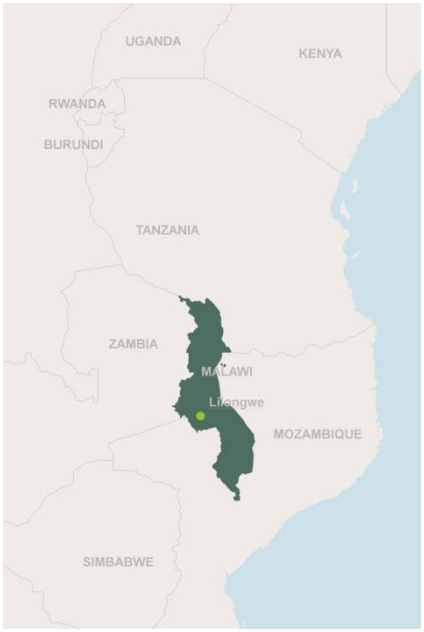
Ex post evaluation – Malawi

Sector: Health policy and administrative management (CRS Code 12110)
Project: Support of Health Sector Strategy I-III
(I) 2005 66 521* (BM) 2007 70 032, (II) 2007 66 501, (III) 2009 67 257
Programme executing agency: Ministry of Health, Government of Malawi



Ex post evaluation report: 2014

		Planned, (I-III)	Actual, (I-III)
Investment costs (total)	EUR million	**1,277.94	**1,435.89
Own contribution	EUR million	1,252.10	1,410.10
Counterpart contribution	EUR million	1,121.86	1,265.21
Funding	EUR million	25.80	*25.80
of which BMZ budget funds	EUR million	25.80	***25.80

*) Random sample 2014**) Amount relates to entire SWAp I - III;
***) EUR 3.5 million of this sum used separately for a German-Norwegian Initiative (Component B) (not evaluated here).

Description: The three FC tranches supported the Malawian government's reforms of its health policy as part of a sector-wide approach (SWAp). The measures focused on providing health services by means of a supply system decentralised during the project term. The financing was handled via a basket of donors. Tranche III comprised both the continuation of the basket funding (Component A) and the German-Norwegian Mother-Child Health Initiative (Component B) that is not evaluated here. A complementary measure to improve financial management was also funded.

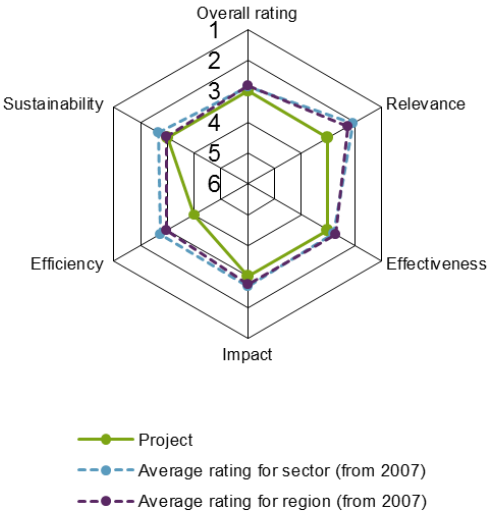
Objectives: The overall objective of the three projects was to improve the health of the Malawian population (especially poor women and children). This was to be achieved by making better use of basic health services (Essential Health Package) through improving access to such services and their quality (project objectives).

Target group: The target group is the Malawian population, with particular regard to the poor population as well as women and children in rural areas. This should have reached 80-90 % of the population, especially socially deprived groups (including, first and foremost, women: mothers and expectant mothers).

Overall rating: Note 3 (all 3 phases)

Rationale: Despite unsatisfactory efficiency but boosted by satisfactory sustainability, a sharp improvement in health indicators resulted in an altogether satisfactory overall rating.

Highlights: It is clear on the whole that due to its very weak capacities, the project-executing agency (Ministry of Health) was out of its depth with implementing a relatively complex and dense reform to decentralise and simultaneously improve health services.



Rating according to DAC criteria

Overall rating: 3 (all 3 phases)

After weighing up all the criteria we rate the impact of the three projects as satisfactory.

General conditions and classification of the projects

The three FC projects are evaluated together for the following reasons:

1. In terms of their implementation arrangements, they are coherent serial projects (basket approach[1] in co-financing with other donors).
2. They relate to the same health reform programme that called for the implementation of a joint strategy in the health-care sector. It is, therefore, impossible to separately evaluate the effectiveness, efficiency and overall developmental impact of the individual projects, each of which has an implementation period of one to two years.

The "German-Norwegian Mother-Child Health Initiative" (Component B of Tranche III, EUR 3.54 million) is decoupled from the basket funding and not part of the evaluation. Although the initiative also promotes the sector strategy, it pursues other objectives and applies a different form of financing (project based instead of basket funding). Thus the ex-post evaluation pertains to the following FC volumes:

- (I) 2005 66 521, EUR 5 million
- (II) 2007 66 501, EUR 5 million (II, BM) 2007 70 032, EUR 0.6 million(III) 2009 76 257, EUR 6.5 million (only Component A)

Relevance

The basket approach aimed to improve the population's health. This was extremely relevant in terms of development policy since the poor health of the population also constituted a barrier to social and economic development in Malawi, which in many cases was exacerbated by the spread of under nutrition amongst the people. Inadequate nutrition amongst children in particular leads to an elevated rate of illnesses.

The basket programme is in line with the government's sector policy and the Malawi Growth and Development Strategies I (2006-2011) and II (2011-2016), especially with regard to reducing poverty by promoting social sectors, public private partnerships, etc.. This approach is also consistent with the government's health policy developed in conjunction with donors. Yet the design of the programme did not take proper account of the institutional and structural weaknesses of the health system, in relation to finance and procurement management for example. The sector-wide approach implemented for the first time in Malawi's health sector was uncharted territory for the institutions at various levels (budgeting, accountability, proper awarding of contracts). Significant structural bottlenecks in the health sector, for example the inadequate human resource and procurement management, especially at decentralised levels, should have been considered more in the design phase, i.e. the trade-off between service provision and decentralisation.

The health sector is a priority area for German-Malawian development cooperation. The programme fits in well with the priority area of German-Malawian cooperation, where the overall programme objective was defined as improving access to and use of basic high-quality health services (Essential Health Package), especially regarding sexual and reproductive health (including the fight against HIV/AIDS).

With regard to the criteria of coherence, complementarity and coordination, the donor organisations involved in the health sector work largely in a coordinated and complementary fashion. Many donors have

[1] Basket funding, according to BMZ Sector Strategy Paper: "Donors collectively fund a spending plan for the implementation of a specific bundle of measures derived from a sector strategy. The agreed measures have earmarked funds (…). The funds are paid into a separate account and reported on-budget…"

agreed on a basket funding approach with a common work programme. Almost 90 % of the donor financing set aside in the national budget was provided for SWAp I (fiscal years 2004/05-2009/10) as part of the basket funding; the remaining 10 % or so was made available for project based financing. In spite of this, the monitoring and evaluation of the SWAp programme was not sufficiently coherent at the central and local levels. Moreover, in crisis situations, such as the economic and governmental crisis during the Mutharika government's second period in office (2009-12), there was no concerted approach among donors vis-a-vis the government. To sum up, the relevance of the three projects was rated as satisfactory.

Relevance rating: 3 (all phases)

Effectiveness

The aim of the programme was to ensure better use of decentralised health services, with the main focus on improved access to and a defined scope of essential services. The main indicators to measure target achievements are summarised below:

Greater use and impact of basic health services		
PLANNED indicator	**ACTUAL indicator**	**Target achievement**
(1) The proportion of one-year-old children vaccinated against measles is still 82 % (2005).	89 % of all children are vaccinated against measles after they reach the age of one (HIMS 2012/13) 85 % (MICS 2014).	+
(2) Increase in ratio of surveyed population that is satisfied with the health services. (no baseline study)	NORAD study on patient satisfaction (2010/11): - 76.4 % rural areas - 83.6 % urban areas NORAD study, 2013 - 60 % of all those surveyed were largely/completely satisfied with CHAM health services* - 35 % of all those surveyed were largely/completely satisfied with state health services - 68 % of all those surveyed were satisfied with the supply of medicines (public institutions)	**No clear assessment impossible**
(3) Increase in contraceptive prevalence rate from 28.1 % (DHS 2004) to 40 % in 2011.	- 42 % (Multiple Indicator Cluster Survey 2010/11) - 59 % (MICS 2014)	+
(4) Increase in ratio of childbirths in the presence of qualified personnel from 38 % (HMIS 2004-05) to 75 % (2011).	- 52 % (2008/09) - 87 % (MICS 2014)	+
Better access to quality basic health services		

(5) Full range of basic health services available in 60 % of all health centres (2006: 15 %)	74 % of all health institutions offer the full range of basic health services (KfW 2011)	+
(6) Reach a standard level of personnel in at least 85 % of all health centres (2007: 40 %)	27 % of all health-care institutions fulfil the staffing ratio for hospital doctors and 45% the staffing ratio for nurses/midwives. (KfW 2011)	--
(7) Planned supervisions with documented feedback in 80 % of cases (2006: 71 %)	The ratio of documented supervisions totalled 63 % in 2011. By contrast, the number and quality of supervisions seems to be rising. It is unclear how reliable the base data is (KfW 2011).	--/?
(8) Increase in use of curative "first-time care": at least one first-time care/inhabitant/year (2007: 0.9 inhabitants)	- 1.3 first-time care/inhabitant (Ministry of Health 2010) - 1.1 first-time care/inhabitant (HIMS 2012/13)**	+
(9) At least 65 % of the employees surveyed are satisfied with their working conditions	No data, since this indicator is not part of routine data surveys.	No info
(10) Increase in average implementation rate of annual action plans at national level and in the districts from 70 % to over 85 %	No reliable statement possible on implementation rate of annual action plans.	No info

*) In CHAM institutions the sometimes elevated user fees were too expensive in some cases for the poor population, which is why higher earning groups of the population benefited more from the services.
**) Indicator does not cover the municipal level, which is particularly relevant for the poorer target group.

Not all of the target figures were achieved or evaluated. In a regional comparison, Malawi performs better than average in terms of the ratio of medically supervised births, pre/post-natal care and contraceptive prevalence for example, in spite of its very below-average gross national product per capita and the equally low (roughly 1/3) health-care spending per capita. Thus, overall, the target achievement can be considered satisfactory.

Effectiveness rating: 3 (all phases)

Efficiency

On the one hand, the basket funding provided funding for qualitative and quantitative improvements of sectoral services, while on the other, in agreement with the government and other donors, it opened up the potential to promote structural changes enabling more efficient investments in the long term. This basket funding potential was only partially used for reforms in the health sector. Improvements included the monitoring system for medicine supplies, the institutional set-up of the Central Medical Store as well as staff management and cooperation with the private sector (service level agreements with CHAM health centres). Little progress was made in general areas of accountability.

The basket funding donors agreed upon a package of measures with the government every year. However, this budgeting was not very needs-driven (based on burden of disease and taking equity aspects into

account) and instead focused more on inputs, driven amongst other things by the expected absorption of funds.[2] The planning was primarily based on reported needs from health centres, which were consolidated at district level. The insufficient capacity at this level led to mistakes in planning. The mechanisms available to plan and manage the basket approach paid too little attention to it. For example, the monitoring and evaluation system comprised a variety of proven indicators, but for lack of data there was no continuous quantification of the indicators.

The ratio of health-care spending (including basket funding) in the total budget rose from 11 % (2004/05) to 14 % (2011/12); this almost reached the target in the Declaration of Abuja from 2001[3] – though mainly following an increase in donor financing. Budget funds are increasingly channelled directly to the districts; real growth totalled 55 %, but the district allocation ratio subsequently fell again.[4] The basket funding was initially implemented within the planned timeframe. However, delays did emerge because the Ministry of Finance was late in forwarding basket funding on to the Ministry of Health[5], and because of a payment stop caused by irregularities with procurement (non-compliance with agreed procedures).

Given the rather slow progress on improving management capacities at the Ministry of Health and its decentralised levels over the period, the procurements which were not always in line with demand and the cases where agreed procedures were circumvented (almost 3% of the co-financing amount of SWAp I) we rate the overall efficiency of the project as no longer satisfactory.

Effectiveness rating: 4 (all phases)

Impact

The overall development policy objective of the basket funding was to improve the health of the Malawian population (especially the poor, women and children). The following proxy indicators were used to evaluate the overall objective:

Proxy indicator (PLANNED)	Proxy indicator (ACTUAL)	Target achievement
(1) Infant mortality (under 1 year old) fell from 76/1,000 (2000-04) to 48/1,000 (2011).	49/1,000 (World Bank 2011) 53/1,000 (MICS, 2014)	+
(2) Child mortality dropped from 133/1,000 (2000-04) to 76/1,000 (2011).	77/1,000 (World Bank 2011) 85/1,000 (MICS, 2014)	+
(3) Maternal mortality fell from 984/100,000 (2000-04) to 560/100,000 (2011)	460/100,000 (WHO, 2010) 574/100,000 (MICS, 2014)	+
(4) Reduction in HIV prevalence among pregnant women between the ages of 15 and 24, from 14.3 % (2005) to < 12 % by 2011	- 12.3 % (MOH 2008) - 7 % (HIMC 2012/13)	+
(5) Increase in life expectancy at birth from 40 years (NSO 2005) to 45 years (2011)	- 54 years (2011 World Bank)	+

[2] Cf: DfID (2010), p. 40.

[3] At a summit meeting of the African Union, the countries pledged to spend 15 % of their budgets on health care.

[4] Cf: DfID (2010), p. 39.

[5] World Bank (2009), p. 8.

The indicators initially confirm a sharp improvement in the health of the Malawian population over the last 10 years; the trend has taken a small step back recently according to the latest figures, but remains slightly below/above the target figure. Given the high ratio of basket funding in the overall donor funding and also relative to the national sector budget, we can assume that the basket funding made a key contribution to this development.

The three FC tranches were a significant help in financing health-care spending and the ongoing operation of the health-care system. Structural impacts were achieved in few areas and to a rather minor extent. Considering the large donor community involved in the sectoral approach, these structural reforms fall way short of expectations. To sum up, the overall developmental impacts of the projects are considered satisfactory.

Impact rating: 3 (all phases)

Sustainability

The basket funding made a significant contribution to financing basic health services. The Malawian health system is still highly dependent on external financing. The government's share in financing the health budget stood at 46 % in 2009/10, and has since fallen to roughly 20 %. No radical change is expected here given the high number and variety of financing organisations in the health sector. National budget planning processes at the Ministry of Health are subject to political influence, which can lead to a shift in priorities. No drastic changes are anticipated here either. The development of private, sustainable financing instruments, such as the introduction of micro insurance, savings groups, etc. has yet to be tackled. The focus is still on developing new, alternative sources of financing.

The institutional reforms pushed through with the purpose of securing the efficient implementation of future projects are still in place, particularly regarding human resources management, the monitoring of supply chains and with regard to public-private partnerships. While the capacities connected with national procurement procedures have also been expanded, the question remains whether this will result in long-term acceptance and "ownership". Moreover, planning is more needs-driven now with the District Health Management Teams' supervision of health services.

By contrast, the significant weaknesses observed in the running of health institutions still apply today, which limit the access to and use of basic health services. The main problems are the severe lack of medical equipment, the shortages of medicines and the inadequate maintenance of medical equipment. There is also an insufficient number of health facilities which means limited availability, particularly in remote regions. Overall, the sustainability of the projects is rated as satisfactory.

Sustainability rating: 3 (all phases)

Notes on the methods used to evaluate project success (project rating)

Projects (and programmes) are evaluated on a six-point scale, the criteria being **relevance, effectiveness, efficiency** and **overarching developmental impact**. The ratings are also used to arrive at a **final assessment** of a project's overall developmental efficacy. The scale is as follows:

Level 1	Very good result that clearly exceeds expectations
Level 2	Good result, fully in line with expectations and without any significant shortcomings
Level 3	Satisfactory result – project falls short of expectations but the positive results dominate
Level 4	Unsatisfactory result – significantly below expectations, with negative results dominating despite discernible positive results
Level 5	Clearly inadequate result – despite some positive partial results, the negative results clearly dominate
Level 6	The project has no impact or the situation has actually deteriorated

Ratings level 1-3 denote a positive assessment or successful project while ratings level 4-6 denote a negative assessment.

Sustainability is evaluated according to the following four-point scale:

Sustainability level 1 (very good sustainability): The developmental efficacy of the project (positive to date) is very likely to continue undiminished or even increase.

Sustainability level 2 (good sustainability): The developmental efficacy of the project (positive to date) is very likely to decline only minimally but remain positive overall. (This is what can normally be expected).

Sustainability level 3 (satisfactory sustainability): The developmental efficacy of the project (positive to date) is very likely to decline significantly but remain positive overall. This rating is also assigned if the sustainability of a project is considered inadequate up to the time of the ex post evaluation but is very likely to evolve positively so that the project will ultimately achieve positive developmental efficacy.

Sustainability level 4 (inadequate sustainability): The developmental efficacy of the project is inadequate up to the time of the ex post evaluation and is very unlikely to improve. This rating is also assigned if the sustainability that has been positively evaluated to date is very likely to deteriorate severely and no longer meet the level 3 criteria.

The **overall rating** on the six-point scale is compiled from a weighting of all five individual criteria as appropriate to the project in question. Ratings 1-3 of the overall rating denote a "successful" project while ratings 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 ("overarching developmental impact") and the sustainability are rated at least "satisfactory" (rating 3).