of the coupons. As one Village Head explained, "*Being the village headman in this village of Makioni, I received five coupons. I just distribute to the poorest people in the village although I am also poor. I did that because people thought I am keeping coupons yet I did not apply anything in my fields. I wanted to make people happy*". This does however at times lead to bad feelings about the distribution of coupons (8 FGDs), such as shouting or foul language (even fighting), most of which is aimed towards Village Heads or Traditional Authorities (TAs). For example, "*Being Village Headman Kasoti, I have faced bad experiences. There was a certain man who came to me and shouted with foul language while my family members were there just because I missed him during registration. However, I called the police to jail him*".

4.53 Partly as a consequence of this limited supply of coupons, it seems that a market has developed in some areas with coupons being bought and sold: "*Vendors can just find coupons through buying. Vendors negotiate with them to buy coupons. This is just like monopolizing the rights of the farmers who are poor, for them to have money to buy some other things. These vendors may collect and buy more coupons from farmers…Vendors can just hire people to buy on behalf of themselves and then give the money afterwards*". Similarly, "*The open market traders buy coupons from vulnerable poor farmers and resell in smaller measurements, i.e. per kilogram*".

4.54 Overall though, and despite the limited numbers of coupons making targeting more challenging, it seems that poor households were generally reached.[54] Amongst district officials and local service providers, many saw that targeting had been effective (15 SSIs). As one District Education Manager (DEM) summarised, "*A cross-section of people benefited; the poor were included and … I should think the majority were the poor. But as you are aware this type of programme… some people would still find their way in, even if they are not that poo*r". In some interviews this was attributed to the process whereby the villages selected the beneficiaries, so for example: "*The villages were selecting themselves and so we believe that they selected the targeted people. These people were not selling the coupons if there were any doing such malpractice then it was 1 percent because most people's priority is farming which is a livelihood*". And similarly: "*We were briefing the local leaders so that they choose the right people, the poor, the poorest, so we were able to see that they were the right people. Of course it was happening that there are some people who were not the poorest but they were able to get coupons but at least the right people were the ones to receive*".

4.55 For those district officials and service providers that saw the targeting as being an issue (11 SSIs), some were vague about the problem, while other cited instances of better-off people benefiting (3 SSIs), or not enough coupons for every poor household to benefit (3 SSIs), or other reasons such as cheating and selling of coupons. Some of this was however conjecture, and not substantiated with specific examples. For instance one DADO said that, "*I don't have official documents so that may be some of the coupons went to the politicians and like but not a politician but somebody who was not supposed to benefit under this [programme]*". In other cases it was a more general sense that the better-off might be benefiting: "*I think the government should still do more because I have seen some of those who are benefiting are better off than those who are left out. I think the way they target, there is need for more to be done*".

Implementation issues

4.56 Villagers mention several concerns about the implementation of AISP. These tend to fall into a number of categories: (i) issues about registration, (ii) the timeliness of coupon distribution, (iii) problems with accessing fertilizer, and (iv) concerns about corruption and dishonest practices. These are discussed below.

[54] The term "poor" here is used to indicate the general poor, rather than the poorest households.

4.57 **The registration process:** Very few villagers mentioned problems with the registration process itself (2 out of 18 FGDs). The main difficulties appear to result from insufficient numbers of coupons, and the process of request/ verification and then being informed that they'll get very few coupons. A few comments were however provided on the registration process:

> *"We are young people within this village we finished secondary school and we passed final exams but we are not employed, so we have thought that we must be entrepreneurs in agriculture, when coupons comes they don't allow us to register because we are still dependent to our parents"*.

> *"Even the beneficiaries themselves, they tend to exaggerate because they know input subsidy is a good programme, so instead of giving the correct information of the actual beneficiaries, the number of farmers, they would tend to exaggerate writing more people. So there is need to really verify so that one takes us more time to do the exercise"*.

> *"Chiefs registered so many people but the government officials came to reduce the numbers and they said they reduce more and more. So such reduction caused people to receive only seeds and others fertilizer and some to the flexible coupons"*.

4.58 **Timeliness:** On the timeliness of the AISP, a third of the discussion groups said that they received the coupons on time (6 out of 18 FGDs) – and particularly villagers in Mulanje (4 FGDs), though also in Salima (2 FGDs). Others in Salima received the coupons on time, but found that there were not enough coupons (a further 3 FGDs): "*We received in time and the consignment of the fertilizer was good. There were more bags of fertilizer but the coupons were not enough. Hence, this made ADMARC to remove some tonnes of fertilizer to where people had coupons. We had to use transport at almost K800 to buy fertilizer at Salima [town] and other places where we can get the fertilizer*".

4.59 A further group of respondents received their coupons late (4 out of 18 FGDs, all in Mzimba):

> *"We received very late the coupons; hence, we did not buy the actual variety [type] of fertilizer in time. This has made us apply the fertilizer not in good time. For example, instead of applying CAN during the first weeks of maize, we were applying UREA… Moreover in December, we are food secure, therefore we buy food rather than to buy fertilizer. We don't have enough money during this month"*.

> *"We don't have adequate access to the fertilizer subsidy. We received very late and we are used to go to Mzimba to buy the fertilizer since Mtwalo ADMARC did not have fertilizer. We were paying MK250 and MK100 for transportation from Mtwalo town to here at Barubachirwa. We bought fertilizer at MK1000 instead of MK800"*.

4.60 As one DEM added, "*It has been a challenge when it comes to the timing of the input programme itself. For example, where rains start earlier you find that the onset of rains will not differ from region to region, but when the Government is giving out these things, it says rains*

will start from the South, come to the centre and then the North. What I have noted is that in some cases, people may start earlier and the product is not available so like basal dressing will not be there for people to apply even the seed itself…. by the time they get the seed people may have already planted some other type of maize seed… then you find that farmers lose heart in terms of planting the hybrid. Because they will not wait".

4.61 There are also problems in gaining access to fertilizer in good time, and this was largely due to the distances needed to travel to suppliers (4 out of 18 FGDs). For example, "*We did not receive the inputs in time. We go to Eswazini and Ekwendeni to look for fertilizer, we spent 2 weeks in the field looking for fertilizer, apart from K800, we pay almost K3000 for transport, sometimes if we have more bags it used to cost us K8000*". Or, "*We received in time but the distance to buy the fertilizer was long; people were going to Salima up to Chipoka looking for fertilizer. Some of them are still keeping the coupons because they did not have money for transport. They did not have D compound fertilizer for tobacco. Instead were using CAN*". The situation was particularly difficult in Mzimba district, where out of the 6 FGDs, they all either received their coupons late or had difficulties getting hold of the fertilizer because of distances and poor road conditions; "*Despite planting hybrids seeds and applying fertilizer, we received the inputs very late because of the poor road here, it was very difficult for trucks to deliver inputs, therefore, we received the inputs very late. We received NPK when maize was in the knee high and UREA when the maize was just three weeks old*".

4.62 The indirect costs of transportation can add a lot to a bag of fertilizer. As one person explained, he bought the fertilizer for MK 1,000 instead of MK 800 (£3), but with the transport costs it came to MK 2,000 (£7) in total.[55] This seems to have been a particular difficulty in Mzimba, a view supported by the DADO and a NGO staff member:

> *"In mid-December to January we find that some of the roads are impassable to big vehicles, and even the small vehicles like three-tonnes, might reach those areas with difficulties. So if inputs have not been delivered in adequate continuity in those areas we find that it becomes a problem for farmers to access these inputs within their vicinity. They have to walk long distances sometimes even using more transport; its like we are still adding on to the cost of the bag, and because of congestion at those markets centres they also have to wait for maybe two, three to four days. So it means we are also spending from their pockets".*

> *"The challenges which farmers are facing is the side of transport. The transportation means like roads. This affects them for instance during rainy seasons - if they want inputs, they can't buy at that particular time. Sometimes roads are in bad conditions, therefore, it takes time to come and collect the inputs like farm inputs like maize seed. So it takes time for them to plant the maize because they don't plant in the actual time".*

4.63 **Fertilizer application:** The challenge of late coupons coupled with problems getting hold of fertilizer supplies can result in applications not tallying with the planting

[55] Based on an average exchange rate of MK 280 for 2008 (HM Customs).

season. As one farmer explains, "*During the first days of rainfall, we receive UREA instead of NPK… Hence, it is difficult for us to apply correctly the fertilizer and this reduces our agricultural production. Our village is so large, therefore we share the fertilizer in a 20 litre bucket so that everyone should have access to fertilizer*". Similarly, "*Only UREA and NPK for maize production was available for sale. Those who received D compound and CAN coupons for tobacco were unable to access fertilizer unless they travelled to Salima or Chipoka. People were disappointed with this situation because they were unable to buy*".

4.64 **Misappropriation and unfairness:** A significant proportion of the villagers suspected underhand practices in the distribution of coupons and fertilizer (10 FGDs). It is not possible to substantiate these examples, but they range from the selling of coupons, to registers not tallying with the actual number of beneficiaries, fake coupons and instances of people paying above the norm for fertilizer despite possessing a coupon. This appears to be more common in Mzimba (5 FGDs) and Salima (4 FGDs). For instance:

> *"Some heard on the radio that fertilizer with a coupon was going at K800… I bought fertilizer at Mzimba ADMARC at K1000 because they told me"*.
>
> *"Our worry was that after spending 2 to 3 days in the line, we used to see some people coming and buying fertilizer and leaving the line. Upon asking them, they were saying, 'you need to have something for you to have access to fertilizer', meaning that we were obliged to add money - maybe K200 - to give it to the sales clerk"*.
>
> *"We have noticed some corruption from fertilizer coupons because, the number they register doesn't tally with the number of the registered beneficiary"*.
>
> *"We noticed that some people were selling fake coupons to people within this village at the rate K6000 and then when they go and buy the fertilizer they were told that this is fake coupons. This not good for us poor villagers"*.
>
> *"I am assuring you that I bought fertilizer at K1000 instead of K800. This was bad for me. I could have used K200 for other items"*.
>
> *"We believe that AISP is better programme but the government officials like from agriculture do take some coupons from us. Because the number of the coupons are not tallying with the number of the villagers…As such this has caused some disagreements between our village headmen and us. Village head men are not wrong but the top government people"*.
>
> *"This year our extension staff signed the coupons. Those ones that were signed in Mulanje so it was easy to identify the fake coupon; these coupons were not signed by the authorized signatory… In the market we had some cases whereby there were some fake coupons, but these were easily identified because the sales officer would refer back to say that this is not the genuine signature, can you go back"*.

Social protection

4.65 Under the AISP there appears to be some confusion about the target group - with both a general sense that the poor (as opposed to the better-off) should be reached (see paragraphs 4.54 to 4.55), as well as in some cases, the poorest, most vulnerable and orphans being seen as the prime target group. As one Village Head explained, ""*What was happening was that they were choosing the poorest and the orphans upon having briefed them. They had a register for keeping the names of all beneficiaries*". Even a district level, there was a sense from some officials that the focus was on the most vulnerable: "*Distribution, yes distribution, this time focuses on the most vulnerable groups. We know in Malawi they are very poor people; we are talking of the actual poor. We are targeting the ultra poor… the people who are very, very poor, who are able to afford may be one meal a day or no means at all. So those are the ones that have been targeted in that programme [AISP]*". People however have different perspectives on who are the poor or not-so-poor, and the separation between the 'poor' and the 'poorest' is highly problematic. As one DEM explained, "*It is difficult to talk of who is vulnerable who is very poor because when you go out in the village like… when people went out register, everybody was saying 'I am poor, so register everybody in this village'…*".

4.66 For the poorest that did receive coupons under AISP, there is mention of them selling these coupons as a form of coping strategy; as money for food/maize or other essential items was seen as more pressing (see paragraph 4.53). "*These days, fertilizer is being sold using coupons and these coupons are not enough for everybody. They are given only to poor people and it happens that that poor person can take that coupon and sell it to buy maize. But what is needed is to remove this system of coupons so that everybody should have an equal chance of buying cheap fertilizer, in that way we will have food… if it were like it used to be in the past when everybody bought cheap fertilizer, we could have food and sell the surplus*". And similarly, "*The rich are the ones who were having coupons. The poor were targeted but the problem was with the poor because they would go to the rich with the view of selling the fertilizer coupons especially because of scarcity of food amongst the poor. The rich were able to buy coupons for cheap fertilizer*".

4.67 More generally however, there is not much mention of social protection programmes or other forms of support. Only a few interviewees mentioned how the old, orphans, the disabled and most vulnerable are supported (i.e. mostly through NGOs, rather than government schemes):

> *On social protection, we have programmes in the district but they are not covering enough. For the orphans, especially for those who are going to secondary schools, we have a programme on school fees from NAC (National AIDS Commission) that is helping at least a bigger number of children; so orphans who are asking for a bursary, at least they are being helped. Because there are at least millions: 30 million maybe, for school fees, which is coming from NAC. Other sources I don't know, but for NAC at least people are benefiting. For the elderly and the aged I have heard no big programmes on the elderly and the aged. But it's only for the disabled where I heard there are programmes from CBR. The CBR are from*

MACOHA and they are doing programmes on helping the disabled. And recently we are helped by these … from I think American Peace Group, that for the rights of the disabled. That has also helped a bigger number of the disabled people".

"On social protection, orphans, there are NGOs which are looking after the orphans and there is an NGO that is also helping the old people. On agriculture the aged people are also able to access subsidized fertilizer and also health services at the health center in the area. When people access health services they are strong and they are able to do daily jobs that everyone does".

"In social protection… there is a deliberate programme of cash transfer which is done in the country. People are able to work for the facilities by the end of the day they get about MK 200.00 a day and they work for about 10 days or 12 days and they get MK 2400.00. In that way, they are creating assets for themselves but at the end of the day they are able to get something which they can use…for their own benefit. In that way there is some sort of improvement and in social protection recently there is distribution of food crops, maize. They are also distributing to those vulnerable persons… Apart from that, instead of preventing people from doing ganyu [piece work] now and again, or instead of waiting for handouts, people are trying to do something to get money from it. In the past we used to just sit down and wait for someone to give us something but I think that's not the situation now. People have developed a hardworking spirit to earn a living for themselves…".

"In Mulanje if we are doing something good, it's because we are committed because we are working under very difficult situations. We do not have resources, so in social protection, not much is very good and we cannot deliver. The government is not committing more resources in social protection and even NGOs, when we had Oxfam, and Oxfam is gets funding from DFID, yes we could see that something is being done in social protection. But now Oxfam is gone, it's not easy to do something. When Oxfam was here, we were able to conduct labour inspections every month because we had resources. But when it pulled out, we are even having difficulties to service our vehicle… we are unable to have fuel for us to conduct labour inspections".

4.68 The Malawi Social Action Fund (MASAF) is mentioned several times, particularly in relation to public works (mainly road construction) for cash (7 FGDs, 5 SSIs). Many said that the cash was not enough and that few people benefited. For example, "*Public works for MASAF also are not enough because only 5 or 20 people are able to have such opportunities out of 80 households*". Others however cited instances where the MK 2,000 earned for 10 days work (about £7.10) was put towards purchasing subsidized fertilizer. For example, "*We had some MASAF projects which we were working for the construction of a rural road. We received K2,000 per 10 days. Some of us had to buy fertilizer but some did not because the money was used to have some household items. Some of our friends did not participate in this project. Only 10 to 20 people. However, some were not happy with this*". And similarly, "*I heard that there is a road which MASAF is constructing. It is assisting a lot of people in terms of transport because it is all bush here but if they clear the bush then cars are able*

to pass. However, money received from such projects is helping people to buy some farm inputs because they do this before growing season and food although it is not enough".

4.69 Others mentioned MASAF in terms of different projects such as to construct schools, planting seedlings and afforestation projects. For example, "*we have seen MASAF also with the public works system programme coming in to encourage communities to plant seedlings… So it's one way of soil conservation*". And, "*Under the MASAF project, the community replanted some trees and those that planted trees received MK200 per day for a period of 10 days. The money realized was supposed to be used for buying subsidized fertilizer (this was a government initiative)*".

Wider impacts on poverty

4.70 Respondents did not discuss in too much detail the broader impact of programmes and services on poverty in their location. Out of twelve FGDs that mentioned these matters, two-thirds of the discussion groups felt that poverty was decreasing due to these programmes (8 out of 12 FGDs).[56] As one person said during one of these discussions, "*Things have changed drastically, because people have food and we are sharing and we are trading within ourselves. Some diseases have been reduced like cholera and malnutrition*". Half of these more positive responses also linked these improvements explicitly to the subsidized fertilisers made available under the AISP (4 FGDs). One farmer explained how those people who had access to subsidised fertilizers were having more food and sharing amongst themselves – and that services generally were reducing poverty because people are selling some crops like tobacco, cotton and others. To quote another smallholder, "*Yes [the subsidy does make a difference]; poverty has been reduced, now people have enough food to last for 8 to 10 months unlike the previous years when they only had maize for 4 months*".

4.71 Nevertheless, at least a third of the discussion groups also felt that poverty was either the same or decreasing (4 FGDs). This was on a couple of occasions linked to an insufficient number of coupons. So for example, "*the coupons are not enough and this has contributed to lower production of crop production. Therefore, poverty is still improving [increasing]*". And likewise, "*It is difficult for us to say that fertilizer subsidy has assisted a lot in this village. It has just assisted small [few] households… Therefore, a little bit, things are changing. The increase in poverty could also be due to a shortage of coupons, HIV/AIDS, early pregnancies in the sense that families are getting bigger. We need a universal subsidy*".

Remarks:

[56] It should be noted that agricultural production in Malawi can fluctuate greatly between years due to changing weather conditions, and that in any one year, this can give the impression that life is progressively getting better – only to upturned the following year. Perceptions about trends therefore need to be treated with caution, particularly as at the time of the fieldwork, the 2008/09 season was considered to be a better than recent years.

- In general the AISP appears to have made a difference to farmers, and their likely production for the year. There is however no clear line between the poor and not so poor and the general view is that not enough coupons were delivered under the AISP. This sometimes led to tensions and difficulties as Village Heads and Traditional Authorities having to decide who would receive the coupons (and who would not). As a result, some of the 'middle-poor' may not have been reached.
- There is some confusion about the target group for the AISP, with some respondents saying that the priority was for the vulnerable, elderly and orphans. For the very poorest who did receive coupons however, the strategy seems to have been to sell the coupons due to more pressing needs – calling into question whether the AISP is really able to assist the poorest.
- Not much mention was made of other assistance for the very poor or vulnerable (elderly, disabled, orphans, etc), indicating perhaps that this is a neglected area of support. Except for MASAF which provides small cash injections (about MK 2,000 for 10 days, or around £7s), little mention was made of other social protection schemes.
- The arrival of late coupons was an issue for some, while for others, the distance required to purchase the fertilizer also delayed access and subsequent application on the fields. Plus the indirect costs due to transportation increased the cost for many farmers – sometimes more than doubling the eventual cost.
- Corruption and dishonesty have been major concerns about the AISP, with a significant proportion of villagers suspecting or experiencing problems. This may call into question the efficiency of the process.

5. Summary and conclusions

5.1 This section sets out a summary of the main findings, as well as some conclusions from the study. The findings are based on the qualitative data collected, and reflect the perceptions of the villagers, district officials and other service providers. Therefore while the findings may provide an insight into the lives of ordinary people, they still need to be triangulated with other sources of evidence as part of the main NAO VFM report.

Summary of main findings

5.2 This is a relatively brief summary of the main findings. The purpose of this section is to draw out and synthesize the central themes of the study.

The health sector:

5.3 In terms of disease incidence the perceptions of local people are consistent with what might be expected; i.e. malaria and HIV/AIDS being viewed as the most prevalent, and with (perhaps) the greatest impact on the lives of ordinary people; plus, malnutrition viewed as much more location-specific, dependent on food harvests and the supply of supplements. The understanding of reproductive health seems to have generally improved in recent years but there are still problems gaining access to family planning methods; tuberculosis is mostly viewed in terms of being present yet treatable; and *schistosomiasis* (bilharzias) is seen as generally rare (though more common in the discussions held in Salima and Mulanje).

5.4 Villagers generally take a much broader view of health, and link health outcomes to not only the quality of healthcare provision but actually give greater importance to other factors. These include hygiene practices, the lack of boreholes (scarce and unsafe water), and to the lack of food (long hunger seasons, malnutrition). District officials and local service providers tend to take a narrower view, focusing more on the health system than the broader context.

5.5 Overall, people generally perceive the health situation as improving although villagers tend to be less positive than those who work in the sector (such as DHOs, HSAs, medical assistants, nurses, midwifes, etc.). It is difficult to attribute these improvements to only a few key factors however, as people cite so many factors. In recent years it does seem that increased awareness about diseases and available treatments (such as for TB, HIV/AIDS, reproductive health) has helped reduce incidences – alongside the better supply of drugs (particularly ARTs) and greater resources (SWAp funds, medical staff and NGO provision). These are all seen as contributory factors.

5.6 In terms of service provision, distance and transportation costs are seen as major constraints to healthcare access, and more so for the poor and elderly. This is made worse when the nearby health centre is unable to provide the care required, and patients are referred to another health centre or hospital for treatment.

5.7 Indeed, healthcare facilities are perceived by many villagers as inadequate. This is seen as especially due to insufficient staff numbers to deal with the demand (resulting in long waiting times and overworked staff). Villagers also generally perceive the physical infrastructure and equipment at health centres as inadequate, although district officials and those working at these facilities do not cite this as a major concern. Indeed, the examples of insufficient equipment are so diverse that it is difficult to draw out a common theme. Medical supplies seem to have improved in some instances, although most villagers' continue to face problems due to stocks running out (sometimes being told to purchase panado or aspirin from the local stores). Some district officials also face unpredictable supplies. Finally, there are also some examples of poorly qualified staff or improper behaviour, but this does not appear to be an overriding concern.

5.8 NGO and particularly CHAM provision is seen as generally more effective than government services, though the gap may be closing. Some villagers are however concerned that government medicines are less effective, perhaps indicating problems with the dispensing and the lack of appropriate medicines.

5.9 For HIV/AIDs, there appears to be good provision of VCT services. People however experience problems with access to ARTs from their health centre – though the programme is still being rolled out. Problems with getting hold of ARTs can also lead to further travel to the district hospital. This can sometimes be viewed as a barrier to access due to the cost of transportation. It also appears that PMTCT services are beginning to be implemented through more health centres.

Agriculture and social protection:

5.10 In the broader context, views on the environment are fairly evenly split amongst those that see it as improving (although problems persist) and those that continue to see problems of soil quality, erosion and deforestation. Clearly environmental activities are taking place (tree planting, contour ridges, manure, agro-forestry) in some areas, though it is not clear whether this is sufficient given the continued reliance on inorganic fertiliser (an indication of poor soil quality).

5.11 People face many challenges in agriculture, though the views of villagers appear mostly preoccupied with access to inputs, and particularly subsidized fertilizer. Access to farm inputs (fertilizer and seed) are seen as by far the major constraint to smallholder farming – and hence why difficulties getting hold of subsidized fertilizer (through the coupons) ranks so highly. Of the other challenges, villagers mainly cite erratic weather patterns, soil degradation, hunger and food insecurity, high input prices (especially commercial fertilizer) and markets. On markets, villagers give examples of selling a wide range of crops but often in small quantities to meet particular needs (such as corrugated iron for roofing, maize for consumption, school fees, etc). Many villagers complain of low prices, with vendors coming to villagers to purchase crops.

5.12 While some villagers view the current state of agriculture as improving, it is seen as a more mixed picture than for health. District officials (DADOs, DPDs, etc) and local

service providers (mostly extension workers, NGO staff, ADMARC Market Officers) generally perceive the changes as more positive over the past 5 years. It seems that access to subsidized fertilizer (under the AISP) is seen as a major factor in improving farming (maize production) in recent years. Other factors are also cited, such as extension services and improved rainfall.

5.13 In terms of service delivery in agriculture, there is a varied situation. Villagers mostly commented on the AISP, while district officials and local service providers generally saw agricultural services as going someway to meeting the needs of smallholder farmers. The major concerns were with a lack of staff (and skilled staff) for extension services, plus the distances to agricultural suppliers.

5.14 Overall, the AISP appears to have made a difference to farmers and their likely production for the year. Targeting remains an issue, as people generally felt there were insufficient coupons to meet their needs, and Village Heads and Traditional Authorities had sometimes to make difficult decisions in distributing coupons. For some, coupons arrived late and coupled with the distance to suppliers, sometimes led to delays in the application of fertilizer. Indeed the distance to suppliers was sometimes a key factor, resulting in a doubling or more of the eventual cost of obtaining the subsidized fertilizer. Corruption and dishonesty have also been a major concern, with a significant proportion of villagers suspecting or experiencing problems.

5.15 There appears to be very limited coverage in terms of social protection for the very poorest and most vulnerable (elderly, disabled, orphans, etc). The Malawi Social Action Fund appears to be the most widespread in the areas visited, though with limited cash injections for poor households. Some mention is made of NGO programmes but coverage appears to be limited.

Preliminary conclusions

5.16 In order to make progress on the health outcomes (e.g. the MDGs), it is important to ensure that support is joined up, and areas like sanitation and water supply, as well as food security, receive sufficient donor and government support. Likewise with agriculture, subsidized fertilizer meets only the short term needs of farmers; broader concerns also have to be addressed (such as helping people to adapt to erratic weather patterns, safety needs for the poorest that cannot even afford subsidized fertiliser or have other priorities, the increased value from markets, and soil degradation).

5.17 **On health:** Health sector interventions appear to be having some effect. Recent policy changes concerning the role of TBAs also appear to be widely known; with greater numbers of women seeking facility based maternal health care. National TB Programme also appears to have been successful in ensuring that both key messages concerning TB and new sputum collection mechanisms are well known. There appears to be greater availability of Family Planning, possibly related to the expansion of Banja La Mtsogolo's community and tent outreach initiatives – though little evidence from the villages supports this view.

5.18 While it is difficult to attribute some changes in health outcomes directly to the health SWAp, due to the lack of a clear baseline (in this study), it is clear that some district officials perceive improvements in health service provision (as a result of the increased resources, through SWAp and EHRP). In particular, district officials see improvements in staffing, training of HSAs, health infrastructure and the supply of medicines. Health service users also see some changes, particularly in the availability of HIV services. These have been facilitated through pooled funds to the National AIDS Commission, a proportion of which have then been passed on to support Ministry of Health HIV/AIDS activities at district level. The inclusion of NGO healthcare providers, particularly CHAM, in the SWAp appears to have increased access to maternal health and reproductive services. Decentralisation also appears to have helped increase the efficiency of the use of SWAp funds at district level. Some district health officers appear to have access to the resources they require to rehabilitate health centres that they know need improvement.

5.19 Villagers however identify some of the gaps in services for key disease areas, for example: (i) While people are now generally more open to HIV/AIDS testing, some who are tested positive are still stigmatised and there are problems accessing ARTs (though the programme is still being rolled out); (ii) Pregnant women and children have better access to bed-nets, yet access remains a problem for the poor and elderly; (iii) Food supplements from health centres make a difference to malnutrition in some areas, though this does not seem to be consistently applied; (iv) There is improved understanding about reproductive health, yet some still face problems with access to family planning methods; (v) Distances and transport costs are a key barrier to healthcare access, especially with referral cases, and; (vi) health care provision is seen as inadequate by many due to a lack of health professionals, not enough equipment, and shortages of medical supplies.

5.20 **On agriculture and social protection:** The AISP which is supported by DFID appears to have made a difference to maize production (given a relatively good year for rainfall). There are however concerns about targeting (with not enough coupons) and in some areas the late coupons, difficulties getting hold of supplies, indirect costs of transport and corruption/ dishonesty.

5.21 Smallholder farmers however face many challenges which are not addressed through the supply of subsidized fertiliser. In particular: (i) poor soil quality and degradation; (ii) markets that do not work for the poor; (iii) difficulties obtaining input supplies due to the location of suppliers and the commercial prices, and; (iv) understaffed and under-skilled extension services. In addition, people remain vulnerable to hunger and food security despite better harvests of maize in recent years. The poorest do not always benefit from schemes such as AISP, as there can be more pressing needs or vendors can be exploitative. Few other social protection mechanisms appear to be widely available, and while MASAF cash-for-work schemes have had some effect, this seems to benefit few and with relatively little amounts.

Annex 1. Terms of Reference

Annex D

Specification for consultancy services: Qualitative research for a value for money study on DFID's work in Malawi

1. The UK's National Audit Office (NAO) is undertaking a value for money study examining whether the UK's Department for International Development (DFID) is achieving what it set out to in Malawi. The NAO intends that its final NAO report will be published in Autumn / Winter 2009, and this will require the completion of fieldwork by April 2009. The NAO is seeking a Consultant to carry out qualitative research on the results of DFID's work in the health and agriculture sectors in Malawi.

Background to the Work

2. The NAO conducts 'value for money' studies on the work and spending of all UK Government Departments. These reports are then considered by the UK Parliament's Public Accounts Committee. The NAO normally publishes two such reports on DFID each year.
3. DFID has spent nearly £400 million over the last five years in Malawi. This NAO study will examine and report on the extent to which DFID has achieved what it set out to in Malawi in 2003-2008, since the publication of consecutive country assistance plans in 2003 and 2007. It will also examine the reasons for success or under-performance.
4. The study will seek to answer this question by breaking it down into three interlinked levels:
    - Is DFID achieving what it set out to at the national level? Here the study will focus on progress against national targets such as the Millennium Development Goals and DFID's country assistance plans.
    - Is DFID achieving what it set out to at sector level in two case study sectors (health and agriculture)?
    - Is DFID achieving what it set out to achieve at the project level? The study will examine a sample of DFID projects, including those in or contributing to the two case study sectors.
5. At each of these three levels the study will examine secondary data on progress, including DFID's own documentation and available statistics on wider outcomes. The study will then seek to validate this secondary data with primary data collection. Key components of this primary data collection will include:
    - through work by NAO staff, semi structured interviews with DFID staff, other donors, district and central government, delivery partners, and civil society representatives; and a survey of current and past DFID Malawi staff; and

- **<u>through the appointed Consultant</u> [A] focus groups with intended beneficiaries; [B] semi-structured interviews or focus groups with district level officials, and [C] semi structured interviews or another proposed methodology with local service providers.**

Scope of Consultant's work

6. The NAO intends to appoint a Consultant to conduct primary data collection in Malawi to help the NAO to assess the results of DFID's work in the health and agriculture[57] sectors there since 2003. Findings from this work will be incorporated in the NAO report, supported by evidence from the NAO's other data collection and secondary sources described above. The research will examine overall progress in these sectors, whilst focusing on specific areas that DFID has supported, for example the Emergency Human Resources Programme in the health sector and the Agricultural Input Subsidy Programme in the agriculture sector. DFID supports the government of Malawi through General Budget Support, and also supports specific programmes delivered by the government, so this work should examine the delivery of services by the government. Perceptions of corruption in the delivery of services should be sought. The research will collate and analyse interviewees' and focus group attendees' perceptions of problems and successes in the implementation of projects or programmes in these sectors, and their experiences of the results. Purposive sampling of research locations and participants must ensure that results represent as best as possible the diversity of circumstances and experiences within Malawi. **Relevant experience of Malawi and capacity to operate in Malawi, in particular for community level research, will be essential.** The precise scope and approach to this work will be agreed with our appointed Consultant before work starts. The work may consist of up to three work packages, described below. The NAO reserves the right to proceed with all or only one or two of these work packages in the light of bids received. Bidders should bid in accordance with the requirements set out below, but if they have alternative suggestions for how the research should be conducted to better meet the NAO's needs, or to avoid predicted problems, these suggestions and the rationale behind them should also be set out.

[57] For the purposes of this work, consideration of the 'agriculture' sector must include related social protection programmes and issues, since these have been integral to DFID's involvement in agriculture.

7. WORK PACKAGE A: FOCUS GROUPS WITH LOCAL PEOPLE / BENEFICIARIES

The purpose of this work is to obtain the perceptions and experiences of intended beneficiaries of DFID's work, Malawian residents, on progress in the two chosen sectors.

7.1 Focus group content: The topic guide to be used to facilitate discussion in the focus groups must elicit attendees' perceptions and experiences, principally of:

- changes in health and agriculture outcomes, including aspects specifically targeted by DFID such as through the health SWAP and the agricultural inputs subsidy programme;
- perceived reasons for these changes, including exogenous factors and issues of availability, access and quality of services; and
- problems and successes of particular government and donor interventions.

The NAO will provide a draft topic guide to address these issues, which the Consultant will then develop and obtain NAO approval for before use.

7.2 Volume and location of focus group activity: The Consultant will conduct four focus groups, in each of three locations in one district, in each of Malawi's three regions: a total of 36 focus groups (four focus groups x three locations in one district in each of Malawi's three regions). The NAO reserves the right to vary this level of activity in the light of bids received.

In each district, chosen locations should be as representative as possible of circumstances in the district, and should include more remote locations. The NAO will provide a shortlist of districts selected to represent diversity within the country and to avoid unusual or exceptional areas. Subject to discussion and finalisation, the Consultant will use this to select locations. The Consultant should explain in its bid how locations will be selected within the three chosen districts to represent diversity within districts. But for purposes of bidding the consultant should assume that two of the three locations in each of the three selected districts should be at least 10km from a tarmac road, one of which should be at least 20km from a tarmac road.

The four focus groups at each location will comprise two groups on health issues and two on agricultural issues, with separate groups for men and women on each topic (i.e. a group with women on health, a group with men on health, a group with women on agriculture, and a group with men on agriculture).

7.3 Recruitment of focus group attendees

The Consultant will take all reasonable steps to avoid bias in its recruitment of individuals, such as evident political, social, economic, or age characteristics.

The NAO wants to keep focus groups small in order to enable good recording, and good levels of involvement from attendees, and suggests that there should be between 5 and 9 attendees at each focus group.

The NAO recognises that it is customary in Malawi to provide basic food and refreshments for such meetings, and that this incentivises attendance at relatively little cost. The Consultant must provide a fixed budget for this as part of their bid, and ensure that provision is reasonable and commensurate with normal basic hospitality. This should not be construed or presented as payment to attend.

7.4 Conducting the focus groups

The Consultant will ensure that groups are always conducted by at least one trained facilitator with prior experience of the method, and one data recorder.

Focus groups should be conducted in the local language of the location in which they are carried out.

The Consultant should try to minimise any negative impact on communities involved, for example the impact of taking up people's time in a busy agricultural period. The Consultant should set out in its bid how this impact would be minimised.

NAO staff may accompany the Consultant's personnel on any visit.

7.5 Analysis and reporting of focus group results

The Consultant shall ensure that all focus groups are audio recorded, and that verbatim transcripts are prepared in English by an experienced translator and made available to the NAO.

All data should be rigorously analysed, and the Consultant should specify how it will analyse the data to ensure rigour and transparency. The Consultant should specify any software it intends using to analyse the data. The NAO prefers a package such as ATLAS (preferable) or NVIVO to be used and requests that the Consultant outlines any previous experience of using such packages. The NAO prefers ATLAS because the NAO has a license to use the software and also some experience of the package. If such a package is used, the NAO would require the data file.

It is important that the Consultant gives thought to the coding framework and agrees this with the NAO study team before undertaking any analysis. Descriptive statistics such as frequency counts may be used, but it is the analysis of the coding results and suggestions of underlying reasons behind these results that will be of most interest to the NAO study team. The Consultant must therefore make provision for undertaking this detailed level of data analysis.

The Consultant's report must summarise the findings from the focus groups at the following levels of disaggregation:

- Overall findings at national level, for the two sectors
- Divergences between different locations, e.g. regional divergences, divergences between more and less remote locations.
- Divergences and commonalities between different types of respondent e.g. male/female respondents, younger and older respondents.

8. WORK PACKAGE B: DISTRICT LEVEL OFFICIALS

The purpose of this work is to obtain the perspective of senior district officials in and adjacent to the focus group districts on the implementation and effectiveness of DFID's support in the chosen sectors, at a level between DFID Malawi, other donors and central government, and local level beneficiaries and service providers.

8.1 **Content of work:** This work must cover issues as set out in 7.1 above.

The NAO will provide draft topic guides to address these issues, which the Consultant will then develop and obtain NAO approval for before use.

8.2 **Volume and location of activity**

The Consultant may propose one of two options for this work, but must explain its reasoning in its proposal.

Either [i] Semi-structured interviews with District Health Officers and District Agricultural Development Officers for each of the three districts in which beneficiaries focus groups are held, plus those of some adjacent districts.

Required number of interviews: At least 18.

Or [ii] Three DHO and Three DADO focus groups, in one place in each region (6 focus groups in total), each drawn from the 3 district officials of the beneficiaries focus group districts, plus those of some adjacent districts.

Required focus group size: At least 5 individuals in each focus group.

The NAO reserves the right to vary the amount of activity in the light of bids received.

8.3 **Conducting the work**

The Consultant shall ensure that if semi-structured interviews are used, they are always conducted by a trained interviewer with prior experience of the method. The Consultant will also ensure that if focus groups are used, these must be conducted by <u>at least</u> one trained facilitator with prior experience of the method, and one data recorder.

The NAO recognises that it is customary in Malawi to provide basic food and refreshments for such meetings, as well as covering reasonable travel costs, and that this incentivises attendance at relatively little cost. The Consultant must provide a budget for this as part of its bid (with transport and food costs listed separately), and ensure that provision is reasonable and commensurate with normal basic hospitality. This should not be construed or presented as payment to attend.

NAO staff may accompany the Consultant's personnel on any visit.

8.4 **Analysis and reporting of results**

The Consultant shall ensure that any focus groups or semi-structured interviews are audio recorded, and that verbatim transcripts are prepared in English by an experienced translator and made available to the NAO.

Analysis of this qualitative data should be rigorous (see 7.5).

The Consultant's report must summarise the findings at the following levels of disaggregation:

- Overall findings at national level, for the two sectors
- Divergences between different locations, e.g. regional divergences, divergences between more and less remote locations.

9. **WORK PACKAGE C: LOCAL SERVICE PROVIDERS**

The purpose of this work package is to obtain the perspectives of service deliverers drawn from the State, Voluntary and Private sectors and intermediaries such as village headmen as appropriate, on similar issues to those covered in the focus groups, but with a focus on experiences of delivering services or programmes.

9.1 **Content:** This work must cover issues as set out in 7.1 above.

The NAO will provide draft topic guides to address these issues, which the Consultant will then develop and obtain NAO approval for before use.

9.2 **Volume and location of activity**

The Consultant may propose one of two options for this work, but must explain their reasoning in its proposal.

The Consultant must seek views from local service providers in the same nine locations in which beneficiaries' focus groups are held.

Either [i] Semi-structured interviews with service providers in each sector for each of the nine locations in which beneficiaries' focus groups are held.

Minimum number of interviews: 54 (three providers from each sector in each location).

Or [ii] A variant proposal on how to gather the views of service providers.

<u>The NAO reserves the right to vary this level of activity in the light of bids received.</u>

9.3 **Recruitment of participants**

Acceptable participants are:

- **For Health:** Doctors, nurses, clinic administrators, pharmacists, midwives, health extension workers, health surveillance assistants.

These must be drawn from government facilities, as well as other providers such as CHAM.

- **For Agriculture:** Extension workers and advisers, subsidy administrators, village headmen with a role in targeting of coupons, state and private sector agro-dealers.

Participants must be drawn equally from the locations where the focus groups with intended beneficiaries are held (see 7.2).

9.4 **Conducting the work**

The Consultant shall ensure that if interviews are used, they are always conducted by a trained interviewer with prior experience of the method. The Consultant shall also ensure that if focus groups are used, these must be conducted by at least one trained facilitator with prior experience of the method, and one data recorder.

Interviews or other data collection methods should be conducted in the local language of the location where they are carried out, or Chichewa or English, according to the preference of the interviewee.

The NAO recognises that it is customary in Malawi to provide basic food and refreshments for such meetings, and that this incentivises attendance at relatively little cost. The Consultant must provide a budget for this as part of its bid, and ensure that provision is reasonable and commensurate with normal basic hospitality. This should not be construed or presented as payment to attend.

NAO staff may accompany the Consultant's personnel on any visit.

9.5 **Analysis and reporting of results**

Any focus groups or semi-structured interviews are to be audio recorded, and verbatim transcripts prepared in English by an experienced translator and made available to the NAO.

Analysis of this qualitative data should be rigorous (see 7.5).

The Consultants' report must summarise the findings at the following levels of disaggregating:

- Overall findings at national level, for the two sectors
- Divergences between different locations, e.g. regional divergences, divergences between more and less remote locations.
- Divergences and commonalities between different types of respondent e.g. respondents in different roles.

10. GENERAL (ALL PACKAGES)

10.1 In summary, the work will include the following elements and the Consultant must ensure that provision for these is included in the tender and pricing schedule:

- Taking part in a start-up meeting/ telephone conference with NAO staff;
- Agreeing locations for the research in consultation with the NAO team, and going through the appropriate channels to ensure access;
- Preparing topic guides for focus groups and/or semi-structured interviews in collaboration with the NAO study team, based on drafts provided by the NAO study team;
- Recruiting participants;
- Arranging suitable venues and appropriate food/ refreshments;
- Submitting a progress report to the NAO on research planning for approval from the NAO before fieldwork commences, and providing regular updates and liaising closely throughout the duration of the work;
- Conducting the data collection as agreed. NAO team members will be involved in the initial stages of the fieldwork or in the piloting stage, and the methodology must be adjusted following discussion with these NAO staff;
- Making audio recordings of the focus groups and semi-structured interviews;
- Translating and transcribing the focus groups and semi-structured interviews;
- Analysing all of the data collected;
- Writing a report for the NAO, setting out the methodology used, and the detailed findings of the research by the required completion date. The NAO may ask for specific outputs to be included in the report e.g. short case-studies;
- Making available to the NAO unedited transcripts in English of focus groups and semi-structured interviews, and all coded data. Electronic copies are sufficient; and
- Providing at no additional cost to the bid, up to three days time of the assignment leader after submission of the report to the NAO, to respond to any queries from the NAO and from DFID regarding the findings or methodology.

10.2 Other matters

The Consultant will be responsible for ensuring that appropriate confidentiality and anonymity agreements are in place and adhered to, and how it would do this must be described in its bid.

The Consultant's report will be used as a data source for the NAO's published report on the NAO study as a whole. The Consultant's report may also be published as an appendix to the NAO report and/or as a stand alone output available on the NAO website.

11. Timescales and key delivery dates

11.1 The NAO team will be in Malawi in late February 2009, and the Consultant's fieldwork must be timed to ensure that NAO team members can be involved in its initial stages. The NAO intends to publish its report in late October 2009. To allow sufficient time for the NAO to draft a report based on the results of all strands of its fieldwork, including the work to be performed under this Contract, the Consultant's final report must be submitted by early April 2009.

Key task	**Proposed deadline**
Publication of RfP	28 November 2008
Deadline for submission of questions/requests for further information	8 December 2008
Return of tender	1400 hours GMT on 12 December 2008
Evaluation of tender	15-16 December 2008
Interviews/ telephone interviews if required	17-18 December 2008
Award Recommendation to Director for approval and request and issue service order to successful Consultant	19 December 2008
Start-up meeting/ telephone conference	22 December 2008
Contract commences	23 December 2008
Consultant submits progress report on planning	30 January 2009
Fieldwork commences	Mid February 2009
Research/fieldwork completed	13 March 2009
Draft report to NAO	31 March 2009
Final report to NAO	10 April 2009

12. Contract Period

12.1 The Contract shall commence on the date specified in the Contract Award Letter and shall continue until the requirements set out in this Specification have been delivered and received to the satisfaction of the NAO's Contract Manager.

13. Contract Price

13.1 The rates/price(s) set out in the Pricing Schedule shall remain firm for the duration of the Contract period.

14. Invoicing and Payment

14.1 Invoices are to be sent to Accounts Payable, Zone: Green 3.3, National Audit Office, 151 Buckingham Palace Road, London, SW1W 9SS, quoting the relevant purchase order number (which will be included in the Contract Award Letter).

14.2 The payment profile shall be as follows:

Satisfactory completion of fieldwork:	50% of fixed total price payable
[Output e.g. Final Report]	50 %

However, subject to agreement, the NAO might pay some expenses in advance.

14.3 Invoices may only be submitted following the milestone to which they relate. Payment terms are 30 days from receipt of a valid invoice.

15. Project and contract management requirements

The Consultant will be expected to employ its research expertise and make use of its networks and contacts to produce the report outlined above to the timescale specified.

The NAO expects the Consultant to keep the NAO's study team informed of progress and, in particular, if any problems are encountered which might affect delivery to the brief. XXX will be the NAO's first point of contact, and reports must be submitted to her (XXX); in her absence the contact will be XXX (XXX).

Any queries regarding technical compliance with the invitation to tender must be submitted electronically via BiP's Delta-ets portal (www.delta-ets.com).

Annex 2. Bibliography

DFID (2003) *Country Assistance Plan: Malawi 2003-2006*, April 2003, Department for International Development, Malawi.

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ITAD-Kadale (2009), "*Planning report for NAO-ITAD / DFID Evaluation*", internal document, 27th January 2009 ITAD, Hove, UK.

MEJN (2006), from (MEJN), *Delivering the Promises: Making Public Services Accessible to the People: Service Delivery Satisfaction Survey*, Malawi Economic Justice Network (MEJN), Malawi.

NAO (2008), *Specification for consultancy services: Qualitative research for a value for money study on DFID's work in Malawi*, Terms of Reference, Annex D, National Audit Office, London, UK.

Norad (2008) *Malawi Health Swap Mid-Term Review: Summary Report*, 26 January 2008, Norwegian Agency for Development Cooperation (Norad), Oslo, Norway.

Phiri, A. (2007) *Comparative Analysis of Potential Economic Impact of Alternative Agricultural and Rural Development Models: The case of Africa Invest and Civil Society Organizations in Malawi*, Bunda College of Agriculture, Lilongwe, Malawi.

Annex 3. District Selection

Region	District	1 - Remoteness	2 – Budgetary Allocations	3 – Agro-ecological conditions	4 – Politics	5 - Poverty	6 – Quality of services
North	Chitipa [Pop: 163,271]	Remote – poor infrastructure through hills, especially during rainy season, closest city is Mzuzu (~200km)	254.53 kwacha per capita health budget allocation (MHEM)	Farming area – mainly smallholders	Leaning towards one party (DPP)	67.2% poverty incidence, 10.8% HIV prevalence	170,000 population per doctor 3,600 population per nurse Not many NGOs exist in the district, mostly dependent on SWAP Ministry of Health main service provider
North	Nkhata Bay [Pop: 195,545]	Remote – lakeside, closest city is Mzuzu (100-150km)	284.7 kwacha per capita health budget allocation (MHEM)	Fishing communities, also cassava, maize, rice and a tea estate	Multi-party harmony (majority DPP). Tonga people known for speaking their minds	63% poverty incidence, 10.8% HIV prevalence	100,000 to doctor 2900 to nurse
North	Mzimba [Pop: 600,377]	District of Mzuzu city	160.3 kwacha per capita health budget allocation (MHEM)	Water scarcity and high proportion of unused arable land, but also diversity of agriculture, smallholders and large tobacco and coffee plantations, also Irish potatoes, maize	Leaning towards one party (DPP) although other parties exist. District is powerful in decision making (due to culture and size of district).	50.6% poverty incidence, 5.2% HIV prevalence	50,000 to doctor 1700 to nurse Poor accessibility to health centres for outlying areas.
Central	Ntchisi [Pop: 223,223]	Nearest city Lilongwe (100-150km)	210.86 kwacha per capita health budget allocation (MHEM)	Agriculture mainstay – mainly maize and smallholder tobacco although some dairy farming	Multi-party harmony (majority MCP)	47.3% poverty, 10.8% HIV prevalence, low literacy levels	230,000 to doctor 4000 to nurse Not many NGOs
Central	Lilongwe [Pop: 1,165,636]	Central	136.31 kwacha per capita health budget	Agriculture – maize as the main food crop and	Multi-party harmony (majority MCP)	37.5% poverty incidence, 11.5%	20,000 to doctor 2800 to nurse

			allocation (MHEM)	tobacco estates and other cash crops such as paprika, soya beans, groundnuts		HIV prevalence	Many NGOs Unique problems with referral system (health centre direct to central hospital as no district hospital). Over-congestion. Projects to strengthen city health centres and create a district hospital
Central	Salima [Pop: 331,308]	Central – along lakeshore, good road access from Lilongwe (~100km)	192.89 kwacha per capita health budget allocation (MHEM)	Fishing – but also cash crops such as tobacco and cotton (smallholders), maize and millet (sorghum) food crop	Multi-party harmony	57.3% poverty incidence, 8.9% HIV prevalence	180,000 to doctor 2950 to nurse Many NGOs
South	Mangochi [Pop: 755,039]	Remote, lakeside (~250km from Blantyre)	107.23 kwacha per capita health budget allocation (MHEM)	Fishing communities – could assess impact of agricultural assistance in terms of adopting cash crops since fish stocks are depleting, also tourism	Leaning towards one party (UDF)	60.7% poverty, 20.8% HIV prevalence, high teenage pregnancy rate	120,000 to doctor 5100 to nurse Many NGOs 'Chinamari' (female circumcision) practice still occurs
South	Mulanje [Pop: 539,753]	Not remote (~100km from Blantyre) but border district with Mozambique (East)	144.63 kwacha per capita health budget allocation (MHEM)	Tea main cash crop, (smallholders and large estates) – but attempts at crop diversification	Multi-party harmony	68.6% poverty incidence, 19.8% HIV prevalence	560,000 to doctor 3600 to nurse But good accessibility to health facilities. Densely populated district Many NGOs
South	Chikwawa [Pop: 450,609]	Not remote (~60km) border district with Mozambique (South West)	134.24 kwacha per capita health budget allocation (MHEM)	Low rainfall district, main cash crop maize (winter) and millet (sorghum), some cotton production – interesting to observe different agricultural efforts	Multi-party harmony	65.8% poverty incidence, 10.8% HIV prevalence	470,000 to doctor 5200 to nurse

Annex 4. Topic Guides

TOPIC GUIDELINES FOR AID BENEFICIARIES [A] *FOCUS GROUP DISCUSSION* **HEALTH**

A: OUTCOMES

A1. Overall: How do you perceive the current state of health in your area? / What are the key challenges in terms of outcomes?

A2. How do you perceive overall change in health outcomes in your area compared to [5] years ago?

A3. Unpack the overall statements at A1 and A2 according to the main outcomes - What has got worse, stayed the same or improved?

[It will not be possible in the context of a focus group to analyse reasons for all the outcomes in the below table. The facilitator should invite the group to agree the outcomes that are of most importance to them, and proceed to in-depth discussion on only these (probably about 3)]

[Facilitator may prompt using the following list]

Health **(derived from health conditions prioritised in the Essential Health Package)**
Vaccine preventable diseases
Malaria
Reproductive Health
Tuberculosis
Schistosomiasis

Acute Respiratory Infections
Acute Diarrhoeal Diseases
HIV/AIDS and other Sexually Transmitted Infections
Malnutrition and nutrition deficiencies
Eye, ear and skin infections
Treatment of common injuries
Other health outcomes that the group identify as having changed

B: REASONS FOR THE REPORTED OUTCOMES

B1. What does the group perceive as the reasons for the selected outcomes [about 3] worsening/ improving/ staying the same?

[Differentiate between external factors and those which authorities directly influence]

C: DELIVERY OF SERVICES

C1: IS THE RIGHT RANGE OF SERVICES BEING PROVIDED

C1a: Is the range of services to meet the area's most important needs in health being provided?

[To confirm that EHP is active / being provided at all in this area, and well-scoped to meet needs.]

[At this point, the facilitator should try to avoid discussion of the quality of these services, or issues of access.]

C1b: Has this changed over the last [5] years?

C2: USE OF/ ACCESS TO THE SERVICES/ PROGRAMMES

[Note: This part of the topic guide aims to focus on DFID-funded programmes/ services. In Health the Essential Health Package and Emergency Human Resources Programme are so broadly based in scope that divergence from this focus is unlikely.]

C2a. Can you use / get access to the services/ programmes provided? If not, why not?

[For those who report problems accessing services at all the facilitator may prompt for barriers to access including:

- *Direct and Indirect Cost factors*
- *Timeliness of the medical services*
- *Distance / location*
- *Restricted entitlement/ poor targeting*
- *Corruption / Unfairness*
- *Inefficiency*
- *Limited awareness, service information*
- *Previous bad experiences / reputation]*

C2b. Has this changed compared to [5] years ago? [IE. How has access / the types of people who actually benefit changed]

C3: ADEQUACY OF SERVICES / FITNESS FOR PURPOSE

["Where services are present and being used, do they meet the beneficiaries' needs"]

C3a. Are the health services being provided meeting your needs? Why/ why not?

In a discussion of reasons why services are or aren't meeting needs, factors that may be prompted for include:

Health
Staff [numbers / skills / other]
Adequacy of facilities / equipment
Availability of drugs/ medication

Cost
Others identified by consultant

C3b. Has this changed compared to [5] years ago? How?

C3c. If there are non-government health [e.g. CHAM facilities] in the area, the pros and cons of using these relative to government services should be probed.

D: WIDER OUTCOMES

(beyond the sectors under discussion)

D1: Are the services/ programmes in the health sector [those funded by DFID as well as others] having an impact on poverty in general?

[This question should get at broader poverty outcomes of health programmes].

Are other areas of life more significant in causing poverty to increase or decrease?

[This discussion of poverty may include non-financial welfare.]

TOPIC GUIDELINES FOR AID BENEFICIARIES [A]

FOCUS GROUP DISCUSSION

AGRICULTURE / SOCIAL PROTECTION

A: OUTCOMES

A1. Overall: How do you perceive the current state of agriculture/social protection in your area? / What are the key challenges in terms of outcomes?

A2. How do you perceive overall change in agriculture/social protection outcomes in your area compared to [5] years ago?

A3. Unpack the overall statements at A1 and A2 according to the main outcomes - What has got worse, stayed the same or improved?

[It will not be possible in the context of a focus group to analyse reasons for all the outcomes in the below table. The facilitator should invite the group to agree the outcomes that are of most importance to them, and proceed to in-depth discussion on only these (probably about 3)]

What has got worse, improved or stayed the same?

[Facilitator may prompt using the following list]

Agriculture/social protection
Farm productivity
Food security
Incomes from agriculture
Livelihood security resulting from social protection
Nutrition

Natural resources e.g. deforestation, soil quality, water quality
Other outcomes relating to agriculture/ social protection that the group identify as having changed
Other agriculture/social protection outcomes that the group identify as having changed

B: REASONS FOR THE REPORTED OUTCOMES

B1. What does the group perceive as the reasons for the selected outcomes [about 3] worsening/ improving/ staying the same?

[Differentiate between external factors and those which authorities directly influence]

C: DELIVERY OF SERVICES

C1: IS THE RIGHT RANGE OF SERVICES BEING PROVIDED

C1a: Is the range of services to meet the area's most important needs in agriculture/social protection being provided?

Notes: [Agriculture/Social Protection - To confirm whether all aspects of AISP (e.g. seed subsidy), as well as other services not directly supported by DFID (e.g. social protection, agricultural extension services) are being provided at all in this area, and well-scoped to meet needs.]

[At this point, the facilitator should try to avoid discussion of the quality of these services, or issues of access.]

C1b: Has this changed over the last [5] years?

C2: USE OF/ ACCESS TO THE SERVICES/ PROGRAMMES

[Note: This part of the topic guide aims to focus on DFID-funded programmes/ services. DFID's role in Agriculture/Social Protection is currently limited largely to the Agricultural Input Subsidy Programme and pilots for social protection schemes, although in the past it has been involved in social protection programmes and broader agricultural work. So the facilitator will need to limit discussion on the delivery of agricultural services or programmes that DFID is not involved in, e.g. Irrigation schemes.]

C2a. Can you use / get access to the services/ programmes provided? If not, why not?

[For those who report problems accessing services at all the facilitator may prompt for barriers to access including:

- Direct and Indirect Cost factors
- Timeliness of the medical services
- Distance / location
- Restricted entitlement/ poor targeting
- Corruption / Unfairness
- Inefficiency
- Limited awareness, service information
- Previous bad experiences / reputation]

C2b. Has this changed compared to [5] years ago? [IE. How has access / the types of people who actually benefit changed]

C3: ADEQUACY OF SERVICES / FITNESS FOR PURPOSE

["Where services are present and being used, do they meet the beneficiaries' needs"]

C3a. Are the agriculture/social protection services being provided meeting your needs? Why/ why not?

In a discussion of reasons why services are or aren't meeting needs, factors that may be prompted for include:

Agriculture/social protection
Staff [numbers / skills / other]
Location and performance of suppliers
Availability of inputs
Cost
Targeting
Timeliness [e.g. of voucher and input availability/ distribution in AISP - were these obtained for use before the rains?]
Others identified by consultant
Any problems with the use of fertilisers or hybrid seeds

C3b. Has this changed compared to [5] years ago? How?

C3c. If there are non-government health/ agriculture/social protection services [e.g. agricultural input suppliers] in the area, the pros and cons of using these relative to government services should be probed.

D: WIDER OUTCOMES (beyond the sectors under discussion)

D1: Are the services/ programmes in the sector [those funded by DFID as well as others] having an impact on poverty in general? [

This question should get at broader poverty outcomes of[health/ agriculture/ social protection] programmes].

Are other areas of life more significant in causing poverty to increase or decrease? *[This discussion of poverty may include non-financial welfare.]*

TOPIC GUIDELINES FOR DISTRICT OFFICIAL [B]

SEMI-STRUCTURED INTERVIEW

HEALTH

A: HEALTH OUTCOMES

A1. Overall: How do you perceive the current state of Health in your area? / What are the key challenges in terms of outcomes?

A2. How do you perceive overall change in Health outcomes in your area compared to [5] years ago?

A3. Unpack the overall statements at A1 and A2 according to the main outcomes - What has got worse, stayed the same or improved?

[Guidance: It will not be possible in the context of a short interview to analyse reasons for all the outcomes in the table below. The facilitator should invite the interviewee to specify the 3 outcomes that are of most importance to them, and proceed to in-depth discussion on only these. The specific outcomes listed below are those that the Essential Health Package supported by DFID is aiming to improve.

- Vaccine preventable diseases
- Malaria
- Reproductive Health
- Tuberculosis
- Schistosomiasis
- Acute Respiratory Infections
- Acute Diarrhoeal Diseases
- HIV/AIDS and other Sexually Transmitted Infections
- Malnutrition and nutrition deficiencies
- Eye, ear and skin infections
- Treatment of common injuries

- *Other outcomes relating to Health that the interviewee identifies as requiring comment in terms of change or failure to change.*

B: REASONS FOR REPORTED OUTCOMES

B1. What do you perceive as the main reasons for the three outcomes worsening/ improving/ staying the same?

[Differentiate between external factors and those which authorities directly influence]

C: DELIVERY OF SERVICES

C1: IS THE RIGHT RANGE OF SERVICES BEING PROVIDED

C1a: Does the range of services being provided in your area address the area's most important Health needs?

[Interviewers' Note: To confirm that the EHP is active / being provided at all in this area, and well-scoped to meet needs]

[At this point, the facilitator should try to avoid discussion of the quality of these services, or issues of access.]

C1b: Has this changed over the last [5] years?

C2: USE OF/ BENEFIT FROM THE SERVICES/ PROGRAMMES

[Note: This part of the topic guide aims to focus on DFID-funded programmes/ services. However, in Health the Essential Health Package and Emergency Human Resources Programme are so broadly based in scope that divergence from this focus is unlikely.]

C2a. Are all people in practice able to make use of/ benefit from the services/ programmes provided? If not, why not?

[Interviewer may prompt for barriers to access including:

- Direct and Indirect Cost factors

- Timeliness of the medical services
- Distance / location
- Restricted entitlement/ poor targeting
- Corruption / Unfairness
- Inefficiency
- Lack of awareness / poor information
- Previous bad experiences / reputation]

C2b. Has this changed compared to [5] years ago?

[i.e. How has access / the types of people who actually benefit changed]

C3: ADEQUACY OF SERVICES / FITNESS FOR PURPOSE

["Where services are present [C1a] and being used [C2a], are they being delivered in a way which meets the beneficiaries' needs?"]

C3a. Are the services/ programmes meeting the needs of the community you serve? Why/ why not? What problems are there with their delivery? What aspects are working well?

To identify the reasons whether services are being effectively and efficiently delivered, the interviewer may prompt for:

Staff deficiencies [numbers / skills / other]

Location of suppliers

Availability of key inputs, particularly medication / drugs

Cost

Targeting

Timeliness?]

C3b. Has this changed over the last [5] years? [E.g. In what ways is the EHP better/ worse than previous provision. Has the implementation improved since it started?

C3c. Whether delivery of the DFID funded programmes could be improved in reasonably straightforward ways that did not depend on the granting of additional resources.

C3d. If there are non-government providers [e.g.CHAM] in the area, the effectiveness of these relative to government services should be probed.

Invite the two most important strengths and weaknesses of each in terms of efficient and effective service delivery.

D: WIDER OUTCOMES (beyond Health)

D1: Are the services/ programmes in the sector [those funded by DFID as well as others] having an impact on poverty in general?

[This question should get at broader poverty outcomes of Health interventions].

Are other areas of life more significant in causing poverty to increase or decrease?

[This discussion of poverty may include non-financial welfare.]

Supplementary question areas to District level officials only

Whether the Health challenges affecting the District have particular characteristics vs. other Districts.

Whether the Ministry of Health has a good understanding of the particular Health challenges of the District.

- [Whether the monitoring / feedback that the Ministry requires is relevant/ sufficient/accurate?

Whether the Ministry's understanding is shown in the way that the District is resourced and otherwise supported by the Ministry.

Whether donors demonstrate a good understanding of the particular challenges of the District.

[Prompt in terms of donor visits, and subsequent donor actions or interventions as a result. Question is about donors in the round but DFID examples are especially relevant]

How well Service Level Agreements with CHAM facilities are being implemented.

TOPIC GUIDELINES FOR DISTRICT OFFICIALS [B]

SEMI-STRUCTURED INTERVIEW

AGRICULTURE/ SOCIAL PROTECTION

A: AGRICULTURE/SOCIAL PROTECTION OUTCOMES

A1. How do you perceive the current state of agriculture/social protection in your area? / What are the key challenges in terms of outcomes?

A2. How do you perceive changes in agriculture/social protection compared to [5] years ago?

A3. Unpack the overall statements at A1 and A2 according to the main outcomes - What has got worse, stayed the same or improved?

[Interviewer may prompt for outcomes that DFID's work is aiming to improve, as well as some other outcomes which DFID is not directly aiming to improve]

- Farm productivity [issues may relate to yields, sustainability of high input farming etc]
- Food security [including whether food prices are lower/ less volatile]
- Incomes from agriculture [e.g. are more households selling maize]
- Nutrition
- State of natural resources e.g. deforestation, soil quality, water quality
- Functioning markets for agricultural inputs and products [e.g. are retailers more accessible?]
- Levels of social protection provision for the rural poorest
- Other outcomes relating to agriculture/ social protection that the interviewee identifies as having changed

B: REASONS FOR REPORTED OUTCOMES

B1. What do you perceive as the reasons for outcomes worsening/ improving/ staying the same?

[Differentiate between external factors and those which authorities directly influence]

C: DELIVERY OF SERVICES

C1: IS THE RIGHT RANGE OF SERVICES BEING PROVIDED

C1a: Is the range of services to meet the area's most important needs in agriculture and social protection being provided?

[To confirm whether all aspects of AISP (including e.g. seed subsidy), as well as other services not directly supported by DFID (social protection, agricultural extension services) are being provided at all in this area, and well-scoped to meet needs]

[At this point, the facilitator should try to avoid discussion of the quality of these services, or issues of access.]

C1b: Has this changed over the last [5] years?

C2: USE OF/ BENEFIT FROM THE SERVICES/ PROGRAMMES

[Note: This part of the topic guide aims to focus on DFID-funded programmes/ services. DFID's role in Agriculture/Social Protection is currently limited largely to the Agricultural Input Subsidy Programme and pilots for social protection schemes, although in the past DFID's has been involved in social protection programmes and broader agricultural work. So the facilitator will need to limit discussion on the delivery of agricultural/ social protection services or programmes that DFID is not involved in, e.g. Irrigation schemes.]

C2a. Can all kinds of people make use of/ access the services/ programmes provided **in practice** Why?

[Interviewer may prompt for barriers to access including:

- Direct and Indirect Cost factors

- Timeliness of the service [e.g. delivery of vouchers and inputs at the required time]
- Distance [e.g. to input suppliers]
- Entitlement/ targeting Corruption / Unfairness
- Inefficiency
- Lack of awareness, poor information
- Previous bad experiences / reputation]

C2b. Has this changed compared to [5] years ago? [E.g. How has the types of people who benefit from AISP changed compared to previous input programmes?]

C3: ADEQUACY OF SERVICES / FITNESS FOR PURPOSE

["Where services are present [C1a] and being used [C2a], are they being delivered in a way which meets the beneficiaries' needs?"]

C3a. Are the services/ programmes meeting the needs of the community you serve? Why/ why not? What problems are there with their delivery? What aspects are working well?

In a discussion of reasons why services/programmes are/aren't meeting needs, and problems with services/programmes, the following factors, as well as others identified by consultant, may be prompted for:

Staff [numbers / skills / other]

Location of suppliers

Availability of inputs

Cost

Targeting

Any problems with the use of fertilisers or hybrid seeds

Timeliness of voucher and input availability/ distribution [i.e. were these obtained for use before the rains?]

C3b. Has this changed over the last [5] years?

[E.g. In what ways is the current AISP better/ worse than previous input programmes (TIP/ Starter Pack)? Has the implementation of AISP improved since it started?]

C3c. Whether delivery of the DFID funded programmes could be improved in reasonably straightforward ways that did not depend on the granting of additional resources.

C3d. If there are non-government providers [e.g. agricultural input suppliers] in the area, the effectiveness of these relative to government services should be probed.

D: WIDER OUTCOMES (beyond agriculture/social protection)

D1: Are the services/ programmes in the sector [those funded by DFID as well as others] having an impact on poverty in general?

[This question should get at broader poverty outcomes of agriculture/ social protection programmes].

Are other areas of life more significant in causing poverty to increase or decrease?

[This discussion of poverty may include non-financial welfare.]

Consider also wider beneficiaries.

[EG. there may be benefits of the AISP for those who do not receive vouchers].

Supplementary question areas to District level officials only

Whether the agriculture/social protection challenges affecting the District have particular characteristics vs. other Districts.

Whether the relevant Ministries have a good understanding of the particular agriculture/social protection challenges of the District.

- [Whether the monitoring / feedback that the Ministries require is relevant/ sufficient/accurate?

Whether the Ministries' understanding is shown in the way that the District is resourced and otherwise supported by the Ministry.

Whether donors demonstrate a good understanding of the particular challenges of the District.

[Prompt in terms of donor visits, and subsequent donor actions or interventions as a result. Question is about donors in the round but DFID examples are especially relevant]

TOPIC GUIDELINES FOR LOCAL SERVICE PROVIDERS [C]

SEMI-STRUCTURED INTERVIEW

HEALTH

A: HEALTH OUTCOMES

A1. Overall: How do you perceive the current state of Health in your area? / What are the key challenges in terms of outcomes?

A2. How do you perceive overall change in Health outcomes in your area compared to [5] years ago?

A3. Unpack the overall statements at A1 and A2 according to the main outcomes - What has got worse, stayed the same or improved?

[Guidance: It will not be possible in the context of a short interview to analyse reasons for all the outcomes in the table below. The facilitator should invite the interviewee to specify the 3 outcomes that are of most importance to them, and proceed to in-depth discussion on only these. The specific outcomes listed below are those that the Essential Health Package supported by DFID is aiming to improve.

- Vaccine preventable diseases
- Malaria
- Reproductive Health
- Tuberculosis
- Schistosomiasis
- Acute Respiratory Infections
- Acute Diarrhoeal Diseases
- HIV/AIDS and other Sexually Transmitted Infections
- Malnutrition and nutrition deficiencies
- Eye, ear and skin infections
- Treatment of common injuries

- *Other outcomes relating to Health that the interviewee identifies as requiring comment in terms of change or failure to change.*

B: REASONS FOR REPORTED OUTCOMES

B1. What do you perceive as the main reasons for the three outcomes worsening/ improving/ staying the same?

[Differentiate between external factors and those which authorities directly influence]

C: DELIVERY OF SERVICES

C1: IS THE RIGHT RANGE OF SERVICES BEING PROVIDED

C1a: Does the range of services being provided in your area address the area's most important Health needs?

[Interviewers' Note: To confirm that the EHP is active / being provided at all in this area, and well-scoped to meet needs]

[At this point, the facilitator should try to avoid discussion of the quality of these services, or issues of access.]

C1b: Has this changed over the last [5] years?

C2: USE OF/ BENEFIT FROM THE SERVICES/ PROGRAMMES

[Note: This part of the topic guide aims to focus on DFID-funded programmes/ services. However, in Health the Essential Health Package and Emergency Human Resources Programme are so broadly based in scope that divergence from this focus is unlikely.]

C2a. Are all people in practice able to make use of/ benefit from the services/ programmes provided? If not, why not?

[Interviewer may prompt for barriers to access including:

- Direct and Indirect Cost factors
- Timeliness of the medical services

- Distance / location
- Restricted entitlement/ poor targeting
- Corruption / Unfairness
- Inefficiency
- Lack of awareness / poor information
- Previous bad experiences / reputation]

C2b. Has this changed compared to [5] years ago?

[i.e. How has access / the types of people who actually benefit changed]

C3: ADEQUACY OF SERVICES / FITNESS FOR PURPOSE

["Where services are present [C1a] and being used [C2a], are they being delivered in a way which meets the beneficiaries' needs?"]

C3a. Are the services/ programmes meeting the needs of the community you serve? Why/ why not? What problems are there with their delivery? What aspects are working well?

To identify the reasons whether services are being effectively and efficiently delivered, the interviewer may prompt for:

Staff deficiencies [numbers / skills / other]

Location of suppliers

Availability of key inputs, particularly medication / drugs

Cost

Targeting

Timeliness?]

C3b. Has this changed over the last [5] years? [E.g. In what ways is the EHP better/ worse than previous provision. Has the implementation improved since it started?

C3c. Whether delivery of the DFID funded programmes could be improved in reasonably straightforward ways that did not depend on the granting of additional resources.

C3d. If there are non-government providers [e.g.CHAM] in the area, the effectiveness of these relative to government services should be probed.

Invite the two most important strengths and weaknesses of each in terms of efficient and effective service delivery.

D: WIDER OUTCOMES (beyond Health)

D1: Are the services/ programmes in the sector [those funded by DFID as well as others] having an impact on poverty in general?

[This question should get at broader poverty outcomes of Health interventions].

Are other areas of life more significant in causing poverty to increase or decrease?

[This discussion of poverty may include non-financial welfare.]

TOPIC GUIDELINES FOR LOCAL SERVICE PROVIDERS [C]

SEMI-STRUCTURED INTERVIEW

AGRICULTURE/SOCIAL PROTECTION

A: AGRICULTURE/ SOCIAL PROTECTON OUTCOMES

A1. How do you perceive the current state of agriculture/social protection in your area? / What are the key challenges in terms of outcomes?

A2. How do you perceive changes in agriculture/social protection compared to [5] years ago?

A3. Unpack the overall statements at A1 and A2 according to the main outcomes - What has got worse, stayed the same or improved?

[Interviewer may prompt for outcomes that DFID's work is aiming to improve, as well as some other outcomes which DFID is not directly aiming to improve]

- Farm productivity [issues may relate to yields, sustainability of high input farming etc]
- Food security [including whether food prices are lower/ less volatile]
- Incomes from agriculture [e.g. are more households selling maize]
- Nutrition
- State of natural resources e.g. deforestation, soil quality, water quality
- Functioning markets for agricultural inputs and products [e.g. are retailers more accessible?]
- Levels of social protection provision for the rural poorest
- Other outcomes relating to agriculture/ social protection that the interviewee identifies as having changed

B: REASONS FOR REPORTED OUTCOMES

B1. What do you perceive as the reasons for outcomes worsening/ improving/ staying the same?

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C: DELIVERY OF SERVICES

C1: IS THE RIGHT RANGE OF SERVICES BEING PROVIDED

C1a: Is the range of services to meet the area's most important needs in agriculture and social protection being provided?

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[At this point, the facilitator should try to avoid discussion of the quality of these services, or issues of access.]

C1b: Has this changed over the last [5] years?

C2: USE OF/ BENEFIT FROM THE SERVICES/ PROGRAMMES

[Note: This part of the topic guide aims to focus on DFID-funded programmes/ services. DFID's role in Agriculture/Social Protection is currently limited largely to the Agricultural Input Subsidy Programme and pilots for social protection schemes, although in the past DFID's has been involved in social protection programmes and broader agricultural work. So the facilitator will need to limit discussion on the delivery of agricultural/ social protection services or programmes that DFID is not involved in, e.g. Irrigation schemes.]

C2a. Can all kinds of people make use of/ access the services/ programmes provided **in practice** Why?

[Interviewer may prompt for barriers to access including:

- Direct and Indirect Cost factors
- Timeliness of the service [e.g. delivery of vouchers and inputs at the required time]
- Distance [e.g. to input suppliers]
- Entitlement/ targeting Corruption / Unfairness

- Inefficiency
- Lack of awareness, poor information
- Previous bad experiences / reputation]

C2b. Has this changed compared to [5] years ago? [E.g. How has the types of people who benefit from AISP changed compared to previous input programmes?]

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C3c. Whether delivery of the DFID funded programmes could be improved in reasonably straightforward ways that did not depend on the granting of additional resources.

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D: WIDER OUTCOMES (beyond agriculture/social protection)

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Are other areas of life more significant in causing poverty to increase or decrease?

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Consider also wider beneficiaries.

[EG. there may be benefits of the AISP for those who do not receive vouchers].