

Ex-post evaluation

Strengthening PPP in the Health Sector, Malawi

Title	Strengthening Public Private Partnerships in the Health Sector in Malawi		
Sector and CRS code	Basic health care, 12220		
Project number	2009 67 190		
Commissioned by	Federal Ministry for Economic Cooperation and Development, BMZ		
Recipient/Project-executing agency	Ministry of Health of Malawi (MoH), Christian Health Association of Malawi (CHAM)		
Project volume/ Financing instrument	EUR 6.83 million, FC grant		
Project duration	November 2011 to March 2021		
Year of report	2023	Year of random sample	2023

Objectives and project outline

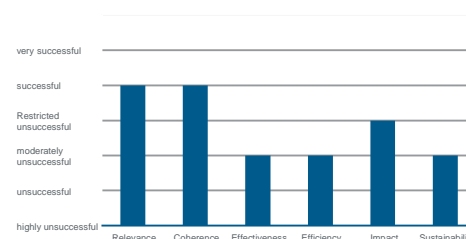
The objective at outcome level was to increase the availability, use and quality of essential services in mother-child care. At impact level, the aim was to contribute to improving the health of the Malawian population, especially that of women and children in rural areas. Through the cooperation of the state with the umbrella organisation of private care facilities run under church sponsorship (CHAM) it was intended to expand and equip existing facilities with the aim that they could provide basic services to mothers and children free of charge with refinancing of operating costs via the state under service level agreements (SLAs).

Key findings

Due to internal and external factors, the results are significantly below expectations; the project is therefore rated as rather unsuccessful:

- The *public private partnership* (PPP) approach was suitable for improving basic health care in remote, rural areas and was aligned with the partners' objectives (relevance).
- The project was consistent with German Development Cooperation and the involvement of other donors who also supported and still support the financing of the SLAs.
- The capacity created is less than expected and in some cases not utilised. The reasons for this include access barriers (fees due to insufficient coverage with SLAs), staff shortages and lack of electricity supply, as well as poor maintenance (effectiveness).
- From an allocative perspective, cooperation with existing facilities was efficient. However, the selection of equipment did not correspond to the needs and conditions in parts. The cooperation with one construction company in 15 remote locations lead to significant delays.
- The maternal, infant and child mortality rates have fallen in Malawi; it is plausible that the project has contributed to this, albeit to a lesser extent than intended (impact).
- The capacities of the state, CHAM, the health care facilities and their proprietors (churches) are not sufficient for sustainable operation in conjunction with impending donor cuts and multiple challenges in the healthcare due to extreme weather events and epidemics (sustainability).

Overall rating:
moderately unsuccessful



Conclusions

- The selection of medical equipment must be based on local conditions and needs, taking into account capacities for maintenance and repair.
- In PPP approaches, the capacities of all parties involved are crucial to success.
- Investment measures must include all necessary connections such as electricity and water supply from the outset.
- When there are multiple remote project sites, one contractor cannot mobilise appliances, equipment, materials and manpower across all sites in parallel, which causes delays in implementation.

Ex-post evaluation – rating according to OECD-DAC criteria

Overview of partial evaluations:

Relevance	2
Coherence	2
Effectiveness	4
Efficiency	4
Overarching developmental impact	3
Sustainability	4
Overall rating:	4

General conditions and classification of the project

The **Christian Health Association of Malawi (CHAM)** is the umbrella organisation of 183 health care facilities and 11 training institutes (2021) run by churches. It is the largest non-governmental health service provider in Malawi, particularly for remote and underserved areas. CHAM health care facilities provide around 30% of health care services. In addition, CHAM trains around 80% of medical professionals with intermediate qualifications. CHAM's mission is to coordinate members by providing administrative, technical and financial support for better and effective delivery of health care services and training of human resources for health. The majority of CHAM health care facilities belongs to the Catholic Church (48%), followed by the Presbyterian Church (18%), the Anglican Church (11%) and the Seventh Day Adventist Church (10%). The others are supported by different churches. CHAM health care facilities charge fees for their services, which are subsidised indirectly, as the Ministry of Health (MoH) finances a large proportion of CHAM health care facilities' staff. For example, CHAM health care facilities have lower fees than purely private providers.

Since 2002, the Malawian Government and CHAM have been working together under Service Level Agreements (SLAs) to provide access to a defined set of free health care services by CHAM health care facilities in catchment areas where no public health care facilities exist. The SLAs between the MoH and CHAM and/or the downstream District Health Offices (DHO) and CHAM health care facilities enable the facilities to provide certain services of the Essential Health Package (EHP) free of charge, for women and children. The state reimburses the respective operating costs of the CHAM health care facilities.. The EHP is offered free of charge at state-owned health care facilities. The SLA programme has been expanded over the years (cf. Effectiveness). Depending on the agreement, the SLAs may include the following packages:

Scope of Health Services covered by SLAs

The scope of health services provision (Interventions) is based on a district health service mapping, the available capacity of the CHAM Unit and the available resources allocated as a budget ceiling.

Maternal and Newborn Health (MNH) Services	OPD <input type="checkbox"/> Inpatient <input type="checkbox"/>
Paediatric under 5 Yrs Services	OPD <input type="checkbox"/> Inpatient <input type="checkbox"/> Nutrition Rehab. Unit (NRU) <input type="checkbox"/>
Paediatric 6–12 Yrs Services	OPD <input type="checkbox"/> Inpatient <input type="checkbox"/>
Adult Conditions Services	OPD <input type="checkbox"/> <input type="checkbox"/> Inpatient Non-Communicable Diseases <input type="checkbox"/>
Surgical services	<input type="checkbox"/>
Full EHP	<input type="checkbox"/>
Outreach services	<input type="checkbox"/>
Other services	<input type="checkbox"/> specify

Source: Sample SLA contract

Brief description of the project

Investments in health care facilities run by Christian churches under the umbrella of CHAM were intended to improve the supply, access and quality of essential services, especially in mother-child care. The aim was to improve coverage of basic health services, particularly in hard-to-reach areas with a lack of coverage by state health care facilities within a radius of 8 km. To this end, MoH and CHAM have concluded or should conclude SLAs that determine which basic health services will be provided to the population in the catchment area free of charge and will be refinanced by the MoH.

Against this background, 15 CHAM health care facilities¹ – of which two are community hospitals and 13 are health centres – in the central region of Malawi were supported by measures in the area of infrastructure and equipment (mainly maternity wards), with the aim of expanding their range of services in the area of mother-child health both quantitatively and qualitatively and fulfilling the functions of the respective care level: *Basic Emergency Obstetric and Newborn Care* (BEmONC) for Health Centres and *Comprehensive Emergency Obstetric and Newborn Care* (CEmONC) for Community Hospitals.

The project's target group was the population in the catchment area of the supported CHAM health care facilities which are located in rural areas with a high proportion of poor people. The focus was on pregnant women, mothers and children whose services are primarily covered by SLAs. In addition, the CHAM health care facilities' staff also stood to indirectly benefit from better working conditions and staff accommodation.

Breakdown of total costs

The majority of the funds amounting to around EUR 3.3 million was used for construction measures, while around EUR 1.4 million was used for medical equipment, furniture and commodities, and around EUR 1.4 million went towards consulting services. Lower amounts were allocated to support for organisation and management, institutional support and other infrastructure such as electricity supply connections. Aside from providing office space for the consultant, no own contribution from CHAM was planned. The proprietor churches provided land and were obliged in investment agreements to safeguard operating, maintenance and repair costs. The MoH also did not provide for an own contribution at the time of the appraisal, only indirectly and project-independently via its participation in the operating costs of the facilities via the SLAs and the financing of the salaries of employees at CHAM health care facilities.

In EUR million	Inv. (planned)	Inv. (actual)
Investment costs (total)	6.83	6.83
Counterpart contribution	0.00	0.00
Financing	6.83	6.83
<i>of which BMZ budget funds</i>	<i>6.83</i>	<i>6.83</i>

¹ State health care in Malawi is predominantly provided at three levels of health care facilities (1) hospitals, (2) community hospitals and (3) health centres.

Map of the central region of Malawi with the project locations²



Evaluation according to OECD-DAC criteria

Relevance

1. Policy and priority focus

The goal of the Malawian government is to develop the country into a “prosperous and independent industrialised country with a medium income” by 2063. There is still a long way to go, as Malawi is still in 169th place out of 191 countries, with GDP per capita of USD 634 in 2021 (2010: USD 472) and a Human Development Index of 0.512 in 2021/2022, and therefore is still in the low range (2010 in 153th place out of 169 countries). A total of 80% of the population lives off subsistence farming. Three quarters of the population suffer from moderate to severe food insecurity. The nutritional situation among children remains alarming, with around 35% of children chronically malnourished and with stunted growth for their age, according to the World Food Programme.

The first **Health Sector Strategic Plan** (HSSP 2011-2016) from the period of the appraisal aims to “improve the quality of life of all the people of Malawi by reducing the risk of ill health and the occurrence of premature deaths, thereby contributing to the social and economic development of the country” and identifies the strengthening of public-private partnerships as a strategy for future health financing. The second HSSP (2017-2022) has the objective of *Universal Health Coverage* and aims to achieve this, among other things, by improving the availability and quality of health care infrastructure and medical equipment; the plan also states the goal that everyone

² Note: As part of the evaluation, four health centres (Malambo, Chintembwe, Matanda, Tsangano) and one community hospital (Nambuma) were visited. Chitole health centre was not included in the project. At Ludzi Community Hospital, very little equipment overall and no CEMoNC-relevant equipment in particular was financed, which is why it was subsumed among the BEMoNCs/health centres as part of the evaluation.

should have access to a health care facility within 8 km of where they live. In 2011, 81% of the population lived within a maximum distance of 8 km from the nearest health care facility, and in 2016 this figure was as high as 90% following the construction of a new district hospital and 11 health centres. Nevertheless, the distance to a health care facility remains a central barrier to access for the majority of women and therefore also for the children they care for. The national health strategy stipulates that the distance should be reduced to 5 km by 2030. The third HSSP (2023-2030) is, under the motto *Reforming for Universal Health Coverage*, recognising that funds for health services are inadequate, and has consequently defined a new *Health Benefits Package* to replace the previous *Essential Health Package*, considering the limited funds. However, the current strategy aims at equal access to and improving the quality of health care as well as improving the availability and quality of health care infrastructure and equipment at all levels of care. With the expansion and improvement of basic health care through cooperation with CHAM as a central partner of the Malawian government, the project fits into all three strategic plans.

In its **2020–2024 strategic plan**, **CHAM** focuses on the provision of health services and technical support coordination to ensure quality, alongside a focus on improving governance and financing. The objectives also include ensuring adequate infrastructure at the health care facilities.

The intention to expand health care by integrating CHAM health care facilities for the provision of basic health services under SLAs as a public-private partnership connects the government with CHAM. The following figure shows the structure of the health care levels and the division between state and private owners. It also illustrates the importance of CHAM health care facilities for providing health care in rural areas.³

Chart 1: Health care facilities and their owners

Table 1: Distribution of health facilities by type and ownership

Facility Type	Facility Owner					Total
	Govt	Private for profit	CHAM	Private non-profit	NGO	
Clinic	20	233	7	46	46	352
Dispensary	49	2	2	8	1	62
Health Centre	364	4	109	7	5	489
Health Post	89		5		1	95
Hospital	49	9	41	1		100
Grand Total	571	248	164	62	53	1098

Source: Malawi Harmonized Health Facility Assessment (2019)

Source: HSSP III (2023-2030)

The project's objectives of expanding access to basic health services are directly aligned with **SDG 3**, in particular with sub-goal 3.8 on general health care and access to high quality basic health services, as well as with sub-goals 3.1 and 3.2, by focusing on mothers and children.

In addition, the project is in line with the **German Federal Government's strategy on global health**, in particular with regard to strengthening health systems and supporting partner countries in developing comprehensive, safe, high quality and acceptable health services for all people. Every person's right to the highest level of physical and mental health that can be achieved individually is a central human right.

The focus on mother-child health fosters **gender equality** by reducing maternal mortality resulting from preventable complications associated with pregnancy and childbirth. Unhindered access to sexual and reproductive health is not directly addressed by the project, due to the cooperation with Christian, including some Catholic, health care facilities. Quite in contrast, depending on their religious understanding, CHAM health care facilities do not explicitly offer family planning services in some cases. **Inclusion** was not specifically addressed with the project or taken into account in the design.

³ In addition to the facilities listed, there were also 5,090 *outreach clinics* in 2016, which were mainly operated by the state (19% only by CHAM), as well as 3,542 state *village clinics*. Against the backdrop of decentralisation in the health sector, the MoH still monitors the country's five tertiary hospitals in addition to assuming responsibility for strategy, design, follow-up, quality assurance and resource mobilisation. At district level, the *District Councils* monitor and manage the district health services and budgets. The high number of private health care providers is also reflected in high health expenditure out of their own pocket – in 2018/19 this amounted to 11.9% of total health expenditure (THE).

2. Focus on needs and capacities of participants and stakeholders

Access to basic health services is crucial for the predominantly poor to very poor rural population of Malawi. Although health indicators have improved over recent years and decades, health care services in Malawi overall remain at a low standard with significant deficits. Maternal mortality, child mortality and infant mortality have decreased (cf. Impact). Life expectancy in Malawi has increased consistently between 2009 and 2019 from 57 to 67 years for women and 51 to 61 years for men, prenatal screening numbers have increased, and HIV prevalence and incidence have decreased, as have incidences of tuberculosis. However, the main burden of disease continues to result from the lack of adequate health care services for mothers and newborns, followed by HIV/AIDs, respiratory diseases, tuberculosis, and malaria.

Particularly in rural, hard-to-reach areas, coverage with health care services is not as good and the difficulties and costs for the population to reach remote facilities are prohibitively high, a factor that has been exacerbated by high inflation. This makes it essential to improve access, on the one hand by providing greater coverage over shorter distances and on the other hand by providing basic health services free of charge. Due to the significant burden of illness in the area of mother-child health, the focus on this is justified, even if this does not guarantee equal access for the entire population in the catchment area of the health care facilities.

In general, the health care system has been consistently overstretched. In recent years, this was particularly due to the COVID-19 pandemic, the cholera epidemic and the resurgence of the wild polio virus, as well as extreme weather events.

3. Appropriateness of design

The core problem of inadequate basic health care, mainly in rural areas and especially in hard-to-reach areas, was correctly identified. It was true that access to the nearest facility is restricted by costs for services, besides the distance, and this remains true today. CHAM health care facilities' capacities and equipment were often insufficient for providing sufficient basic health care services. It was therefore conceptually right to support CHAM health care facilities where no state-owned health care facilities provide the desired health care coverage and within a radius of a maximum of 8 km. At the time of the appraisal, it was planned to select CHAM health care facilities for promotion that had an SLA for mother-child health – initially it was not explicitly stated which age classes should be covered. The selection criteria for identifying the CHAM health care facilities to be promoted that were defined during the appraisal only referred to *maternal and neonatal health* (MNT). Infrastructure investments as well as equipment and accompanying training were intended to increase the availability and quality of essential services, in particular mother-child care, as well as their use. This was intended to contribute to improving the health of the Malawian population, particularly that of women and children in rural areas.

Better working environments and staff accommodation should also improve the situation for (medical) staff as an indirect target group, which in turn can have a positive effect on the provision of services on the one hand and staff availability at the remote locations on the other.

This approach of cooperation with existing private facilities instead of the development of new health care facilities is understandable in the light of the limited funds in the health care sector and the necessary prerequisites for a successful contribution to supply were correctly identified, including the associated risks during the appraisal: the refinancing of the operating costs for the free provision of services by the private health care facilities under SLAs with the MoH is crucial for access, but harbours risks in view of the MoH's narrow financial scope. The focus on mother-infant health is logical, even though basic health services should be equally available to the entire population.

4. Response to changes/adaptability

The CHAM health care facilities to be funded were selected as part of a needs analysis at the start of the project based on clear selection criteria. The optional investment in a warehouse for medicines to support the revolving medicine fund set up by CHAM, which was included in the appraisal, was not realised.

Summary of the rating

Overall, the programme's design is aligned with the partners' objectives as well as with global objectives and the priorities of the German Federal Government and is in and of itself conducive to achieving the targets. Because of this, the relevance is classified as successful.

Relevance: 2

Coherence

5. Internal coherence

The measure is embedded in the Development Cooperation (DC) programme "Support for the health sector in Malawi" and is aligned with the country and sector strategy. German DC in Malawi focuses on reproductive health, the provision of basic health services and strengthening the health system. While the project to be evaluated was focused on private CHAM health care facilities, a further project also supported state-owned health care facilities (2014 68 164) and was expanded to include results-based financing approaches (2011 65 638). In the latter case, it turned out that CHAM health care facilities in the vicinity of RBF facilities registered a temporary slight downturn in assisted births, as women in the RBF facilities benefited from conditional cash transfers.

Due to the diverse donor landscape and the high risk of corruption, the Health Sector Joint Fund was introduced in 2015 as a coordinating donor instrument following the donor's withdrawal from (sector) budget support as a result of the cashgate scandal (see below). German Financial Cooperation (FC) is also financing an ongoing programme for basic health services under the HSJF (HSJF I-IV: 2015 67 304, 2017 67 623, 2019 67 397, 2021 67 427). Measures include new construction and rehabilitation of health care infrastructure, procurement of medical equipment and maintenance contracts, RBF approaches, vaccination campaigns, procurement of vaccines and contraceptives, as well as emergency aid measures. However, the measures are primarily oriented towards the users of public health care facilities.

6. External coherence

The donor community in the Malawian health sector is highly fragmented, although the major donors mainly focus on the national strategic objectives of the respective HSSP. Donors have been covering around 55% of the total expenditure for the health system in Malawi for years, with HIV/AIDS diagnosis and supply being financed almost entirely by donors. As the MoH has very limited capacities, coordination usually takes place on the donors' initiative, with the large bilateral donors coordinating in the *Health Donor Group*. The FC's main partners are the UK (FCDO) and Norway (RNE), as well as UNICEF and UNFPA for procurement. The evaluated project addressed the central region while other donors focused on the north and south, thereby avoiding duplications by larger donors.

Since the end of 2016, FC's involvement in the Malawian health sector has been via the *Health Sector Joint Fund* (HSJF), which pursues a new coordinated donor approach in the health sector. The HSJF is currently an essential instrument of FC, FCDO (United Kingdom) and RNE (Norway) are the most central partners. There are also plans in place to anchor additional donors here. Donor financing via the HSJF is additionally of particular importance for the project, as under the HSJF Norway and FCDO also finance SLAs with CHAM health care facilities (as well as recently health care facilities belonging to the Islamic Health Association of Malawi, IHAM). Due to the vital importance of donor contributions, possible cuts in the provision of funds threaten success in the health sector, including for the project to be evaluated. Within the framework of the HSJF, there were discussions on the declaration of own contributions by Malawi; to ensure subsidiarity to the partner's own efforts, the issue of actual own contributions by the state compared to funds from the HSJF is closely monitored by the donor side.

The large number of donors, NGOs as well as religious missions at national, regional and local level makes coordination difficult – as many as 280 implementation partners in the Malawian health sector have been reported. An overview of the involvement of different churches and their cooperation with foreign charities related to CHAM health care facilities could not be obtained as part of the evaluation. However, CHAM's goal that all cooperations with CHAM health care facilities should be implemented via CHAM does not yet appear to have been achieved. Various statements at the CHAM health care facilities on site also indicate that smaller cooperations are in place and are at least helping to overcome some bottlenecks.

Summary of the rating:

The internal coherence can be assessed as successful due to the complementary and continuous involvement in different areas of basic health care, including family planning and vaccination programmes, even though the projects as part of the RBF approach had a slightly negative effect on the demand for some CHAM health care facilities due to the target group's price sensitivity (temporarily). The external coherence with regard to the larger donors is successful; less successful or transparent is the cooperation and complementarity of the direct support of CHAM health care facilities by the sponsor churches or external supporters. Overall, however, the coherence can still be assessed as successful.

Coherence: 2

Effectiveness

7. Achievement of (intended) targets

The objective of the project at outcome level was to increase the availability and use as well as the quality of essential mother-child health care services.

The target achievement at outcome level is summarised in the table below:

Outcome-level target achievement table:

Indicator	Status at baseline (2014)	Target value	Actual value at final inspection (2021)	Actual value at EPE
(1) Number of births per year in the supported BE-mONC facilities (health centres)	9,635** (7,607 ***)	5% increase to 10,117	9,944 (Value includes all supported CHAM health care facilities, not just BE-mONC)	8,093 (2022)* Not met with reference to baseline 2014 and absolute target value. Meets Inception Report 2013 with 5% increase
(2) Number of caesarean sections performed in the two participating CEmONC facilities (community hospitals)	271 (only one CEmONC)	Increase by 5% to 640 per year (for both CEmONC, target value adjusted for EPE ⁴)	311	460 (2022)* Not achieved Caesarean sections are only performed in one of the two CEmONCs.
(3) Utilisation rate of the procured equipment in the two CEmONCs (ultrasound)	0 Procured as part of the project.	2,224 ultrasound examinations for pregnant women	515	2,300 (2022)** Partially achieved Solely fulfilled by one of the two CEmONCs.
(4) Number of health facilities with service level agreement (SLA)	9	15 all supported health care facilities have an SLA	n/a	14 SLAs Not achieved

*Information provided by the health care facility as part of the evaluation for 2022, **Source: Final report of the consultant ***Source: Inception report of the Consultant 2013

⁴ Cf. Annex – the target value was also supplemented for the second, newly established OP according to the catchment area.

In general, the CHAM health care facilities are in a fairly good condition (especially also in comparison to public health care facilities) and can provide the services according to demand. However, demand is not nearly as high as for public facilities. CHAM health care facilities charge fees if the services are not covered by SLAs. These fees are indirectly subsidised as the MoH (at least partly) finances CHAM health care facility staff. As a result, they are lower than at purely private health care facilities. Nevertheless, fees significantly limit access, especially for vulnerable sections of the population, thereby preventing the target group's need from being adequately met.

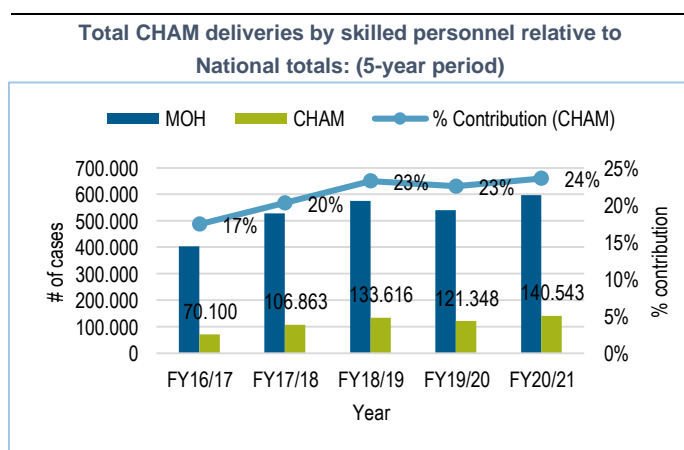
8. Contribution to achieving targets

The planned **infrastructure** was built and the **equipment** delivered; the measures were completed between March 2017 and November 2019. Not all investments are used, as the visit of five of the 15 health care facilities and a survey of all 15 facilities showed. Examples include:

- a) at one CHAM health care facility (Tsangano Health Centre), the newly built obstetrics ward and its equipment have never been used, as there is still no connection to the electricity supply;
- b) at one CHAM community hospital (Nambuma Hospital), the newly built and equipped operating theatre has never been used, according to its own information due to a lack of an anaesthetist;
- c) at one CHAM health care facility (Matanda Health Centre), the water pump has been broken for three years, there is no water supply and the built showers are also not in operation;
- d) a significant proportion of the equipment supplied was no longer suitable for use. For example, only three out of ten CHAM health care facilities equipped with electrical sterilisers (autoclaves) used them; the majority were no longer functional despite the fact that maintenance contracts were concluded;
- e) the supplied refrigerators were not used at any of the CHAM health care facilities visited⁵.

In the first two cases, the visits showed that the equipment is still in its packaging and has usually been improperly stored for years waiting for use; water had already got into the operating theatre building. Regarding the equipment, the warranty period and the maintenance contracts have expired before it has been used⁶. Particularly in the case of the operating theatre, the impact on service provision for the target group is significant, as no caesarean sections can be performed on site; a total of around 60 referrals to the next-nearest hospital must be made per month. It must be taken into account that transfers are associated with considerable challenges – availability of the ambulance and fuel, accessibility of the roads, in particular during the rainy season, availability of staff to accompany the transport, and coverage by the SLA; according to the employees, many transfers cannot be carried out successfully⁷.

The indicators for the **use of the facilities** are only partially met and not sufficiently successful in terms of target achievement. Indicator 1 regarding the 5% increase in assisted births by the *health centres* (BEmONC) is met or not met according to their information, depending on



Source: CHAM Annual Report 2021 (source: HMIS-DHIS2)

⁵ It must be taken into account that these refrigerators are not (may not be) used to cool vaccines or cold packs for the vaccination campaigns. The national vaccination programme is implemented vertically and has its own cold chain infrastructure.

⁶ Although the COVID-19 pandemic has generally made it significantly more difficult for suppliers to provide maintenance services due to access restrictions, there was also the impression on site that the health care facilities were not aware of their requirements.

⁷ The health care facilities reported 25 to 408 transfers for 2020, while the figures for 2015 were significantly lower. However, not all health care facilities have ambulances to carry out the transfers. If not covered by an SLA, patients incur costs of between MK 15,000 and 25,000, i.e. EUR 8 to 15.

the baseline reference value⁸; when compared with the data at the time of the consultant's 2013 inception report, five of the 13 *health centres* experienced a downturn instead of an increase in births (one CHAM health care facility did not report). Only one *health centre* achieved or, in this case, exceeded the absolute increase in births per CHAM health care facility expected in the inception report. In general, the number of assisted births has experienced a downturn due to the COVID-19 pandemic, but is recovering, as the graph shows. With regard to the use of the investments at the two *Community Hospitals* (CEmONC), the second and third indicators were achieved by one (Mua Hospital) in terms of its share. The other hospital (Nambuma Hospital) contributes values of 0 here, as the operating theatre and the equipment incl. ultrasound device are not in use. Unfortunately, the ultrasound device is also not being used for prenatal screening or other examinations.

The aim of the project was for CHAM health care facilities to meet **the national standards for obstetrics and neonatal care** applicable to their levels of service provision. This was not achieved in at least four of the 15 facilities (another four did not provide any information). As the operating theatre is not in use, Nambuma Hospital could not be upgraded to a hospital with *Comprehensive Emergency Obstetric and Neonatal Care* (CEmONC) as planned. Three *Health Centres* reported during the evaluation that they cannot provide all the *signal functions of Basic Emergency Obstetric and Neonatal Care* (BEmONC). In this regard, it was also reported that the policy requirements regarding preventive examinations by the CHAM and state health centres are difficult to meet, as, for example, an ultrasound should be performed for every pregnancy, but suitable equipment is only available (or should be available) at hospital level. A lack of laboratory equipment also makes treatment more difficult, which can then only be carried out on a symptom-guided basis. CHAM health care facilities are only able to test for malaria and HIV.

Utilisation of CHAM health care facilities was measured with a particular focus on births, as the project aims at mother-child health. In addition, the evaluation also looked at the development of the number of cases of **outpatient treatment (OPD cases)**. There is no uniform picture of this – where CHAM health care facilities provided their own information, they reported an increase since 2015 in five cases. When comparing the data from CHAM health care facilities for 2022 with the data from the consultant's 2013 inception report, outpatient treatments decreased overall across all supported CHAM health care facilities and in nine of the 15 CHAM health care facilities. Increases and decreases vary greatly in their extent, so the overall picture is very heterogeneous. It must be taken into account that not all cases of outpatient treatment are covered by SLAs (see below), which significantly restricts access for the target group. According to CHAM health care facilities, SLAs cover between 1% of cases of outpatient treatment (Mua Community Hospital with SLA for mothers and newborns only) and 90% of outpatient treatments (Tsangano Health Centre with SLA for mothers, newborns and children under five years). Local estimates by CHAM health care facilities assume that the majority of the predominantly very poor target group cannot afford the fees and therefore have no access to services not covered by SLAs⁹. As a result, patients who require services subject to payment often arrive too late at CHAM health care facilities and can then no longer be (adequately) helped, although the facilities try to make services available without payment on the basis of Christian charity in many cases. Utilisation is much higher at state-owned health care facilities, where all services of the Essential Health Package are offered free of charge. During the visit to a government facility for comparison, it was reported that a single physician would treat 150-200 outpatient cases per day. None of the CHAM health care facilities supported as part of the project achieved this to any extent (39 per day on average in 2022). In the discussions, it was also repeatedly reported that the utilisation rate at state health care facilities is much higher.

At the start of the project, only nine of the 15 CHAM health care facilities identified had a **Service Level Agreement** (SLA) with the responsible *District Health Office* (DHO). Due to the remoteness and the need for support, contrary to the objective during appraisal, FC in consultation with the MoH agreed to support CHAM health care facilities that do not yet have an SLA, but for which the DHO confirmed that it wanted to conclude an SLA after the project measures were completed. This seemed reasonable in view of the fact that the CHAM health care facilities with SLAs usually already had the basic prerequisites for the provision of services to mothers and newborns, as this is a prerequisite for an SLA. Contrary to the information in the final report of the consultant (March 2023) and the final inspection (March 2021), the surveys of the 15 facilities carried out as part of the evaluation showed that one CHAM health care facility has never had an SLA before and another only since October 2020.

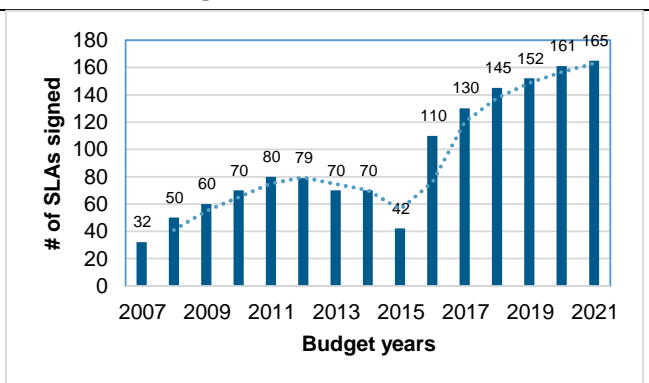
⁸ The consultant's final report does not show whether the figures refer to all 15 health care facilities or only the 13 health centres, but it can be assumed that the total was reported for all supported health care facilities and that target achievement was therefore assumed with the inclusion of the community hospitals.

⁹ The cost of a birth without any complications is 10,000 kwacha (about EUR 5.5), but even minor complications can lead to this figure quickly increasing twofold or more. (Information from CHAM healthcare facility on site)

For three of the 15 CHAM health care facilities, the SLAs were suspended for two years. As a result, one third of the CHAM facilities supported had not been covered by SLAs consistently since the project was completed.

The **service coverage of the SLAs** is also decisive for the use of CHAM health care facilities: eight CHAM health care facilities have SLAs that only cover service provision for mothers and newborns, while six CHAM health care facilities also provide services for children under five years of age through the SLAs (one health care facility has no SLA). According to reports from the CHAM health care facilities, at one CHAM health care facility, the number of births attended increased from 4 to 16 per week within two years as a result of the SLA; at another, the suspension of the SLA led to the number of births attended decreasing from over 300 to around 24 per year. Due to the fact that the availability and scope of the SLAs significantly influence the sustainable use of the created capacities, the problems with the SLAs significantly impair the effectiveness and therefore also the achievement of the project's indicators. Nevertheless, the total number of SLAs in Malawi has more than doubled since the appraisal, as the graph shows. However, no statement can be made here either about the scope of services covered by the SLAs nor their actual implementation. It was also repeatedly reported that payment of the SLAs did not take place over months (see Sustainability).

Number of SLAs signed from 2007-2021

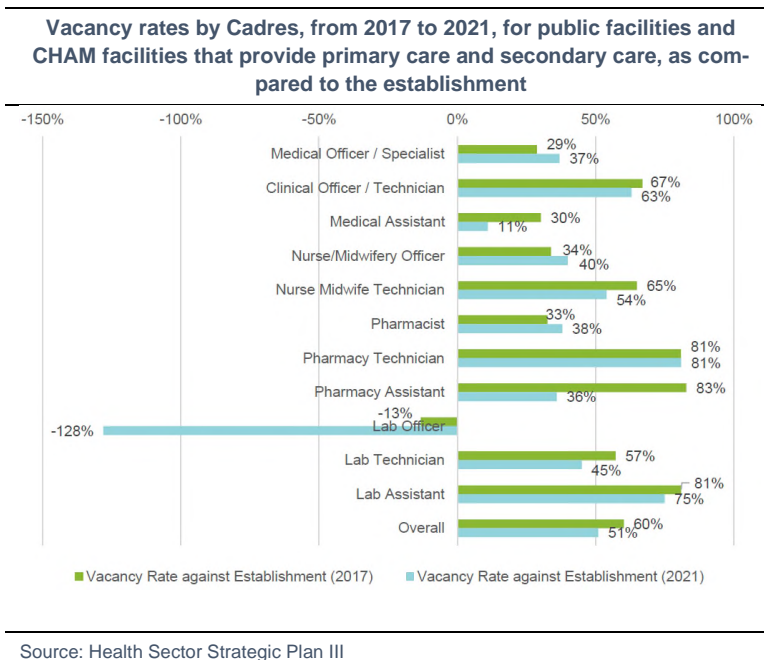


Source: CHAM Annual Report 2021

Another decisive factor for the use of the infrastructure and equipment for the provision of services for the target group is the guarantee of an (uninterrupted) **electricity supply** at the health care facility, especially when it has electrical equipment. Since, contrary to the selection criteria, five locations did not have an electricity connection, the project was to ensure infrastructure expansion. On evaluation, 4 out of the 15 CHAM health care facilities reported that they did not have 24 hour power or that not all parts of the health care facility were connected to the power grid. In the case of one CHAM health care facility, the new obstetrics ward built as part of the project has not yet been connected to the electricity grid and has therefore not been used (see above). Almost all CHAM health care facilities report that they have no (functioning) emergency power supply. Adequate **water supply** is also important for the health care facilities, but unfortunately is not available for all of them (3 out of 15) or is only available to a limited extent (a further 6 out of 15). Three CHAM health care facilities have not provided any information on this. In two of the three cases without a functioning water supply, the investments in the water supply were made as part of the project. Mua Hospital reported that the water is not treated and that the water supply for the operating theatre's sluice area is not functioning. Therefore, the hygiene level does not meet the requirements for an operating theatre; significant hygiene challenges are to be assumed.

The measures to improve **maintenance and repair** have not been successful. Tools and spare parts were financed and procured for the CHAM maintenance unit. These were lying unused and unsorted in a container at the CHAM secretariat in Lilongwe at the time of the evaluation. According to CHAM, the maintenance unit has never worked – there is a lack of technical staff and financial resources. The CHAM health care facilities visited also did not know that spare parts were available from CHAM. A total of 100 employees of the supported CHAM health care facilities were trained in the proper use, cleaning, maintenance and handling of equipment as well as in maintenance contracts for the equipment and in building maintenance in 2018, but only in a few isolated cases staff trained during the project could be identified during evaluation. Staff at most of the CHAM health care facilities were unaware of the maintenance and repair instructions delivered as part of the training. Signs were made in the local language (Chichewa) explaining the use of the incineration plants and the precautions – these were also no longer to be found at all sites visited.

Staff shortages are and remain an enormous challenge, especially medical staff shortages – not only at the level of the supported CHAM health care facilities, but also at national level. The vacancy rates reported by the supported CHAM health care facilities stand at as high as 53% (24% on average); for medical staff, this figure is as high as 63%. In addition, not all employees of CHAM health care facilities are financed by the MoH: 8 CHAM health care facilities reported that they finance some of the staff themselves, with a share of up to 43%. The staff housing supported by the project was very well received. The CHAM health care facilities welcomed the investments, especially in view of the attractiveness of the remote locations for staff recruitment, which nevertheless remains difficult. According to the evaluation, the project’s accompanying training measures for BEmONC (50-60 participants) and CEmONC surgical staff had no far-reaching effect in view of the high staff turnover. The following graph shows that staff shortages are also a common problem throughout the country. According to HSSP III, 2.85 healthcare professionals reached 1,000 people in Malawi in 2020 – the WHO target is at least 4.5/1,000. With regard to the CHAM facilities, however, it must also be taken into account that the capacity utilisation and thus the burden on personnel is much lower than in state-owned health care facilities.



The supply of **medicines** is a challenge for the health care facilities. As the public supply via the DHO does not work according to the CHAM health care facilities, most CHAM health care facilities have to make the procurements themselves from pharmacies or wholesalers in the capital; no CHAM facility reported on the procurement of medicines via the CHAM medicine fund, the expansion of which was an option as part of the project. However, some CHAM facilities stated that prices are an even greater challenge than availability – especially since the user fees and their reimbursement by MoH are not increased in line with rising prices. If services are not covered by SLAs, patients have to pay for the medication themselves. In general, there was an impression on site that the availability of medicines at CHAM facilities is better compared to state-owned facilities. This is certainly partly due to their financial autonomy and, albeit low, revenue from fees.

9. Quality of implementation

Implementation responsibility was transferred from MoH to the CHAM Secretariat. Due to the capacity bottlenecks already evident during the appraisal, an international consultant provided support in the implementation. The difficult-to-access project locations made it difficult for both the consultant and the CHAM Secretariat to have close-meshed management and supervision in the field. The owner churches were formally involved via investment agreements, but were not involved in the further implementation. They do not fulfil their commitment to support CHAM facilities, including in the context of maintenance and repair, or do not do so to the required extent. In retrospect, it would have been necessary to integrate them more closely into planning and implementation and to keep track of their contributions to operation and maintenance if they were to ensure the sustainable use of the investments (see Sustainability).

Parts of the medical equipment financed via the project were of low quality, so that patient beds and birthing beds in particular were declared to be inadequate during the final inspection. In the meantime, these beds have been repaired or completely newly delivered and replaced – but some of the defective beds are still being used for periods of peak occupancy that arise from sharp upticks in malaria cases during the wet season, as Nambuma Hospital reported, for example.

Where CHAM health care facilities did not have power connections from the nationwide power provider ESCOM, the necessary supply and output for installing the connections became part of the project. However, implementation was significantly delayed – at the 2021 final inspection, 5 CHAM units were still not affiliated, see above for the current situation.

The quality of monitoring must be critically assessed from an evaluation perspective, especially in view of the fact that some of the reports and data from the same year of evaluation also did not sufficiently represent the actual challenges and difficulties faced by the project.

Safety and HIV/AIDs awareness measures for workers on the construction sites were planned, there were no indications of problems during the evaluation.

10. Unintended consequences (positive or negative)

The surrounding community has also benefited from the connection of some CHAM health care facilities to the national electricity supply. No other unintended effects were identified during the evaluation.

Summary of the rating

The effectiveness is significantly below expectations due to (a) the lower than expected use of the created capacities, (b) the fact that a significant part of the investments is (no longer) used, (c) the necessary maintenance is not being carried out and (d) the insufficient (necessary) conditions for access and operation through SLAs – even if the promoted CHAM health care facilities continue to provide services within their capacities under the respective circumstances.

Effectiveness: 4

Efficiency

11. Production efficiency

The implementation was significantly delayed and took 11 years from the signing of the financing agreement (November 2011) to the consultant's final report (March 2023)¹⁰ instead of the – optimistic – estimate of three years at appraisal. The project was therefore only fully completed in 2023 instead of 2014 when the consultant's final report was issued. The reasons for this were in particular delays in the design as well as the necessary decision making processes and approvals, but mostly in the implementation of the construction measures. One construction company was chosen for all 15 remote locations spread across the central region. However, it was impossible for the contractor to mobilise the resources required for the start of construction at all locations at the same time (including equipment, machinery, materials and manpower). Due to the contract structure, it was not possible to remove some of the services and reassign them. The delayed provision of the buildings meant that equipment and devices had to be stored. Therefore, the warranty of the equipment expired before it was used and the shelf life of consumables expired (e.g. laboratory equipment). The supply of beds of inferior quality in particular also led to further delays due to necessary repairs and replacement deliveries – this also coincided with the supply chain restrictions caused by the COVID-19 pandemic. The connection of CHAM health care facilities to the electricity supply that was taken over by the project also proved to be lengthy, probably also due to the low priority on the part of the contractors and the national electricity supplier. Due to the long duration, the consulting costs were close to 40% higher at the end than estimated at the time of the appraisal and amounted to around 20% of the total costs.

12. Allocation efficiency

In principle, from an allocative perspective, it made sense to strengthen existing CHAM health care facilities in difficult-to-reach areas with a predominantly very poor population; they supplement the coverage with state health care facilities where these do not exist. In addition, the state already finances a large proportion of staff at CHAM health care facilities. The effort required to establish new state-owned health care facilities would have been

¹⁰ The final follow-up by KfW took place as early as 3/2021, but the power connections had not yet been completed and the need to repair the beds had been determined.

significantly higher and the development of personnel capacities alone would probably have been much more difficult. The supported CHAM health care facilities were selected based on generally appropriate criteria (including distance to the next facility, population in the catchment area, utilisation, operating and maintenance budget, personnel, SLA). The focus on the central region can also be derived on the basis of neonatal, infant and child mortality, as the following table shows – the central region was still behind the north and south in DHS 2015 surveys. CHAM also received support, in particular from Norwegian Church Aid in the north and south.

Year	Data Source	DHS/MICS subnational regions (Health equity monitor)	Neonatal mortality rate (deaths per 1000 live births) ⁱ	Infant mortality rate (deaths per 1000 live births) ⁱ	Under-five mortality rate (deaths per 1000 live births) ⁱ
2019	MICS ⁱ	north	22.0 [16.4-27.6]	33.0 [26.5-39.5]	43.2 [36.0-50.4]
		central	21.3 [17.5-25.1]	37.3 [32.8-41.8]	59.6 [53.8-65.4]
		south	24.5 [20.8-28.2]	42.7 [37.5-48.0]	60.6 [54.9-66.3]
2015	DHS ⁱ	north	21.2 [16.3-26.0]	37.0 [31.4-42.6]	57.2 [49.7-64.6]
		central	29.4 [24.6-34.2]	49.7 [44.0-55.4]	81.4 [74.9-87.9]
		south	25.2 [22.1-28.3]	45.6 [41.4-49.8]	73.1 [67.3-78.9]

Source: WHO¹¹

The fact that the criteria deviated in particular with regard to the existence of SLAs has weakened the allocation efficiency – how decisive SLAs are for the utilisation of healthcare services was explained in Effectiveness. It can also be assumed that the target group was not able to meet the demand from government institutions, as the cost of transport to health care facilities more than 8 km away can be estimated as prohibitively high, also against the background of rising fuel prices, inflation, and difficult conditions during the wet season.

The results of the evaluation indicate that some of the equipment supplied does not meet the requirements of CHAM health care facilities or align with their practices, and is also unsuitable given the general conditions at these facilities (e.g. electricity supply), especially in view of the non-functional maintenance and repair practices. This applies in particular to (electrical) equipment that was never used or is no longer being used, as some of it is no longer functional, has not been subject to a complaint under the extended warranty, has not been repaired (cannot be repaired) and no spare parts are available at the level of CHAM health care facilities. For example, out of the ten financed electric autoclaves/sterilisers, only three still work. Lack of or inadequate electricity supply limited the use of electrical equipment from the outset – as part of the implementation, an extra generator had to be procured in 2018 so that staff at the CHAM health care facilities without electricity could be instructed in the new electrical equipment and trained in maintenance; however, the equipment could then not be used until the electricity supply was ensured (in 2021 at the final inspection, five CHAM health care facilities were still not connected to the electricity supply). The refrigerators financed for BEmONCs are not used at all, as they are reportedly not required (cf. Effectiveness). The blood bank refrigerator at Nambuma Hospital is not being used either, as no blood transfusions are carried out – there is a lack of commodities and the necessary emergency power supply. These circumstances limit allocation efficiency, as it can be assumed that conventional equipment that medical staff are familiar with could have made a greater contribution to the target group's quality of care.

Summary of the rating

Production efficiency was affected by the significant delays resulting from the limitation to one contractor and the fact that 15 predominantly extremely remote and hard-to-reach locations were being supported. The public-private partnership approach, the aim of which was that existing CHAM health care facilities would cover the gaps in government health care facilities, is suitable from an allocation perspective. The deviation in the criteria with regard to an existing SLA again limits this approach and the allocation efficiency, because without an SLA, the treatment costs must be borne by the target group, most of whom cannot afford them. The same applies to the fact that equipment and medical devices were not sufficiently selected in accordance with the circumstances and needs. Overall, the efficiency of the project is significantly below expectations.

Efficiency: 4

¹¹ <https://apps.who.int/gho/data/node.searo.NODESUBREGchildmortality-MWI?lang=en>

Impact

13. Overarching developmental changes (intended)

The objective at impact level was to contribute to improving the health of the Malawian population, especially that of women and children in rural areas.

The following indicators are used for the evaluation to give a rough summary of the achievement of the impact-level objective.

Table Impact-level target achievement:

Indicator	Status PA (2011)	Target value DC programme	Actual value DHS 2015/16	Actual value at EPE
(1) Reduction in maternal mortality (MMR)	2010: 675/100,000	350/100,000 (2022)	439/100,000	349 (2019, MICS) 381 (2020, UN and World Bank estimate) Expected to be achieved
(2) Reduction in infant mortality (IMR)	66/1,000	22/1,000 (2022)	42/1,000	26/1,000 (2020, MICS) Expected to be achieved
(3) Reduction in child mortality (U5MR)	129/1,000	50/1,000 (HSSP III target for 2024)	64/1,000	56/1,000 (2019/2020, MICS) Expected to be achieved

The positive downwards trend in maternal, neonatal and infant mortality rates demonstrates Malawi's progress in healthcare in general. Particularly with regard to maternal and infant mortality, the progress is certainly largely due to the increase in the total number of births attended in health care facilities from 77.7% in 2010 to 92.8% in 2015/16 (DHS) and 96.4% in 2019/2020 (MICS). Mortality rates are generally higher in rural areas than in urban areas: these figures stand at 42 vs 30 for infant mortality and 58 vs 42 for child mortality (MICS 2019/2020). The education and income levels of mothers also continue to have a significant influence here. Infant mortality is 50/1,000 for the poorest fifth of the population and 31/1,000 for the richest fifth. For child mortality, the figures stand at 62/1,000 and 39/1,000 for the poorest and richest fifths of the population respectively. Data for 2022 is not available with regard to the proxy indicators, which is why target achievement can only be assumed to be probably fulfilled by extrapolating the trend.

14. Contribution to overarching developmental changes (intended)

It can be plausibly assumed that the funded health care facilities that cover costs through an SLA contribute to better care of mothers and children and thus contribute to better health status of these demographic groups. However, the limited effectiveness of the project – utilisation less than expected and only slightly more than during the appraisal – has a limiting effect on the contribution to overarching changes. The extent to which the investments have influenced the health care of mothers and children cannot be quantified in the evaluation. However, it can be assumed that – despite the fact that the project was less successful than anticipated and in some cases far less successful than anticipated – the improved conditions at the CHAM health care facilities, with more space and beds as well as incentives for qualified staff via staff housing, are having a positive effect on health care. This not only benefits mothers and children with services covered by SLAs, but also means that other services can be offered in general, such as vaccinations, HIV/AIDS services and more or fewer family planning services free of charge, depending on the religious character of the owner church. In addition, the – albeit few – paying patients also benefit from better equipment. Finally, it remains to be taken into account that the utilisation of healthcare services in Malawi had generally declined during the COVID-19 pandemic, but now appears to be increasing again.

A sustained consolidation of staff and financial capacities at the level of the CHAM health care facilities and the CHAM Secretariat, among other things for maintenance and repair, is rather unlikely.

It is plausible to conclude that, depending on coverage by an SLA, the measures were not able to extend the scope of services to the intended extent¹²— in particular for other parts of the population apart from mothers and newborns. CHAM health care facilities would probably have continued to provide their services without the investment, albeit under worse conditions, as they cover gaps in government-provided care in rural areas with mainly poor to very poor populations. The fact that equipment in the unused buildings (cf. Effectiveness) is not used elsewhere calls into question the need for it.

15. Contribution to (unintended) overarching developmental changes

The project intended to use sustainable building materials and therefore avoid firewood consumption, the associated deforestation and emissions. It initially relied on concrete-stabilised clay bricks, which were not available in Malawi, which is why it switched to “ecobricks”. Unlike conventional bricks, these are burned in a more resource-efficient way with minimum use of charcoal and increased use of solid waste. However, there was only one provider in Malawi for this too. Ecobricks were used at 12 of the 15 facilities according to the implementation consultant; the rest were built with cement-stabilised earth blocks. These are produced on the construction site itself, which reduces transport costs, but according to the consultant, they are still more expensive than ecobricks as the amount of cement used means that more energy is required for cement production. In addition, these earth blocks are not as durable as fired bricks. The introduction and dissemination of sustainable building materials has therefore proved more difficult than thought, but the use of ecobricks has at least partly contributed to their spread in the country, where bricks are mainly fired with wood (charcoal).

Investments in the safe disposal of medical waste were also relevant from an environmental perspective. By building incinerators and placenta pits, medical waste management has also been improved, even if this is not always carried out according to specifications.

As part of the project, Nambuma Hospital was connected to the electricity grid, which benefited the entire municipality, as the community then in turn benefited from the connection to the national electricity supply in its entirety with the associated socio-economic effects.

Summary of the rating

In view of the continuation and expansion of the health services of CHAM health care facilities in line with the general trend, the impact can be assessed as moderately successful, whereby the limited target achievement with regard to access and quality of care remains below expectations against the background of the lack of effectiveness previously discussed.

Impact: 3

¹² In quantitative terms with regard to the forecast for capacity utilisation figures per CHAM health care facility according to the inception report and in qualitative terms with expansion of the service spectrum of the *signal functions* per supply level.

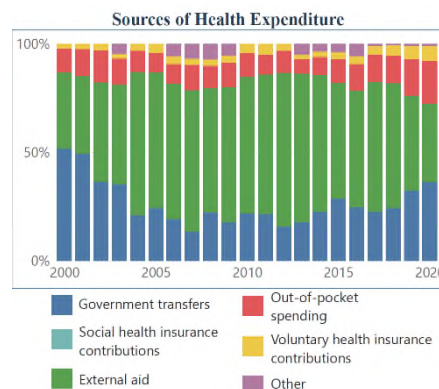
Sustainability

16. Capacities of participants and stakeholders

The risks, in particular for the sustainability of the project, were correctly identified during the appraisal. Many of these have also arisen (cf. Annex 2). Public expenditure on health is stagnating at around 8.5% of the total budget, significantly below the Abuja target of 15% and the SADC average of 11%. Health expenditure is generally highly dependent on external donors and increasingly also on individual direct payments, as the graph shows.

Increasing extreme weather events such as Cyclone Freddy, the COVID-19 pandemic and the challenges posed by the ongoing cholera epidemic as well as the resurgence of the wild polio virus have once again significantly overburdened government capacities and the health system.

Due to the **limited (financial) capacities of the state** and therefore also of the Ministry of Health, the structures at both national and district level are weak. This is related to the SLAs and the staff situation, which have a direct impact on the sustainability of the project. This is because the sustainable operation of the supported health care facilities depends on these two intersections between the state and CHAM:



- Lack of **SLAs** or SLAs with low coverage, outstanding payments or which have been discontinued currently appear to significantly jeopardise the prospect of sustainable use, as SLAs form the basis for the sustainable use of the services (cf. Effectiveness). In addition, delays in or lack of payment for SLAs are placing a strain on the relationship between MoH and CHAM. At health centre level, although the SLAs only cover their operating costs, they significantly widen their scope of use, which is why it can be assumed that a lack of SLAs also has a significant impact on the financial situation of CHAM health care facilities. According to media reports, payments of 2.3 billion Kwacha (approx. EUR 1.26 million) for the 2022/2023 financial year and 817.3 million Kwacha (approx. EUR 450,000) for 2023/2024 were still outstanding for all CHAM health care facilities as at the evaluation date of July 2023. The arrears in payments make operation of the facilities more difficult and place the availability of care for mothers and children into jeopardy.
- The financing of **staff** at CHAM health care facilities by MoH is of significant importance for covering operating costs and for providing an expanded range of health care services that are not covered by SLAs at a subsidised cost. Recurring and persistent interruptions in procedures for the recruitment and replacement of staff due to austerity policies limit the availability of staff at all levels and lead to CHAM health care facilities sometimes hiring/having to hire staff at their own expense.

Prior to the invitation to tender for investments, the duties and obligations under the public private partnership of the relevant actors in the project structure were defined in *investment agreements* between the responsible owner churches (as owners/operators), the respective DHO (responsible for monitoring health services on behalf of the MoH), MoH (as project executing agency responsible for general project supervision and allocation of funds to the districts) and CHAM (as project implementation unit for project design, execution and supervision). This also included the owners' commitment to provide sufficient funds for operation, but in particular also for the **maintenance and repair** of the equipment and infrastructure. According to the management staff of the CHAM health care facilities, this commitment has not been fulfilled or has not been sufficiently fulfilled. In principle, the CHAM health care facilities have more or less financial autonomy depending on the owner and cover their operating costs through user fees or reimbursements under the SLAs. However, both fees and SLA reimbursements only cover operating costs – SLAs cover as little as 70% of costs (CHAM Annual Report 2021). For this reason, the health care facilities are not able to carry out major maintenance or repair measures without external support. The extremely limited technical capacities for maintenance and repair work affect the entire health care sector, which is why frequent equipment failures are not an isolated phenomenon. The support provided by the project was also unable to have a lasting effect here (cf. Effectiveness). It would make sense for MoH and CHAM to transfer the unused equipment from one mother-child ward as well as the unused equipment from the operating theatre (cf. Effectiveness) at least to other CHAM health care facilities where such equipment is used. There was no clear evidence during the evaluation that this infrastructure will be put into operation soon.

The **CHAM Secretariat** receives its financing through membership fees, project management fees and real estate. CHAM plays a central role in ensuring timely payments of SLAs and salaries, and represents the interests of CHAM health care facilities in this respect to the MoH. In its 2020-2024 strategic plan, CHAM clearly mentions the weaknesses of the organisation, including a lack of internal control with the risk of losing donors, but also the high risk of declining direct donations to CHAM health care facilities from foreign donation organisations. Therefore, two important objectives of the strategy are to improve governance and control. Monitoring has been rather weak so far, as shown in the data collection for the evaluation, but there are efforts to improve this, for which CHAM has developed a *Monitoring and Evaluation Framework (2020–2024)*.

The COVID-19 pandemic has also placed great demands on and overwhelmed CHAM health care facilities, especially as information and equipment, including medicines for COVID-19 treatment and prevention, were not immediately available. Usage of general health services fell in 2019 and 2020 and began to recover afterwards.

OPD/IPD service performance indicator data: 2017-2021

Performance Indicator	2017	2018	2019	2020	2021	2021 National Contribution %
Total outpatients	1,721,218	2,237,082	2,122,903	1,696,536	1,890,995	Fluctuating (11)
Total admissions	239,565	285,357	254,436	198,737	210,893	Increasing (29)

Source: CHAM 2021 Annual Report

At the **level of the individual CHAM health care facilities**, the evaluation revealed that they provide services and medicines also if these are not covered by SLAs and if the patients do not have the funds and are most likely not able to pay later; i.e. the CHAM health care facilities are then not paid for their services. The reimbursement of costs by the SLAs has also been significantly delayed again and again – one CHAM health care facility reported that it had not received a reimbursement by the SLA for seven months. According to the CHAM health care facility, one consequence of the lack of funds is that they have to resort to using a debt account at wholesalers in the capital in order to procure necessary medicines. Finally, it remains unclear how the financial situation at the level of CHAM health care facilities will develop over time and how their financial survival will be achieved. According to local information, the owner churches do not play a central role in this, as most CHAM health care facilities have indicated that they do not receive financial support from their owners. Although there does appear to be repeated provision of funds, it is unclear where any additional funds are acquired. This intransparency is also addressed by CHAM in its 2020-2024 strategic plan, with the aim that all donors and stakeholders go through the CHAM Secretariat when working with CHAM members.

17. Contribution to supporting sustainable capacities

The project was able to contribute to the sustainable improvement of certain capacities at the respective locations to varying degrees. It can therefore be assumed that the construction of staff housing can also help attract qualified staff for the remote locations in the longer term. Similarly, it can be assumed that patients are cared for in a better way by using better equipment in a better environment with the expansion of health centres. However, the overall capacity for operation, maintenance and servicing of both infrastructure and equipment could not be increased at the level of the CHAM health care facilities or at the level of the CHAM Secretariat in accordance with the intentions at the time of the appraisal, and some facilities cannot meet the requirements for the level of care they are supposed to provide.

The maintenance unit at CHAM is not functioning as designed and lacks technical staff. The maintenance and repair books were also missing at the level of CHAM health care facilities during the evaluation and the staff trained as part of the project were no longer present in the majority of cases. Financing and support from the owner churches, as provided for in the *investment agreements*, does not take place in the majority of cases. The owner churches do not continue regular training for maintenance, nor do they continue to set maintenance budgets, as recommended during the final follow-up for operation.

Consequently, the contribution to supporting sustainable capacities is limited to the use of the infrastructure and equipment for their respective useful life without maintenance and servicing.

18. Durability of impacts over time

Due to the chronic underfinancing of the Malawian health sector with simultaneously limited government budget funds, it can be assumed that Malawi will depend on external support in the long term. The HSJF contributes to the financing of the SLAs with Norwegian and British financing, which will secure the operation of some CHAM health care facilities in the medium term. However, reductions in donor funds will directly affect the longer-term impact of the project. Unfortunately, the Malawian government has not yet been able to provide the necessary funds to cover the running costs for staff, electricity and water supply as well as proper maintenance. Due to the fact that the vulnerable sections of the target group in poverty-stricken areas cannot raise the necessary funds for adequate medical care, they are exposed to considerable risks.

In addition, extreme weather events are set to pose a risk over time. Devastating Cyclone Freddy alone hit 65 health centres in the south of the country in February and March 2023, of which ten were so severely destroyed that they were put out of operation, 41 were partially destroyed and 14 became inaccessible due to destroyed roads and bridges.

Summary of the rating

The fiscal room for manoeuvre is limited, the health care sector is heavily dependent on donor funds, the long term use of investments in CHAM health care facilities is determined by the existence and financing of SLAs, the availability of staff depends on austerity policies, the owner churches are not supporting CHAM health care facilities as planned, and the maintenance and repair capacities are very limited to non-existent. Taking into account the usage restrictions already observed at the time of the evaluation, sustainability is therefore to be assessed as rather unsuccessful.

Sustainability: 4

Overall rating

Overall, the project was relevant and the approach to improve health care in underserved, difficult-to-access rural areas with a public-private partnership between the Malawian government and the umbrella organisation of Christian health facilities CHAM via CHAM health care facilities was suitable. External risks in the financing of the health care sector and of staff have arisen and have impaired the project's success due to a lack of coverage of operating costs. The intended improvements in access to and quality of health care for mothers and children differ between the supported facilities, but generally stand below expectations. The weaknesses in the maintenance structure and financing did not improve as a result of the project. Overall, the project does not appear to have made a significant contribution to ensuring better provision of care for the population over the long term and the results are significantly below expectations.

Overall rating: 4

Contributions to the 2030 Agenda

The project was generally suitable for contributing to Agenda 2030 on improving health care, especially for mothers and children in rural areas affected by poverty, and therefore SDG 3. Particularly the cooperation between the government and the existing CHAM structures was also in line with Agenda 2030. Due to the project's limited success, the actual contributions made in this area are also limited.

Project-specific strengths and weaknesses as well as cross-project conclusions and lessons learnt

The project had the following strengths and weaknesses in particular:

- The approach of supporting the Malawian government in improving basic health care, especially in rural areas without coverage by public facilities, through cooperation with existing health facilities belonging to churches, was promising.
- The far-reaching macroeconomic risks with effects on staff availability and the financing of Service Level Agreements as well as the institutional weaknesses were clearly identified during the appraisal, but could not be sufficiently influenced – the risks have arisen and have limited the sustainable achievement of targets.
- The involvement and commitment of the owner churches to financing the operation, maintenance and upkeep of their health care facility solely via investment agreements at the start of the project was not sufficient.
- Without extensive capacity building, the general lack of structures and capacities cannot be met by financing tools and spare parts as well as maintenance contracts alone.

Conclusions and lessons learned:

- The selection of medical equipment must be based on local conditions and needs/habits, taking into account the capacities for maintenance and repair as well as the power supply situation.
- With public-private partnership approaches, capacities of all partners involved are crucial to success.
- Investment measures must include all necessary connections such as electricity and water supply from the outset.
- When there are multiple remote project sites, one contractor cannot mobilise appliances, equipment, materials and manpower across all sites in parallel, which causes delays in implementation.

Evaluation approach and methods

Methodology of the ex-post evaluation

The ex-post evaluation follows the methodology of a rapid appraisal, which is a data-supported qualitative contribution analysis and constitutes an expert judgement. This approach ascribes impacts to the project through plausibility considerations which are based on a careful analysis of documents, data, facts and impressions. This also includes – when possible – the use of digital data sources and the use of modern technologies (e.g. satellite data, online surveys, geocoding). The reasons for any contradicting information are investigated and attempts are made to clarify such issues and base the evaluation on statements that can be confirmed by several sources of information wherever possible (triangulation).

Documents:

Internal project documentation, consulting reports, studies on health care in Malawi, HSSP I-III, media reports, etc.

Data sources and analysis tools:

On-site visit to 5 out of 15 CHAM facilities, of which 4 health centres and 1 community hospital, as well as survey at all CHAM health care facilities afterwards with support from the CHAM Secretariat.

Interview partners:

MoH, CHAM Secretariat, staff at the visited CHAM health care facilities, target group in the area of the health care facility, GIZ, consultant

The analysis of impacts is based on assumed causal relationships, documented in the results matrix developed during the project appraisal and, if necessary, updated during the ex-post evaluation. The evaluation report sets out arguments as to why the influencing factors in question were identified for the experienced effects and why the project under investigation was likely to make the contribution that it did (contribution analysis). The context of the development measure and its influence on results is taken into account. The conclusions are reported in relation to the availability and quality of the data. An evaluation concept is the frame of reference for the evaluation.

On average, the methods offer a balanced cost-benefit ratio for project evaluations that maintains a balance between the knowledge gained and the evaluation costs, and allows an assessment of the effectiveness of FC projects across all project evaluations. The individual ex post evaluation therefore does not meet the requirements of a scientific assessment in line with a clear causal analysis.

The following aspects limit the evaluation:

The effort involved in accessing the individual supported CHAM health care facilities made it impossible to visit all locations. The selection was made on the basis of the available data on missions to date, whereby locations were selected that had not yet been visited or at least had not been visited by (KfW) missions repeatedly. The insights into the low utilisation and use were rounded off by the subsequent overall survey, whereby the provider also confirmed that visiting a different selection of sites would have led to similar findings.

Methods used to evaluate project success

A six-point scale is used to evaluate the project according to OECD DAC criteria. The scale is as follows:

- Level 1** very successful: result that clearly exceeds expectations
- Level 2** successful: fully in line with expectations and without any significant shortcomings
- Level 3** moderately successful: project falls short of expectations but the positive results dominate
- Level 4** moderately unsuccessful: significantly below expectations, with negative results dominating despite discernible positive results
- Level 5** unsuccessful: despite some positive partial results, the negative results clearly dominate
- Level 6** highly unsuccessful: the project has no impact or the situation has actually deteriorated

The overall rating on the six-point scale is compiled from a weighting of all six individual criteria as appropriate to the project in question. Rating levels 1-3 of the overall rating denote a “successful” project while rating levels 4-6 denote an “unsuccessful” project. It should be noted that a project can generally be considered developmentally “successful” only if the achievement of the project objective (“effectiveness”), the impact on the overall objective (“impact”) and the sustainability are rated at least “moderately successful” (level 3).

List of abbreviations:

BEmONC	Basic Emergency Obstetric and Newborn Care
GDP	Gross domestic product
BMZ	German Federal Ministry for Economic Cooperation and Development
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHAM	Christian Health Association of Malawi
DAC	Development Assistance Committee
DHO	District Health Office
EHP	Essential Health Package
EUR	Euro
FCDO	Foreign Commonwealth and Development Office
FC	Financial cooperation
FC E	FC evaluation
HDI	Human Development Index
HSJF	Health Sector Joint Fund
HSSP	Health Sector Strategic Plan
MoH	Ministry of Health (MoH)
OPD	Outpatient Department (Outpatient)
PPP	Public Private Partnership
SADC	Southern African Development Community
SLA	Service Level Agreement
TC	Technical cooperation
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Children’s Emergency Fund
USD	US Dollar

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Annex 1: Target system and indicators

Project purpose at outcome level		Evaluation of appropriateness (former and current view)				
During project appraisal: Increasing the availability, use and quality of essential mother-child care services.		The target formulation is appropriate, as it addresses both the quantitative (extended capacities) and qualitative aspects, and places the emphasis on use.				
During EPE (if target modified)						
Indicator	Evaluation of appropriateness (appropriate; partially appropriate; not appropriate)	Rationale of appropriateness (for example, regarding impact level, suitability, target level, smart criteria)	PA target level Optional: EPE target level	Baseline status (2014)	Status at final inspection (2021)	Final report consultant (September 2022) EPE 2023
Indicator 1 (PA) Number of births at the supported BEmONC facilities	appropriate	Appropriate indicator for measuring the use of CHAM health care facilities, but a disaggregated survey and reporting per CHAM health care facility would have been useful.	AC target level: 10,117 per year (843/month) 5% increase vs. Baseline	9,635 (7,607 Inception Report 2013)	9,944 (in the final follow-up, reference was no longer made to BEmOC, but to births at all institutions incl. CEmOC)	Final consultant: average: 890/month Information provided by the CHAM health care facilities as part of the EPE for the 13 health centres: 8,093 (11,252 for all facilities incl. the two community hospitals)
Indicator 2 (PA) Number of caesarean sections performed in the two participating CEmOC facilities	appropriate	Appropriate indicator for measuring the use of CHAM health care facilities, but a disaggregated survey and reporting per CHAM health care facility would have been useful. In addition, the target value is not appropriate, as one of the two CEmOCs did not have the means to carry out	AC target level: 285 per year (24/month) 5% increase vs. Baseline EPE target level: 640 Considering that at baseline, in one CEmONC, 271 caesarean sections	271	311	Final consultant: average 41/month Information provided by Mua health care facility as part of the EPE: 460

		caesarean sections before the project. As a result, the above status only referred to the other CEmOC at the time of appraisal.	have already been performed and at the second CEmONC, the operating theatre will need to be opened before caesarean sections can be performed as well as the fact that the catchment area of the second CEmONC is larger.			
<p><i>Indicator (PA)</i> <i>Number of patients referred with complications.</i></p> <p><i>Not adopted!</i></p>	<i>Somewhat appropriate</i>	<i>It would in principle be appropriate to assess the reference system, whereby the levels would then have had to be specified. However, this was not reported in the final follow-up and does not appear appropriate for Malawi, as transfers (can) rarely take place. Not adopted for EPE</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>
<p>Indicator 3 (PA): Utilisation rate of the procured equipment at the two CEmONCs* (e.g. ultrasound, laboratory equipment)</p>	Appropriate	Appropriate in principle, but also here the data should be collected and reported in a disaggregated format according to health care facility.	AC target level: 2,224 USG examinations for pregnant women (average 187/month)	0 The new ultrasound devices were only put into use in 2019, therefore not a base value.	515	Information provided by final report Consultant average 192/month (approx. 2,300/year) at only one CEmONC, at the other the device is still in its packaging.
<p>Indicator 4 (NEW): Number of health centres with SLA</p>	Appropriate	SLAs are critical to usage	15	9	n/a	14

Project objective at impact level						
During project appraisal: Contribution to improving the health of the Malawian population (especially women and children in rural areas)			DC programme objective in accordance with BE 2023: Universal access to and use of high quality basic health services (Essential Health Package) in Malawi is improved, in particular in the area of sexual and reproductive health and rights.			
During EPE (if target modified):						
Indicator	Evaluation of appropriateness (appropriate; partially appropriate; not appropriate)	Rationale of appropriateness (for example, regarding impact level, accuracy of fit, target level, smart criteria)	Target level PA / EPE (new)	PA status (2011)	Status at final inspection (2015/16)	Status at EPE (2023)
Indicator 1 (PA) Reduction in maternal mortality rate	Appropriate.	Default indicator. Target: unspecified in PA.	PA: n/a DC programme: 350/100,000 (adopted for EPE) HSSP III for 2024: 304/100,000	2010: 675/100,000	439/100,000 (DHS)	381/100,000 (2020, estimate by UN and WB)
Indicator 2 (PA) Reduction in infant mortality rate	Appropriate.	Default indicator. Target: unspecified in PA.	DC programme: 22/1,000 (2022)	66/1,000	42/1,000	26/1,000 (2020, MICS) Expected to be achieved
NEW: Indicator 3 Reduction in child mortality (U5MR)	Appropriate.	Default indicator.	50/1,000 (HSSP III target for 2024)	129/1,000	64/1,000	56/1,000 (2019/2020, MICS) Expected to be achieved

Annex 2: Risk analysis

2011 – Appraisal (PA)

2021 – Final follow-up

2023 – Ex post evaluation (EPE)

All risks identified during the appraisal were relevant.

Risk	Relevant OECD-DAC criterion
<p>PA: Malawi is in macroeconomic difficulties due to the off-track status of the IMF programme. The far-reaching discontinuation of donor inflows and the lower than expected revenues in the tobacco industry have led to a significant reduction in the country's foreign exchange reserves. Even at the time of the appraisal, the currency shortage was resulting in serious consequences for the country on both an economic and social level (fuel and electricity supply bottlenecks, fertiliser shortages, limited availability of medicines), which are expected to worsen further during the course of the year. Overall, this means that all population groups will feel the effects of the macroeconomic problems in a short time. Protests against the president have resulted in a tense political situation in the country. This entails high risks for project implementation with low influenceability.</p> <p>Final follow-up: The dramatic macroeconomic situation has stabilised, but remains fragile, particularly due to significant slumps in agricultural production in recent years as a result of climate conditions.</p> <p>Ex post evaluation (EPE): The macroeconomic situation remains difficult.</p>	<p>Sustainability</p>
<p>PA: The project structure of cooperation with CHAM can mitigate implementation risks on the ground. During the on-site discussions, the Ministry agreed to a broad delegation of implementation responsibility to CHAM. However, the relationship between the Ministry and CHAM has been affected by past negative experiences and in the future will also be determined by the current discussions about, for example, the cost structure of the SLAs. The TC-supported development of uniform SLA formats and mutually accepted cost approaches for the services provided will be helpful here. We classify the risk of deteriorating cooperation with negative effects on the project as medium with medium influenceability.</p> <p>Final follow-up: The risk of the critical relationship between MoH and the CHAM Secretariat almost completely disappeared in the years of project implementation, as an SLA framework agreement was reached with the support of the international partners. This significantly relaxed the relationship. Nevertheless, the risk remains due to the different objectives of the two organisations.</p> <p>EPE: The significant arrears in SLA payments on the government's side have led to the re-emergence of tensions between CHAM and MoH.</p>	<p>Effectiveness/Efficiency/Impact/Sustainability</p>
<p>PA: The sufficient availability of funds, also with regard to the financing of SLAs, represents a high risk with low influenceability. The policy dialogue in the context of basket funding may be helpful here.</p> <p>Final follow-up: As Norway and DFID financed the service costs incurred under the SLA through HSJF, the CHAM facilities involved were able to cover costs.</p>	<p>Effectiveness / impact / sustainability</p>

<p>EPE: The financing of the SLAs is not secured, SLAs are not refinanced or are not refinanced in a timely manner, only cover a few services and some of the supported institutions did not even have SLAs. Against the backdrop of a probable decline in donor funds, this risk remains and has already arisen in some cases.</p>	
<p>PA: The severe staff shortage in the sector represents a high risk with low influenceability. In the short term, the projects should only work with facilities that have sufficient staff to provide the required services. In the medium term, the construction of staff housing as part of the project can increase the attractiveness of these rural health facilities and help to stabilise the staff situation.</p> <p>Final follow-up: Staff availability remains a high risk in the long term, as there is a hiring freeze as part of the current austerity policy and measures. CHAM reported 28% vacancies. However, this has not yet affected operations at the supported facilities.</p> <p>EPE: The austerity policy remains in place: no new vacancies will be created and no existing vacancies will be filled. Since the staff at the CHAM facilities are financed by the MoH, this also directly affects the staff situation at the CHAM facilities. Building staff housing cannot directly counteract the general staff shortages, but it can serve as an incentive to work in remote locations.</p>	<p>Effectiveness / impact / sustainability</p>
<p>PA: The existing institutional weaknesses at CHAM and lack of experience in the implementation of similar projects are to be largely compensated for by providing the consultant for the project. The same applies to the work of the ministry departments involved (medium risk, high influenceability). Experience in project implementation and the implementation of the CHAM strategic plan with the support of GIZ will contribute to improving institutional capacity.</p> <p>AK: n/a</p> <p>EPE: The evaluation journey and data collection revealed clear weaknesses in CHAM's capacities. Even if the consultant was able to mitigate this during the implementation, it is also evident, for example in the areas of maintenance and repair, that CHAM does not have the necessary capacities to operate the health facilities sustainably in cooperation with the owner churches.</p>	<p>Impact/sustainability</p>
<p>PA: Based on other projects involving construction measures, there is a delayed risk of delayed project completion. The current shortage of petrol as a result of the country's economic situation exacerbates this risk. We see a high risk with low influenceability.</p> <p>Final follow-up: An additional risk that arose in this project was the delays in the construction measures.</p> <p>EPE: No longer relevant.</p>	<p>Efficiency</p>
<p>Final follow-up: In addition, the COVID-19 pandemic, which has been ongoing since 2020, not only negatively affected the economic situation of the affected population in 2020, but also the utilisation of health care services, which may also have affected the indicator values collected for 2020.</p>	<p>Effectiveness</p>

<p>EPE: Following the sharp decline in the utilisation of services caused by the COVID-19 pandemic, figures for this metric are expected to increase again.</p>	
<p>PA: The overall risk to the sustainable development effectiveness of the FC measure is assessed as high, with moderate influenceability. As the FC measure and the donor-led policy dialogue aim at measures to mitigate the central risks, these risks are justifiable in our opinion.</p> <p>Final follow-up: In the overall assessment of the sustainable achievement of the development policy objectives, we assume a medium risk with low influenceability. The overall difficult economic situation in Malawi remains.</p> <p>EPE: The central risks continue to exist and limit the project's success. The multiple emergencies in the Malawian health sector caused by the cholera epidemic, the resurgence of polio with the need for comprehensive vaccination campaigns and repeated extreme weather events are pushing the Malawian health system to its limits. There is no capacity for maintenance and repair, and not enough basic health services can be provided. The macroeconomic situation and the challenges for the health care sector remain fraught with risk.</p>	<p>Sustainability</p>

Annex 3: Recommendations for operation

Recommendations for operation according to the final follow-up and assessments at the time of the EPE:

- CHAM must ensure that the quality of health services at the health care facilities is ensured through sufficient and qualified staff in order to enable the health care facilities to provide the greatest possible benefit to the population.
 - ⇒ Staff replacements and new hires are made more difficult by the overall situation (see risks). CHAM trains healthcare professionals.
- CHAM should also ensure that all health care facilities have trained staff who can guarantee the correct use of the equipment and perform preventive maintenance and repairs themselves. In addition, CHAM should request laminated posters with operating instructions, preventive maintenance programmes and maintenance contact details from suppliers of sensitive equipment. These posters should be fixed to the wall next to the equipment.
 - ⇒ The project visits and discussions as part of the evaluation have shown that in terms of maintenance and repair, CHAM has not been successful in further advancing its health care facilities. Laminated posters could only be found in isolated cases. By and large, there were no longer any trained staff at the facilities. The CHAM health care facilities reported a lack of support for maintenance and repair, but did not refer to CHAM.
- We recommend the regular continuation of further training measures and refresher training for staff at CHAM health care facilities who perform maintenance, as well as the continuous setting of maintenance budgets by the owner churches.
 - ⇒ None of the CHAM health care facilities visited as part of the evaluation reported that the owner churches had set a maintenance budget. All expenditure must be covered by the revenue. Staff were unaware of further training measures and refresher training.
- CHAM would also be a suitable sponsor for future FC projects, as its health care facilities have better equipment compared to other health care facilities and sustainable operation is more likely due to their financial capacities.
 - ⇒ The capacities at CHAM health care facilities also appeared to be better than those at state facilities during the evaluation, but the utilisation of the facilities is also far from comparable. The situation regarding support from owner churches remained unclear.

Annex 4: Evaluation questions in line with OECD-DAC criteria / ex post evaluation matrix

Relevance

Evaluation question	Specification of the question for the present project	Data source (or rationale if the question is not relevant/applicable)	Rating	Weighting (- / 0 / +)	Rationale for weighting
Evaluation dimension 1: Policy and priority focus			1	0	
1.1 Are the objectives of the programme aligned with the (global, regional and country-specific) policies and priorities, in particular those of the (development policy) partners involved and affected and the BMZ?	Do the targets correspond to HSSP I-II-III and the targets of the German Federal Government in the health sector? Does CHAM have its own strategy, in particular also with regard to cooperation with MoH?	Health Sector Strategic Plan II (HSSP II) 2017-2022 https://www.healthdatacollaborative.org/where-we-work/Malawi HSSP III Malawi Growth and Development Strategy III (MGDS III) 2017 2022 https://cepa.rmpportal.net/Library/government-publications/the-malawi-growth-and-development-strategy-MGDS-III/view National Health Policy (NHP) 2017 2030 CHAM			
1.2 Do the objectives of the programme take into account the relevant political and institutional framework conditions (e.g. legislation, administrative capacity, actual power structures (including those related to ethnicity, gender, etc.))?	Are there reservations regarding the use of services of Christian health care facilities by non-Christian populations? How should the PPP approach between MoH and CHAM be assessed in view of the respective capacities?	On-site discussions Interviews with stakeholders Literature on PPP in Malawi			
Other evaluation question 1	Is the health care system dependent on external financing? What is the government's share of the health budget?				
Evaluation dimension 2: Focus on needs and capacities of participants and stakeholders			2	0	

<p>2.1 Are the programme objectives focused on the developmental needs and capacities of the target group? Was the core problem identified correctly?</p>	<p>Which parts are included in the Essential Health Package and which are covered by SLAs? Do the services offered meet the requirements, in particular those of women and children? What are the access restrictions? Would demand-side elements have been important as with RBF? Effects of external shocks: COVID, cholera, Freddy?</p>	<p>CHAM, consultant and MoH Interviews at HC incl. population</p>		
<p>2.2 Were the needs and capacities of particularly disadvantaged or vulnerable sections of the target group taken into account (possible differentiation according to age, income, gender, ethnicity, etc.)? How was the target group selected?</p>	<p>As things stand, what are the main factors that determine unequal access to health care facilities and health outcomes? Does the clear focus on mother-infant health remain justified? Which services are in particular demand by men? Are the health care facilities accessible?</p>	<p>Site visit – health care facility, CHAM, MoH</p>		
<p>2.3 Would the programme (from an ex post perspective) have had the potential to have other significant gender-related impacts if the project had been designed differently? (FC-E-specific question)</p>	<p>Do women and children face specific barriers to access? How do women and children get to the health care facility?</p>	<p>On-site visit – health care facility, target group</p>		
<p>Evaluation dimension 3: Appropriateness of design</p>			<p>2</p>	
<p>3.1 Was the design of the programme appropriate and realistic (technically, organisationally and financially) and in principle suitable for contributing to solving the core problem?</p>	<p>Was the implementation structure as a PPP between MoH and CHAM as well as the owner churches suitable? Were all relevant partners sufficiently taken into account in the design, also with regard to operation and sustainability (clear structure of responsibilities)?</p>	<p>CHAM, MoH, owner churches, DHO, consultant => implementation agreements</p>		
<p>3.2 Is the programme design sufficiently precise and plausible (transparency and auditability of the target</p>	<p>Were all necessary areas (service provider, financing, staff, medicine availability, etc.) adequately considered?</p>	<p>See above</p>		

system and the underlying impact assumptions)?		
3.3 Were the selected indicators and their value allocation appropriate in their entirety (select one of the following to answer: indicators and values were appropriate / partially appropriate / not appropriate)? The rationale is differentiated according to indicators in Appendix 1. (FC-E-specific question)	See Annex 1	
3.4 Please describe the results chain, incl. complementary measures, if necessary in the form of a graphical representation. Is this plausible? As well as specifying the original and, if necessary, adjusted target system, taking into account the impact levels (outcome and impact). The (adjusted) target system can also be displayed graphically. (FC-E-specific question)	Improved infrastructure (buildings, staff accommodation, medical equipment and furniture as well as maintenance equipment) in the supported health care facilities will make it possible to provide more services of better quality for the target group under the SLA between MoH and CHAM, thereby improving the health of mothers and children as a specific target group and contributing to a better health situation in the population. Target system, see above	
3.5 To what extent is the design of the programme based on a holistic approach to sustainable development (interplay of the social, environmental and economic dimensions of sustainability)?	Has a robust and climate-adapted design been anchored in the strategy? How should the building materials be assessed from an ecological perspective? What is the impact of locally adapted building materials?	Consultant, field visits
3.6 For projects within the scope of DC programmes: is the programme, based on its design, suitable for achieving the objectives of the DC programme? To what extent is the impact level of the FC module meaningfully linked to the DC programme (e.g. outcome impact or output outcome)? (FC-E-specific question)	The design is also suitable for achieving the objectives of the DC programme. DC programme and module are meaningfully linked	Cf. Appendix 1

Evaluation dimension 4: Response to changes/adaptability			2	0	
4.1 Has the programme been adapted in the course of its implementation due to changed framework conditions (risks and potential)?	Apart from different bricks used for the construction project, were there any other major alterations? How is the adjustment in the acquisition of power connections that were not provided by ESCOM to be assessed?	Various			

Coherence

Evaluation question	Specification of the question for the present project	Data source (or rationale if the question is not relevant/applicable)	Rating	Weighting (- / 0 / +)	Rationale for weighting
Evaluation dimension 5: Internal coherence (division of tasks and synergies within German development cooperation)			2	0	
5.1 To what extent is the programme designed in a complementary and collaborative manner within German DC (e.g. integration into DC programme, country/sector strategy)?	The programme is embedded in a DC programme and coherent with the country and sector strategy.	DC programme documentation BMZ Health Strategy			
5.2 Do the instruments of German DC dovetail in a conceptually meaningful way, and are synergies put to use?	Relevant FC and TC projects?	Project documentation On-site discussions Discussions with GIZ			
5.3 Is the programme consistent with international norms and standards to which German development cooperation is committed (e.g. human rights, Paris Climate Agreement, etc.)?	SDGs Gender equality?				

<p>Evaluation dimension 6: External coherence (complementarity and coordination with actors external to German DC):</p>			2	+	Due to the interdependencies with the financing of SLAs, staff, etc., the external coherence is of particular importance
<p>6.1 To what extent does the programme complement and support the partner's own efforts (subsidiarity principle)?</p>	<p>Subsidiarity in the context of donor dependence in the health sector? Continuity in the financing of the SLAs under the PPPs?</p>				
<p>6.2 Is the design of the programme and its implementation coordinated with the activities of other donors?</p>	<p>Which projects of other donors are similar, which use synergies (e.g. training of staff, sector reform, etc.), which are relevant for the framework conditions? Role of owner churches and smaller donors for CHAM health care facilities?</p>	<p>HSJF, FCDO, NORAD,</p>			
<p>6.3 Was the programme designed to use the existing systems and structures (of partners/other donors/international organisations) for the implementation of its activities and to what extent are these used?</p>	<p>To what extent has there already been cooperation between MoH and CHAM? Which other donors support CHAM (facilities)? What other private providers are there and how do they work?</p>	<p>CHAM</p>			
<p>6.4 Are common systems (of partners/other donors/international organisations) used for monitoring/evaluation, learning and accountability?</p>	<p>How are CHAM facilities followed up compared to MoH facilities?</p>	<p>CHAM MoH Consultant District health offices</p>			

Effectiveness

Evaluation question	Specification of the question for the present project	Data source (or rationale if the question is not relevant/applicable)	Rating	Weighting (- / 0 / +)	Rationale for weighting
<p>Evaluation dimension 7: Achievement of (intended) targets</p>			4	0	
<p>7.1 Were the (if necessary, adjusted) objectives of the programme (incl. staff assistance measures) achieved? Table of indicators: Comparison of actual/target</p>	<p>Are the supported health care facilities fully utilised? Including the second CEmONC where the anaesthetist was still missing? Are the health care facilities in operation 24/7? Are adequately trained staff available? Are any of the staff trained for BEmONC still working at the health care facilities? Are all health care facility ambulances in operation? Was this part of the measures? Are staff aware about the maintenance manuals and are they used? Is there a maintenance unit at CHAM? Has the operation of the facilities improved through operational management support measures? Has the quality of services improved? Was it possible to expand the range of service providers (possibly also beyond SLA content) while maintaining sufficient quality (including qualified staff)? Which health care facilities were upgraded to CEmONC or BEmONC as part of the project and did not previously have any obstetric wards? All health care facilities have SLAs (at inception phase 6 out of 16 had SLAs) What are the terms of the SLAs; are they automatically extended? If applicable, what happens in the case of expired procedures?</p>	<p>Consultant report Site visits – health care facilities, DHO, CHAM</p>			

<p>Evaluation dimension 8: Contribution to achieving objectives:</p>			4	o	
<p>8.1 To what extent were the outputs of the programme delivered as planned (or adapted to new developments)? <i>(Learning/help question)</i></p>	<p>Condition of health care facility buildings and equipment? Operation and maintenance? Staff training: Are the trained staff still working at the health care facility?</p>	<p>Project visits</p>			
<p>8.2 Are the outputs provided and the capacities created used?</p>	<p>How high is the utilisation rate of the health care facility?</p>	<p>CHAM, health care facilities, site visit</p>			
<p>8.3 To what extent is equal access to the outputs provided and the capacities created guaranteed (e.g. non-discriminatory, physically accessible, financially affordable, qualitatively, socially and culturally acceptable)?</p>	<p>Access restrictions? Are non-Christian patients treated equally? Accessibility?</p>	<p>Project visits, target group discussions</p>			
<p>8.4 To what extent did the programme contribute to achieving the objectives?</p>	<p>Cf. Outcome-level indicators What is the situation for the individual health care facilities?</p>	<p>See above</p>			
<p>8.5 To what extent did the programme contribute to achieving the objectives at the level of the intended beneficiaries?</p>	<p>See 8.4</p>				
<p>8.6 Did the programme contribute to the achievement of objectives at the level of the particularly disadvantaged or vulnerable groups involved and affected (potential differentiation according to age, income, gender, ethnicity, etc.)?</p>	<p>Women and children – provision of care and coverage with SLAs? Discrimination based on religion?</p>	<p>On-site discussions Health care facility data</p>			
<p>8.7 Were there measures that specifically addressed gender impact potential (e.g. through the involvement of women in project committees, water committees, use of social workers for women, etc.)? (FC-E-specific question)</p>	<p>Do the SLAs only cover mother-child health services or do they additionally cover services that are also used by men?</p>	<p>MOH/CHAM</p>			

<p>8.8 Which project-internal factors (technical, organisational or financial) were decisive for the achievement or non-achievement of the programme's intended objectives? (<i>Learning/help question</i>)</p>	<p>Since when have all health care facilities been connected to the power grid? To what extent did the lack of power limit the operation and use of the equipment?</p>	<p>Reports Site surveys</p>			
<p>8.9 Which external factors were decisive for the achievement or non-achievement of the programme's intended objectives (also taking into account the risks anticipated beforehand)? (<i>Learning/help question</i>)</p>	<p>COVID-19 pandemic with access restrictions has impacted the use of the health care facilities. Have the levels been reached again? What is the availability of medication? Does this differ greatly between health care facilities? How import-dependent is this against the backdrop of the currency shortage? Staff availability even in remote areas? Staff qualifications? Brain drain?</p>				
<p>Evaluation dimension 9: Quality of implementation</p>			4	o	
<p>9.1 How is the quality of the management and implementation of the programme to be evaluated with regard to the achievement of objectives?</p>	<p>MoH, CHAM, consultant, - which other parties are involved?</p>				
<p>9.2 How is the quality of the management, implementation and participation in the programme by the partners/executing agencies to be evaluated?</p>	<p>Overall, how is the design and implementation to be evaluated in light of the substantial building and delivery challenges with significant delays? Were there differences in the quality of implementation in the three project regions North, Central and Central/South, which had different site engineers from the contractor?</p>				
<p>9.3 Were gender results and relevant risks in/through the project (gender-based violence, e.g. in the context of infrastructure or empowerment projects) regularly monitored or otherwise taken</p>	<p>Presence of construction companies in the remote areas – were appropriate measures taken?</p>				

<p>into account during implementation? Have corresponding measures (e.g. as part of a CM) been implemented in a timely manner? (FC-E-specific question)</p>					
<p>Evaluation dimension 10: Unintended consequences (positive or negative)</p>	<p>Note: if there are no unintended effects: → No weighting → No evaluation</p>		2	o	
<p>10.1 Can unintended positive/negative direct impacts (social, economic, ecological and, where applicable, those affecting vulnerable groups) be seen (or are they predicted)?</p>	<p>To what extent was the provision of care restricted or reduced in quality; during the (delayed!) implementation of the construction measures? Was there Medical Council of Malawi supervision? Contribution to socio-economic development through new electricity connection in Chigodi, which benefits not only the HC, but also the entire population in the catchment area (approx. 25,000)?</p>				
<p>10.2 What potential/risks arise from the positive/negative unintended effects and how should they be evaluated?</p>	<p>Would it have been expedient to link electricity supply and health? What are the risks regarding reliable electricity supply?</p>				
<p>10.3 How did the programme respond to the potential/risks of the positive/negative unintended effects?</p>	<p>What actions were taken to ensure ongoing provision of health care during project implementation? Did the design of the buildings sufficiently take into account the increasing extreme weather events? (Climate resilience?)</p>				

Efficiency

Evaluation question	Specification of the question for the present project	Data source (or rationale if the question is not relevant/applicable)	Rating	Weighting (- / o / +)	Rationale for weighting
<p>Evaluation dimension 11: Production efficiency</p>			4	o	
<p>11.1 How are the programme's inputs (financial and material resources) distributed (e.g. by instruments, sectors, sub-measures, also taking into account the cost contributions of the partners/executing agencies/other participants and affected parties, etc.)? (Learning and help question)</p>	<p>Does the equipment (medical equipment and furniture) meet the requirements? How did the delivery of poor equipment and/or poor installation affect operation? Construction defects? What is the impact of low quality building materials? What proportion of the buildings was built with burned bricks instead of sustainable building materials? What was the impact of the construction company's lack of capacity? What are the costs compared to similar projects (RBF or other donors)?</p>	<p>Site visit: Health care facility staff, CHAM, consultant</p>			
<p>11.2 To what extent were the programme's inputs used sparingly in relation to the outputs produced (products, capital goods and services; if possible in a comparison with data from other evaluations of a region, sector, etc.)? For example, comparison of specific costs.</p>	<p>In hindsight, was it expedient to tender the structural measures in just one lot? Was the construction company's capacity sufficient to implement the various construction sites in parallel? Why did the construction company first conclude an amendment for power connections and then remove it three years later? Finally, were residual funds used again for power connections? Would it have been more efficient for some health care facilities to forgo electricity connection to the national grid and opt for decentralised electricity supply? Were there still missing power connections not taken into account in the design? Delays in building meant that equipment had to be stored, which in turn meant that the period of time in which the consumables could be stored elapsed</p>	<p>TE, consultant, CHAM, health care facility</p>			

	before they could be used. What losses resulted from this?			
11.3 If necessary, as a complementary perspective: To what extent could the outputs of the programme have been increased by an alternative use of inputs (if possible in a comparison with data from other evaluations of a region, sector, etc.)?	<p>Could a different, locally adapted construction method have mitigated the building challenges (material availability, etc.)?</p> <p>Did every health care facility cover all needs or would it have been more expedient to have a geographical focus with fewer health care facilities?</p>			
11.4 Were the outputs produced on time and within the planned period?	<p>The planned implementation period of five years was delayed to ten years. Reasons?</p> <p>Defects liability period for construction services ended. What about equipment? Did the warranty period expire without use? If applicable: extended maintenance for an additional two years?</p> <p>For how long was the equipment actually used before the maintenance contracts expired?</p>			
11.5 Were the coordination and management costs reasonable (e.g. implementation consultant's cost component)? (FC-E-specific question)	Was the amount of consulting costs appropriate? How do this compare to similar projects?			
Evaluation dimension 12: Allocation efficiency			3	0
12.1 In what other ways and at what costs could the effects achieved (outcome/impact) have been attained? (<i>Learning/help question</i>)	Would it have been more expedient to supply and support nine state health care facilities?			
12.2 To what extent could the effects achieved have been attained in a more cost-effective manner, compared with an alternatively designed programme?	What was the advantage of the PPP approach compared to supporting state health care facilities?			

<p>12.3 If necessary, as a complementary perspective: To what extent could the positive effects have been increased with the resources available, compared to an alternatively designed programme?</p>	<p>The selection of the central region and districts as well as health care facilities was based on the criteria below. The selection cannot be clearly inferred from health data and provision density. Were the other regions actually adequately addressed by other donors? Were the indicators also appropriate from today's perspective?</p> <ul style="list-style-type: none"> a) Region selection: (MMR, CMR, access to health services and available funds from other donors)? b) According to which criteria were the exact locations selected? c) Was it expedient to only promote health care facilities with existing SLAs, as these already had the basic prerequisites for mother-child health services, otherwise they would not have had SLAs? 	<p>Consultant reports CHAM, MoH, project visits</p>
<p>Note: If the internal identifier PSP (Private Sector Participation; see Inpro under 1.11) was issued for the project or there is generally cooperation with private actors (commercial banks, companies, professional NGOs) in the implementation of FC (private sector as an instrument), the following evaluation question must be taken into account:</p>		
<p>12.4 In what respect were public funds used to supplement the provision of finances?</p>	<p>Additionality of government funds in terms of coverage of the country with EHP?</p>	

Impact

Evaluation question	Specification of the question for the present project	Data source (or rationale if the question is not relevant/applicable)	Rating	Weighting (- / o / +)	Rationale for weighting
<p>Evaluation dimension 13: Overarching developmental changes (intended)</p>			2	o	

<p>13.1 Is it possible to identify overarching developmental changes to which the programme is set to contribute? (Or if such changes are to be anticipated in the future, please be as specific as possible in terms of time.)</p>	<p>How have health indicators developed in Malawi since 2011?</p>	<p>DHS, World Bank, UNICEF, MoH</p>			
<p>13.2 Is it possible to identify overarching developmental changes (social, economic, environmental and their interactions) at the level of the intended beneficiaries? (Or if such changes are to be anticipated in the future, please be as specific as possible in terms of time)</p>	<p>What about the catchment area of the supported CHAM health care facility?</p>	<p>Target group discussions</p>			
<p>13.3 To what extent can overarching developmental changes be identified at the level of particularly disadvantaged or vulnerable sections of the target group to which the programme is set to support? (Or if such changes are to be anticipated in the future, please be as specific as possible in terms of time)</p>	<p>Access restrictions/barriers for specific groups?</p>				
<p>Evaluation dimension 14: Contribution to overarching developmental changes (intended)</p>			<p>3</p>		
<p>14.1 To what extent did the programme actually contribute to the identified or foreseeable overarching developmental changes (also taking into account the political stability) to which the programme was intended to contribute?</p>	<p>Was there a model character or structure-forming effects? Spillover effects on other CHAM or government facilities?</p>				
<p>14.2 To what extent did the programme achieve its intended (possibly adjusted) developmental objectives? In other words, are the project impacts sufficiently tangible not only at outcome</p>	<p>Contribution to national data or regional data able to be derived?</p>				

level, but at impact level? (e.g. drinking water supply/health effects)		
14.3 Did the programme contribute to achieving its (possibly adjusted) developmental objectives at the level of the intended beneficiaries?	See above	
14.4 Has the programme contributed to overarching developmental changes or changes in life situations for particularly disadvantaged or vulnerable sections of the target group (potential differentiation according to age, income, gender, ethnicity, etc.) that the programme was intended to support?	See above – Target group is vulnerable overall	
14.5 Which project-internal factors (technical, organisational or financial) were decisive for the achievement or non-achievement of the programme's intended developmental objectives? (<i>Learning/help question</i>)	Are there any internal project factors that were decisive?	
14.6 Which external factors were decisive for the achievement or non-achievement of the programme's intended developmental objectives? (<i>Learning/help question</i>)	Impacts of the COVID-19 pandemic? Staff availability and qualifications? Barriers to access?	
14.7 Does the project have a broad-based impact? <ul style="list-style-type: none"> - To what extent has the programme led to structural or institutional changes (e.g. in organisations, systems and regulations)? (Structure formation) - Was the programme exemplary and/or broadly effective and is it reproducible? (Model character) 	Spillover effects on other CHAM or government health care facilities? Was it a role model – in terms of design, equipment or operation/maintenance?	

<p>14.8 How would the development have gone without the programme (developmental additionality)?</p>	<p>Can it be assumed that the health care facilities would not have received any promotion and would therefore not have been able to conclude any SLAs and that as a result no free health service would have been provided to the target group without the project? What costs are incurred for the service provided under the SLA for the target group in the case of “direct payment”?</p>						
<p>Evaluation dimension 15: Contribution to (unintended) overarching developmental changes</p>		<p>Note: if there are no unintended effects: → No weighting → No evaluation</p>			3	o	
<p>15.1 To what extent can unintended overarching developmental changes (also taking into account political stability) be identified (or, if changes can be anticipated for the future, please be as specific as possible in terms of time)?</p>	<p>What contribution can the health care facilities make in the context of the COVID-19 pandemic?</p>						
<p>15.2 Did the programme noticeably contribute to unintended (positive and/or negative) overarching developmental impacts or is the programme predicted to contribute to such impacts?</p>	<p>Gender Focus on the most deprived target group at private health care facilities? Environment</p>	<p>Study on PPP with CHam</p>					
<p>15.3 Did the programme noticeably (or is the programme predicted to) contribute to unintended (positive or negative) overarching developmental changes at the level of particularly disadvantaged or vulnerable groups (within or outside the target group; do no harm, e.g. no exacerbation of inequality (gender/ethnicity))?</p>	<p>Hard supply limit after SLA coverage?</p>						

Sustainability

Evaluation question	Specification of the question for the present project	Data source (or rationale if the question is not relevant/applicable)	Rating	Weighting (- / o / +)	Rationale for weighting
Evaluation dimension 16: Capacities of participants and stakeholders			4	o	
16.1 Are the target group, executing agencies and partners institutionally, personally and financially able and willing (ownership) to continue producing the positive effects of the programme over time (after the end of the promotion)?	Is government financing of the SLAs secured in the long term? Financing via HSJF – prospects? DHO: Supervision of the health care facility? Training for sustainable operation? CHAM: Role and capacities in operation? Owner churches: financing of operating costs, maintenance and servicing? Knowledge and implementation of operation and maintenance manuals? Implementation? Documentation? Who takes on responsibility for what?	Budgetary development for health Health expenditure financing structure – HSSP I – III Investment agreements vs. reality in on-site conversations and reports			
16.2 To what extent do the target group, executing agencies and partners demonstrate resilience against future risks that could jeopardise the impact of the programme?	Resilience of the health care facilities after the end of the project?				
Evaluation dimension 17: Contribution to supporting sustainable capacities:			4	o	
17.1 Did the programme contribute to the target group, executing agencies and partners being institutionally, personally and financially able and willing (ownership) to continue producing the positive effects of the programme over time and, where necessary, to curb negative effects?	Is there awareness of the "individual building maintenance schedules prepared for each HU" and are they implemented including documentation at HU level? Is there owner or CHAM supervision? Are the trained staff still at the health care facility? Are they carrying out their roles?				

	Does CHAM again have a maintenance unit that supports the HUs? Training effects ⇔ staff turnover (medical and maintenance)? At HC level, by CHAM or also by MoH?			
17.2 Did the programme contribute to increasing the resilience of the target group, executing agencies and partners against risks that could jeopardise the effects of the programme?	No specification necessary	Discussions with MoH, CHAM, health care facility, target group		
17.3 Did the programme contribute to increasing the resilience of particularly disadvantaged groups against risks that could jeopardise the effects of the programme?	Target group is vulnerable.			
Evaluation dimension 18: Durability of impacts over time			4	o
18.1 How stable is the context of the programme (e.g. social justice, economic performance, political stability, environmental balance)? (<i>Learning/help question</i>)	Financial and staff capacities of the establishments responsible for operation and maintenance (MoH, DHO, CHAM, owner churches, health care facilities)			
18.2 To what extent is the durability of the positive effects of the programme influenced by the context? (<i>Learning/help question</i>)	Influence of the financial situation, development of donor contributions, financing of SLAs, support from owners?			
18.3 To what extent can the positive and, where applicable, negative effects of the programme be considered long lasting?	Capacities for working capital and replacement investments?			
18.4 To what extent can the gender results of the programme be considered long lasting (ownership, capacities, etc.)? (FC e-specific question)	No specification necessary			

Other evaluation question 1	To what extent are infrastructure measures “upgradeable and upscalable”? (e.g. electricity, water systems, building placements (for extensions, etc.) ⇔ drop and go infrastructure)	
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