USAID
FROM THE AMERICAN PEOPLE

SSDI-SERVICES PERFORMANCE EVALUATION

October 2016

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by Dr. Marcel Sagbohan, Dr. Spy Munthali, Dr. Nicholas Kanlisi, Mr. Willie Kachaka and Mr. Dyton B. Mukhuna through DevTech Systems Inc.

SSDI-SERVICES PERFORMANCE EVALUATION

October 14, 2016

AID 612-TO-16-00003

ACKNOWLEDGEMENTS

The SSDI-Services evaluation team would like to thank the individuals who generously took time out of their busy schedules to provide candid information and perceptions on the quality, access, capacity building and HMIS activities implemented under the Support for Service Delivery-Integration (SSDI-Services) Program; all health workers who patiently and kindly answered our questions and filled out a lengthy survey, despite long lines of patients waiting for their attention; the community members and community volunteers (CAG and Care groups) who accepted to speak to us so enthusiastically about their role in improving quality and access in their communities, and participated in focus group discussions in the thirteen districts research sites often with little advance notice. Throughout this evaluation, the team benefited from the support and assistance of Ministry of Health (MOH) directors, managers, district health officers, program coordinators and health care providers, of the Essential Health Package (EHP) in Malawi. The team would like to acknowledge the dedicated USAID Malawi staff who provided on-going feedback and support throughout the evaluation, especially Chimwemwe Chitsulo, USAID/Malawi's Monitoring, Evaluation and Learning Specialist and Contracting Officer's Representative (COR). Lastly, the team is grateful to SSDI-Services, JHPIEGO, Save the Children, Plan International, CARE, Nkhotakota AIDS Support Organization for making their staff and project information available to the team. These professionals are working tirelessly to improve quality and access of EHP services to the Malawian people and build capacity of MOH staff in EHP services and utilization of health data for decision making.

This page is intentionally left blank

CONTENTS

TABLES

FIGURES

This page is intentionally left blank

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
BEmONC	Basic Emergency Obstetric and Newborn Care
CBDA	Community Based Distribution Agent
CBS	Community Based Services
CDCS	Country Development Cooperation Strategy
CMAM	Community Management of Acute Malnutrition
CMED	Central Monitoring and Evaluation Division
CSO	Community Service Organization
DCS	Department of Clinical Services
DHIS2	District Health Information System Version 2
DHO	District Health Office
DHMT	District Health Management Team
DP	Development Partner
DPPD	Department of Policy Planning and Development
EHP	Essential Health Package
FGD	Focus Group Discussion
FP	Family Planning
HAC	Health Advisory Committee
HF	Health Facility
HSSP	Malawi Health Sector Strategic Plan
GI	Group Interview
GIS	Geographic Information System
iCCM	Integrated Community Case Management
IE	Impact Evaluation
iHRIS	Human Resource Information System
IP	Infection Prevention
IPM	Internal Planning Meeting
IPT2	Intermittent Preventive Treatment Second Dose
IT	Information Technology
HIS	Health Information Systems
HIV	Human Immunodeficiency Virus
HQ	Headquarters
HMIS	Health Management Information System
KMC	Kangaroo Mother Care

KII	Key Informant Interview
MoH	Ministry of Health
NAC	National Aids Commission
NASO	Nkhotakota AIDS Support Organization
NGO	Non-governmental Organization
NHA	National Health Accounts
NMCP	National Malaria Control Project
PBI	Performance Based Incentive
PDU	Policy Development Unit
PE	Performance Evaluation
PMP	Performance Monitoring Plan
PMS	Performance Management System
PQI	Performance Quality Improvement
QA	Quality Assurance
RH	Reproductive Health
SBMR	Standard Based Management and Reward
SOW	Statement of Work
SSDI	Support for Service Delivery Integration
SSI	Semi Structured Interview
STA	Senior Technical Advisor
SWAp	Sector Wide Approach
TA	Technical Assistance
ToT	Training of Trainers
TL	Team Leader
USAID	United States Agency for International Development
ZHO	Zonal Health Office

EXECUTIVE SUMMARY

The Support for Service Delivery Integration (SSDI-Services) project was a five-year project worth an estimated US $85,000,000 funding support from United States Agency for International Development (USAID) to the Government of Malawi (GoM) toward the implementation of the Health Sector Strategic Plan (HSSP) 2011-2016. Implemented by a consortium of partners (Jhpiego, Save the Children, CARE International, Plan International) and led by Jhpiego as the Prime, the SSDI-Services project set out to improve the health and well-being of the population of Malawi by implementing an integrated service delivery program that sought to significantly expand and improve quality of priority Essential Health Package (EHP) services at the community and referral (health centers and hospitals) levels in order to achieve the following results:

1. Increased access and utilization of EHP services for women and children that could make a difference in their health and engage men in care.
2. Improved quality of health services at community and facility level in 15 districts.
3. Improved health-seeking behavior by individuals, families and communities.
4. Strengthened health care delivery system through development, testing, and scale up of innovative and sustainable community-based service delivery approaches.

PURPOSE OF THE PERFORMANCE EVALUATION

The purpose of this SSDI-Services end-of-project performance evaluation is to measure the effectiveness, relevance and efficiencies of project activities. Primarily the evaluation aimed to determine the effect of SSDI-Services' interventions on improved service delivery and quality of care at supported community clinics and health facilities; expanded coverage of quality EHP services; and increased uptake of quality integrated EHP. The main objectives of the evaluation included to: 1) determine the extent to which SSDI-Services interventions influenced quality of and access to care; 2) provide in-depth insights into the facilitating and limiting factors of increased service utilization at each level of service delivery; and 3) document progress made towards building MoH capacity to deliver quality EHP services. The evaluation also documented key approaches that contributed to achievement of project outcomes and to provide evidence-based recommendations on key actions required of USAID/Malawi and MoH to further improve integrated health service delivery in Malawi. USAID/Malawi and the MoH are the primary beneficiaries of this report, however, a much wider group of interested stakeholders are expected to utilize the findings and recommendations in their efforts toward more efficient and effective health service delivery in Malawi.

EVALUATION QUESTIONS

The performance evaluation aimed to answer the following key questions:

1. To what extent did SSDI-Services improve quality of care for priority EHP interventions at targeted health facilities and community service delivery points? Were there any adverse or unexpected results on quality of care?
2. To what extent did SSDI-Services improve access to priority high impact EHP interventions in the target health facilities and community service delivery points?
3. To what extent did the direct involvement of MoH staff to facilitate the in-service training of health practitioners, on-the-job mentoring and quality assurance strengthen the MOH's capacity to institutionalize these components as part of routine delivery of high impact priority EHP services?

4. To what extent did SSDI's investments in performance monitoring and Health Information Systems improve the MoH's (national, district and facility) capacity to collect; access and utilize routine service delivery data for decision-making?
5. What are the most significant accomplishments, best practices, and lessons learned from the SSDI-Services activity? Explicitly identify and document the facilitating and inhibiting factors to positive performance for each of the above questions.

EVALUATION METHODOLOGY

The evaluation utilized a mixed-method approach that included both qualitative and quantitative methods. In addition to reviewing data from secondary sources, the evaluation team gathered primary data from two health facilities in 13 out of 15 project districts, for a total of 26 health facilities. A number of Key Informants were interviewed at national, zone and district levels. The main criteria for selecting the districts to be included in the evaluation were 1) representation on Country Development Cooperation Strategy (CDCS), and 2) Comprehensive HIV test and treat program delivery and the Performance Based Incentives (PBI) program.

In summary 34 key informant interviews at National, Zonal representatives, and District level informants, at least 3-4 interviewees per facility including self-assessments, and community-level focused discussions and score-card assessments as well as 15 to 20 client exit interviews per facility were conducted in these sites. To gauge the performance on various indicators and incorporate views of respondents, the team analyzed the collected primary qualitative data in terms of themes and narratives using NVIVO 11 software, while the quantitative primary and secondary data were all analyzed in STATA 14.0 software and excel. Qualitative methods included thematic analysis of primary data collected through KIIs, client exit interviews and focus group discussions. All qualitative data was analyzed using NVIVO 11 software. The team conducted a complementary comprehensive desk review of the project documents provided by USAID and JHPIEGO. The literature review provided insights into the design of the project, the background situation of the service delivery prior to the interventions, and an understanding of a selected list of indicators routinely tracked by the M&E system over the life of the project for triangulation with data collected from primary sources. The 10 core indicators at the center of the services component of the project were reviewed as a requirement of this evaluation.

The evaluation team also completed 26 group interviews (GI) with on average 3-4 health care workers per group at 26 SSDI-Services supported health facilities to gain an in-depth understanding of their experiences with SSDI-Services program interventions.

A total of 112 self-assessment questionnaires were completed. The evaluation team also administered 490 consumer questionnaires to clients upon exit from facility utilization on the day of the evaluation team visit to each facility.

KEY FINDINGS

Q1: On Quality of Care, the performance evaluation found that:

- Quality of Care (QoC) has improved significantly at target HFs and community service delivery points through Quality Assurance (QA) approaches, service integration and community empowerment
- Performance Quality Improvement (PQI) approaches have contributed to improved Quality of Care
- Community mobilization and empowerment has improved quality of care
- More women are satisfied with the capacity of facilities to meet clients' needs than men

Q2: On Access to Care, the performance evaluation found that:

- SSDI-Services expanded coverage of EHP services and provided opportunities for greater access to clients
- Trained HSAs have improved communities access to CBMNH services through village clinics
- SSDI services increased access in hard to reach facilities and communities but distances and transport are still major barriers to access in many places
- Performance Based Incentives (PBI) improved access to services
- Community members agreed that SSDI-Services has increased their access to EHP services

Q3: On Capacity Building, the performance evaluation found that:

- The project built capacity for utilization of TOT, mentorship and supervision
- Trainers were being utilized in mentorship, supervision and follow up activities
- Supervision of health facilities in SSDI districts considerably increased
- Community Score Cards and Community-Based Volunteers facilitated Demand Side Contribution to Improved Quality of service delivery
- Capacity Institutionalization is faced with funding Challenges

Q4: On Use of HMIS and Use of Data for Decision Making, the performance evaluation found that:

- SSDI supported the migration from paper based reporting to DHIS 2, this included provision of equipment
- HMIS has been strengthened at National level
- The project built the capacity at District and HF levels for data collection, reporting, entry in DHIS2 and utilization
- Regular Data collection and reporting are being institutionalized at District level
- Generation and access to data has been increased, and data review and analysis meetings are conducted every quarter
- Some challenges tend to undermine SSDI Services effort to strengthen HMIS

Q5: On Achievements, Lessons Learned, and Best Practices, the performance evaluation found that:

The following were cited as key best practices:

- Establishing 15 HFs that met specific quality standards as centers of excellence
- Using mentorship as a capacity building approach
- Using Standard Based Management and Rewards for improving quality of care
- Regularly conducting facility data review meetings
- Camping 4-5 days in hard to reach areas with delivery of integrated health services.
- Use of Data Reporting Booklets
- Use of Mobile Phone Application for reporting
- Use of Community Score Cards, Community Action Groups (CAGs) and Care Groups
- Employing participatory approaches at designing activities and selected implementation stages

The following were the lessons learned:

Central Level:

- Investment in integrated service delivery in the National Health System has potential for reaching tremendous outcomes

- Inclusive partnerships from initial design stages is conducive to successful implementation and outcomes
- Coordination and harmonization of implementation for many partners is very difficult to achieve
- The Malawi Health System is not yet ready to independently sustain implementation of activities hitherto supported by SSDI after project phase-out
- Service Integration and PBI are effective approaches to improve quality.

District Level:

- By focusing on data quality HFs are enabled to improve other technical domains too
- PBI improves provider's confidence and increases participants program ownership and financial capacity to acquire and maintain equipment, infrastructure and supplies

KEY CONCLUSIONS ON THE FINDINGS

- SSDI interventions had significant positive effects on quality of and access to care
- PBI has great potential for improving Quality of Care
- Clear progress was made towards building MoH capacity
- Inconsistent financing by the MoH threatens the continuity of gains achieved through SSDI

KEY RECOMMENDATIONS

1. MOH and Partners should develop a strategy to scale up the PBI program, IP, Mentorship and Supportive supervision
2. MOH and Partners should progressively extend outreach clinics and CBS to more hard to reach areas
3. Partners and DHMT should integrate their activities and implementation schedules for more efficient use of transportation.
4. For routine utilization of the built capacity strategies, MOH and partners should ensure availability of supportive resources
5. MOH & Partners to improve integration of parallel health related data systems with DHIS2 for synergies
6. MOH and Partners should ensure there are no transitional gaps during program/project phasing to avoid erosion of health gains already attained.

I. PROJECT OVERVIEW

The Support for Service Delivery Integration–Services (SSD-I Services) is an $85,000,000 five-year USAID-funded flagship project that aims to support the Government of Malawi in the implementation of the Health Sector Strategic Plan (HSSP) 2011-2016. The SSD-I Services project is implemented to assure significant expansion of coverage and improved quality of priority Essential Health Package (EHP) services at the community and referral (health centers and District hospitals) levels with the aim of improving the health and well-being of the population of Malawi.

The project was launched in 2011 with JHPIEGO, PLAN, CARE, and Save the Children as principal implementing partners and will close-out in 2017. At the time of inception of the project, Malawi suffered from poor health indicators, inefficient and understaffed service delivery systems, gender inequalities and widespread use of harmful traditional practices. USAID/Malawi sought to address these issues through the inter-related SSD-I programs: 1) SSD-I Services, 2) SSD-I Communication, and 3) SSD-I Systems. The 3 sub-programs were implemented in a coordinated manner and in strong collaboration with Malawi Ministry of Health (MOH) to improve the health of Malawian families. The focus of this performance evaluation is primarily on the SSD-I Services component of the project.

SSDI-Services works at the national level, and in 15 districts in all the five health zones of Malawi. At the national level the project assists the development and review of national policies, strategies, protocols and guidelines. At the zonal, district and health facility level, the project provides direct technical support to implementing high impact EHP interventions.

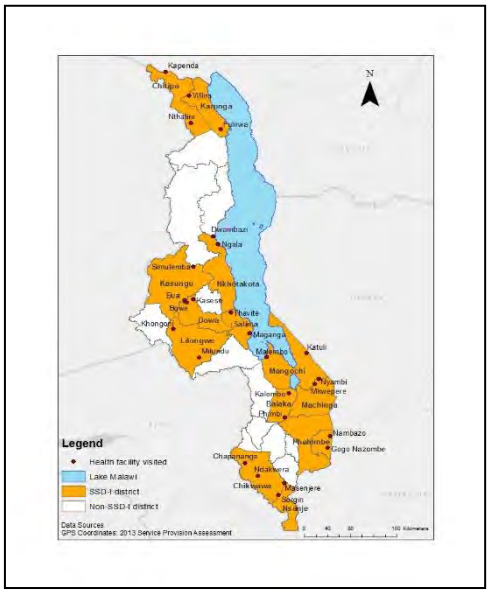


Figure 1: SSDI-Services districts

At the community level, SSD-I Services supports improvements in the coverage and provision of quality high impact EHP interventions through Health Surveillance Assistants (HSAs), outreach clinics and community volunteers (community Action Groups, Community Care Groups and Community Based Distribution Agents). These interventions are supported by both formal and on-the-job-training, mentoring, and supervision using an integrated approach. The project holds regular update and joint review meetings for health workers to encourage greater peer-to-peer support and utilization of data for decision-making. An important aspect of this work is support to community volunteers and promotion of linkages between the community and the health facilities using the community score card approach.

The project has a critical focus on improving the quality and access of EHP services, improving the capacity of health workers and community volunteers to facilitate community access to quality care, and improving MoH's capacity to collect, manage and use data for decision making. SSDI-Services key technical areas of focus included the following:

- Main EHP Areas**:** Maternal Health, Newborn and Child Health, Family Planning and Reproductive Health, HIV/AIDS and TB, Nutrition and Malaria
- Cross-cutting Approaches: Key Technical Areas: Community Mobilization and Community-based Services, Performance Quality Improvement (PQI), Mentoring, Performance Based Incentives (PBI), Monitoring and Evaluation (M&E).

Gender and Disability

Gender and disability issues contribute directly and indirectly to health outcomes. In its activities, SSDI-Services addressed: barriers to use of EHP services and behavior change such as gender biases and inequalities through the use of community based distribution agents (CBDAs), community scorecards, community action groups (CAGs) and care groups. The project facilitated increased involvement of men in safeguarding family health; and incorporated messages of gender mainstreaming and inclusion of people with disabilities into training, mentoring, supervision and health promotion activities.

SSDI-SERVICES PROGRAM VISION, GOAL AND OBJECTIVES

Development Hypothesis

Theory of change/development hypothesis

SSDI-Services postulates that by providing training and mentoring, commodity facilitation, equipment and supplies, effective data management, performance-based incentives, community mobilization and expanded community-based services, the activity will improve the technical capacity of health workers, increase commodity security, improve facility client flow, improve health facility functioning, improve governance and increase the use of data-informed decision-making. These short term outcomes, in turn, are assumed to lead to increased client access to and utilization of health services, improved quality of care, a strengthened health system, improved health-seeking behavior and empowered communities. In the long-term, these outcomes are assumed to result in reduced maternal, newborn and child morbidity and mortality and lowered risk of HIV, ultimately contributing to the goal of "Healthier Malawian Families" according to the SSDI program document.

II. EVALUATION PURPOSE AND QUESTIONS

EVALUATION PURPOSE

The primary objective of the evaluation is to measure and determine the extent to which SSDI Services interventions effected quality of and access to care; provide in-depth insights into the facilitating and limiting factors of increased service utilization at each level of service delivery, and document progress made towards building MoH capacity to deliver quality EHP services.

The findings of this evaluation will inform MOH, USAID, and other development partners in the design and prioritization of future investments in strengthening Malawi's Health System.

To achieve that purpose the SSDI-Services performance evaluation examined the intervention logic; analyzed the completion of planned activities and achievement of performance targets; and assessed how the availability and quality of the EHP services has changed in intervention communities over the life of the project. The evaluation also documents the extent to which SSDI-Services' theory of change proved to be correct and the determining factors for the achievement of project outcomes.

EVALUATION QUESTIONS

The performance evaluation aimed to answer the following key questions:

1. To what extent did SSD-I improve quality of care for priority EHP interventions at targeted health facilities and community service delivery points? Were there any adverse or unexpected results on quality of care?
2. To what extent did SSDI-Services improve access to priority high impact EHP interventions in the target health facilities and community service delivery points?
3. To what extent did the direct involvement of MoH staff to facilitate the in-service training of health practitioners, on-the-job mentoring and quality assurance strengthen the MoH's capacity to institutionalize these components as part of routine delivery of high impact priority EHP services?
4. To what extent did SSDI's investments in performance monitoring and Health Information Systems improve the MoH's (national, district and facility) capacity to collect; access and utilize routine service delivery data for decision-making?
5. What are the most significant accomplishments, best practices, and lessons learned from the SSDI-Services activity? Explicitly identify and document the facilitating and inhibiting factors to positive performance for each of the above questions.

III. EVALUATION DESIGN, METHODS AND LIMITATIONS

The evaluation was conducted between 23rd August and September 23, 2016 and reviewed the period from SSDI-Services inception in April 2012 until June 2016. The core evaluation team consisted of five consultants: Dr. Marcel Sagbohan (Team leader), Dr. Nick Kanlisi (Public Health Specialist- Community Based Services), Dr. Spy Munthali (Public Health Specialist – Facility Based Services), Mr. Willie Kachaka (Research Analyst) and Mr. Dyton B. Mukhuna (Evaluation Specialist). In addition data collection was supported by 12 research assistants from a local research firm, Evidence for Change (E4C) Solutions. Logistics support was provided by DevTech through Ellen Kumwenda a Lilongwe based logistical consultant.

EVALUATION DESIGN

The evaluation methodology used various approaches including preparatory meetings to strategize, a mix of quantitative and qualitative techniques including document review; key informant interviews (KIIs), facility staff interviews and self-administered questionnaire; focus group discussions (FGDs) with community members (male, female, CAG and care groups) and community score cards to collect relevant information, in a non-experimental performance evaluation design focusing on the key evaluation questions. Application of Qualitative and Quantitative approaches was utilized to analyze the secondary and primary data to inform the evaluation and the findings were disseminated to stakeholders in a presentation. The feedback from the workshop and inputs from USAID, JHPIEGO, Social Impact and DEVTECH were incorporated in the final report.

METHODS

Sampling

A multi-stage purposive sampling procedure was used to select the 13 out of 15 SSDI project districts, facilities and individual respondents. The criteria included district representation on core functions of 1) Country Development Cooperation Strategy (CDCS), and 2) Comprehensive HIV test and treat program delivery and 3) the Performance Based Incentives (PBI) pilot program. These three criteria led to the sample of 5 core districts namely Chitipa, Mangochi, Balaka, Nsanje and Nkhotakota which also ensures that all Ministry of Health Zones are represented. An additional 8 districts were selected from across the remainder of SSDI districts to get statistically sufficient numbers of respondents to consumer questionnaires and health facility staff interviews.

The next stage involved strategic sampling of 2 facilities in each of the 13 districts using two approaches; first was the Ministry of Health (MOH) classification of Hard to Reach (HTR) versus non-HTR and secondly a JHPIEGO classification of Best Performing versus Poor Performing facilities on the core indicators of the SSDI project. The 26 facilities visited by the evaluation teams sought equal representation on these two criteria across the 13 districts. At each facility 3 to 4 members of the health workers were included in the sample for staff interviews, the numbers varied with availability of staff at each facility. Within proximity to each facility, one community within 3 Km radius and another community within 3 to 5 Km distance from the facility were sampled with the help of the HSAs to reach two groups of 10 women and 10 men each, and one group of 10 randomly selected women community members respectively. These three groups were then complemented by one Community Action Group (CAG), a designated community leadership (fixed-membership) group introduced by SSDI project as another target for interviews and discussions.

Obtaining Approval and Prior Consent

The evaluation, through USAID, obtained approval from the MoH to conduct the assessment and a written letter was distributed to all targeted data collection points prior to the evaluation team's visit. Similarly, verbal consent was sought from every individual that was requested to participate in the interviews and provision of evaluation information or recording of the discussions by reading a written statement of consent on the first page of each data collection instrument regarding the voluntary nature of their participation.

Data Collection, Analysis and Dissemination

The process of planning and implementing the evaluation was a collaborative effort involving USAID, Dev Tech and SSDI-Services. Several planning meetings were held with key stakeholders; a training workshop was organized for adapting, translating and piloting the questionnaire, and for outlining a report combining the qualitative and quantitative results.

Pretesting of instruments and data collection took place during the period 23rd August and September 23, 2016 in the 13 districts, 5 MOH zones and at national level where MOH, USAID, JHPIEGO and representatives of Implementing Partners' namely Plan, Care International and Save the Children participated in the interviews. The data collection tools are attached as Annex 5.

Data collection was done by a team of 17 members comprising 5 key evaluation staff and 12 enumerators that were split into two sub-teams during field visits. Dr. Marcel Sagbohan and Mr. Dyton Mukhuna led a team of six enumerators who did data collection in Chitipa, Nkhotakota, Salima, Dowa and Kasungu including Mzuzu Zone office. Dr. Nicholas Kanlisi and Dr. Spy Munthali accompanied by six other enumerators collected data in Nsanje, Chikwawa, Phalombe, Machinga, Balaka and Mangochi including Blantyre and Zomba zone offices for South West and South East respectively. In the final week of data collection the two teams converged in Lilongwe to complete Lilongwe district data collection, Zone offices for Central West and East, and Lilongwe national level interviews. During the data collection period Mr. Willie Kachaka was closely working with the field teams while focusing on producing data entry templates, pretesting data entry and interview transcription guides.

Document Review

The team conducted a formal document review prior to the start of the field work as well as during the analysis of the data. This was done in order to better understand the SSDI-Services program, its implementation context, and its intended outcomes and goals. All documents reviewed are listed in Annex 2.

Qualitative Data

The qualitative data was collected through key informant interviews at national, zonal and district levels, specifically program managers, program supervisors and technical leads from USAID, JHPIEGO, PLAN, CARE, MoH and Save the Children representing the management and oversight of the project activities. Group interviews with health care providers at facilities, and Focus Group Discussions (FGD) conducted with representatives of the Community Action Groups (CAG) and members of the communities who utilize the health services and the primary target of the program provided important insights into perceptions of the project's approach and achievements.

Key informant and group interviews

The evaluation conducted 34 KIIs with staff of the following institutions: MOH (national, zonal, and district level officers), USAID/Malawi, SSD-I Services, JHPIEGO, PLAN, CARE, and Save the Children staff. KIIs were also conducted with officials from several local organizations involved in SSD-I Services. A full list of officials interviewed is included in Annex 3. Key Informant Interviews (KII) provided qualitative information on how SSDI- Services' contributions to improvements in the quality of and

access to EHP services, capacity building of health care providers and how the MoH's capacity to collect, access and utilize data for decision making has been built. The KIIs were also useful in exploring attitudes on stakeholder relations and challenges to SSD-I Services results achievements.

The evaluation team conducted 26 group interviews (GI) with average 3-4 health care workers per group at 26 SSDI-Services supported health facilities to gain an in-depth understanding of their experiences with SSDI-Services program interventions.

Focus group discussions

Three sets of FGDs were conducted per facility in the five core districts in the sample. The FGDs included the following sets of participants: women resident within 3 km of target facility and those within 3-5 km of target facility; men resident within 3 km of target facility; and members of CAGs or community care groups. Respondents for the FGDs were selected from areas surrounding 10 health facilities in the 5 core districts. Four local experienced data note takers and four facilitators conducted all the focus groups. In total, 38 FGDs (13 Men FGD's and 26 women FGD's) and documented the views of 385 (148 males and 237 females) beneficiaries of SSDI-Services' interventions. In addition, 38 Community Score Cards were completed with FGDs.

Quantitative Data

The evaluation team also collected primary quantitative data through the use of score cards and a survey administered self-assessments questionnaire which was administered to gauge the quality of and access to care as well as capacity building to use knowledge and data for decision making. A total of 112 self-assessment questionnaires were completed. The evaluation team also administered 490 consumer questionnaires to clients upon exit from facility utilization on the day of visit to each facility. Additionally, the evaluation adopted the scorecard used by SSDI- Services in the communities to gain additional data on the communities' perspective on the quality and access to care.

Secondary data was obtained from SSDI-services program monitoring performance database which provided data on 17 core PMP indicators from 2012 to the end of the project in June 2016.

Quality Assurance

To ensure the collection of the highest quality data, the team collaborated with USAID and SSDI-Services program staff as well as the DEV TECH program manager in the development of the tools and selection of sites. The data capturing was conducted concurrently with data collection to ensure data quality checks during fieldwork. In addition, a USAID staff member observed evaluation site visits in Nkhotakota District and Nankumba HC in Mangochi on 8th and 15 September respectively to observe some of the data collection processes. SSDI-Services program in Lilongwe provided data and detailed clarification on various aspects of program information on request.

Data Analysis

Quantitative data analysis

Quantitative data was entered into CSpro 6.3 software. The quantitative data was analyzed using STATA 14.0 statistical software and Microsoft Excel in order to generate graphs. Secondary data analysis focused on the performance of the 10 core indicators of the SSDI project outlined in Table 5 of the report.

Qualitative data analysis

All Qualitative data (focus group discussion and KII) were recorded. The qualitative data was then transcribed and translated by the team enumerators and checked for quality by key staff.

A preliminary thematic analysis was conducted on the transcribed notes based on the primary research questions and a review of a subset of transcripts. NVIVO 11 software was used for analysis of qualitative

data. The transcripts also included direct quotes by topic that can be used for illustrating trends. The qualitative analysis used two primary approaches that included; theme analysis and narrative analysis. Theme analysis involved organizing data into categories by identifying recurring themes in the data and creating labels under different categories. Narrative analysis was used to examine the relationships between codes.

LIMITATIONS OF DATA

Limitations in the data collection included: the possibility of recall bias among key informants, group interview and FGD participants; the subjectivity of self-reported data; within the limited time in which the interviews had to be done some key informants targeted by the evaluation were missed—particularly with MoH national and zonal officials.

IV. FINDINGS AND RECOMMENDATIONS

EVALUATION QUESTION 1

To what extent did SSDI improve quality of care for priority EHP interventions at targeted health facilities and community service delivery points? Were there any adverse or unexpected results on the quality of care?

1.1 Findings:

Quality of Care (QoC) has improved significantly at target HFs and community service delivery points through Quality Assurance (QA) approaches, service integration and community empowerment.

SSDI-services aims at implementing an integrated service delivery program to expand and improve quality of selected essential health package (EHP) services at the facility and community levels. The project supported 304 facilities in 15 districts. Over the five years of implementation, the project has positively influenced quality of care in the facilities and community service delivery points.

Table 2 below show changes in some indicators of service delivery over the five year period of the project that supports the assertion that quality of care at target health facilities and community health delivery points have improved.

Area of Quality	Before April 2012	After March 2016
Maternal deaths	120.1/100,000 births	52/100,000 births
Neonatal deaths	15.1/1000 births	9/1000 births
Asphyxiated newborns resuscitated	52%	90% (Feb 16)
IPT2 uptake	12%	64%
HIV exposed infants tested within 12 months	7%	94%
Number of health facilities with established capacity to manage acute malnutrition	98	304
Facilities eligible for quality bonus	1/17	12/17

Table 1: Changes in quality of care indicators SSDI-Services-facility data

Source: JHPIEGO end line report, August 2016

Routine SSDI Services M&E reports using data from facility registers from 15 districts and MOH DHIS2 database have documented a substantial reduction in maternal deaths from 120.1/100,000 live births at the inception of the project in 2012 to 52 /100,000 live births in 2016. Neonatal deaths have been reduced from 15.1/1000 live births in 2012 to 9/1000 live births in 2016. No specific targets were set for these indicators at start of the project.

Table 2 also shows that IPT2[1] uptake increased significantly from 12% at baseline up to 64% by 2016 though falling short of the 2016 target of 75%. Ninety percent (90 %) of asphyxiated newborns were successfully resuscitated compared to 52% at baseline. HIV exposed infants tested within 12 months increased from 7% to 94%, (target 55%) and the number of health facilities with established capacity to manage acute malnutrition rose from 98 at baseline to 304 in 2016 above the target of 275. Additionally, the number of facilities eligible for quality bonus—an indicator for reaching certain quality improvements indicators—increased from 1 to 12 within the life of the project. By the end of the project 18 facilities

[11] IPT2- Intermittent preventive treatment second dose.

had achieved recognition status for Performance Quality Improvement (PQI) for Infection prevention and Reproductive health. [Source JHPIEGO (SSDI-Services FY2014 PMP Final Nov.82013.doc]

The community management of acute malnutrition (CMAM) has been successful in maintaining high cure rates. CMAM OTP– cure rate above SPHERE standards (>75% cure rate, <10% death rate and <15% default rate) increase from 80.2 % in April 2012 to 93% in March 2016 (Source: JHPIEGO, End line report 2016).

Observations on substantial improvements in quality of care were also corroborated by perspectives of focus group discussions and consumer surveys administered to community members/ clients. About 80% of respondents to consumer surveys reported that they were satisfied with quality of health services provided to them, and even when disaggregated of gender both men and women were satisfied with the quality of care provided by the health facilities. 81% agreed that quality of care has improved compared to before. (77% hard to reach and 84 % non-hard to reach) and 90% of consumers felt that their health status improved after visiting the health facility. (90% of women and 87% of men) (85% hard to reach and 93% in non-hard to reach areas). Eighty eight (88%) of respondents said the quality of services was better than before. About 92% of women as against 85% of men said that the services were better than before.

It is clear that there is an all-round impression of vast improvements in the quality of care as compared to the pre-project period when drugs stock outs and poor worker attitudes were common place.

Performance Quality Improvement (PQI) approaches have contributed to improved Quality of Care.

Health facilities and community service delivery points require the availability of equipment, supplies and commodities, improved skills of service providers and supervision to be able to meet the quality of care needs of their clients.

SSDI-Services created an enabling environment for the provision of quality care through capacity building e.g. training MOH staff, ToTs, procurement of equipment, Infrastructures improvements (33 sites), mentorship and supportive supervision and community mobilization and empowerment.

The project trained service providers in the 6 technical areas including maternal and new born health, child health, Family Planning and Reproductive Health, HIV/AIDS and TB, Nutrition and Malaria. MOH staffs were also trained in cross cutting areas such as mentorship and supervision. Basic competency training, mentorship and supervision provided knowledge and skills for service providers to deliver quality services. Mentoring and coaching reinforced skills acquisition and use leading to better quality service.

SSDI-Services also successfully integrated service delivery at the facility level (training of a single service provider in multiple skills) such that more services were provide on clients during one visit reducing the need for clients to make multiple visits to the clinic. Similarly, the delivery of outreach services was integrated paving the way for many services to be provided once.

SSDI-Services provided service delivery equipment including blood pressure machines, cord clamps, autoclaves; Delivery sets; Manual vacuum aspirator (MVA) kits, neonatal resuscitator, drug boxes, examination lamps etc. The project also provided infrastructure improvement to created space for quality client interactions. These improvements in 33 facilities included partitioning of spaces to improve privacy for counseling, making extensions to maternity or delivery rooms to provide space to conduct deliveries, building incinerators and placental pits to ensure proper medical waste disposal.

The project also used a number of quality approaches to address improved quality of service including PBI, PQI/SBMR and community mobilization and empowerment.

PBI is a health financing program that incentivizes quality of care and coverage. It encourages the use of standards in delivering services. PBI used a number of approaches to influence quality of care including provision of equipment, development of skills and a bonus for meeting predetermined service quality and utilizations standards. The performance incentives encouraged health facilities to develop innovative approaches to achieving the quality and utilization target indicators (see Annex 7). By the end of the project 12 facilities out of 17 targeted facilities qualified for the performance bonus based on the achievement of the target indicators. Also when PBI was linked up with the use of the PQI approach, many more facilities were able to get recognition status for Infection Prevention and Reproductive Health (IP & RH) due to PBI.

> *"A lesson I have learnt is that "not only what goes into my pocket can motivate me to change behaviour, I can as well change behaviour because I have been given working conditions that are favourable to work."*—Key informant

The collaborative approach, where a group of facilities meet to share ideas and experience, has engendered competition among facilities to reach recognition status. This has contributed positively to improvements in quality of care. However inadequate staff and staff turnover have negatively affected the implementation of the PBI as ToTs, trained providers and mentors move out of their positions.

Community mobilization and empowerment has improved quality of care.

The SSDI- Services and the SSDI- Communications projects worked together and developed a community mobilization strategy to mobilize and empower communities to improve health seeking behavior and ownership by planning with the Health Facilities and communities to address community health issues. These approaches included the use of the Community Score Card, Community Action Groups (CAG), Care groups, Community-based distribution agents (CBDA). The community score card provides input into the quality process at the facility while the care groups screen and identify malnourished children for treatment. The work of care groups expanded from a focus on nutrition messages to cover the entire spectrum of EHP.

> *"Supervision of medical staff by the health committee from different villages which was formed to take care of the facility and the score cards have led medical staff to improve their working performance"*—CAG member

Qualitative data substantiated the increase in quality of care. Respondents to the KIIs, FGDs, and Group interviews said that quality of services had improved significantly pointing to some key quality indicators such as survival of asphyxiated babies, capacity to manage malnutrition and Early Infant Diagnosis (EID) reduction in maternal deaths in the last five years of the project.

More women are satisfied with the capacity of facilities to meet clients' needs of than men.

The Consumer survey showed that about 81% of women were more satisfied with the quality of care they received from the facility than men (about 79%). Also about 90% of women felt their health status had improved as a result of coming to a facility. No adverse or unexpected results on the quality of care were reported.

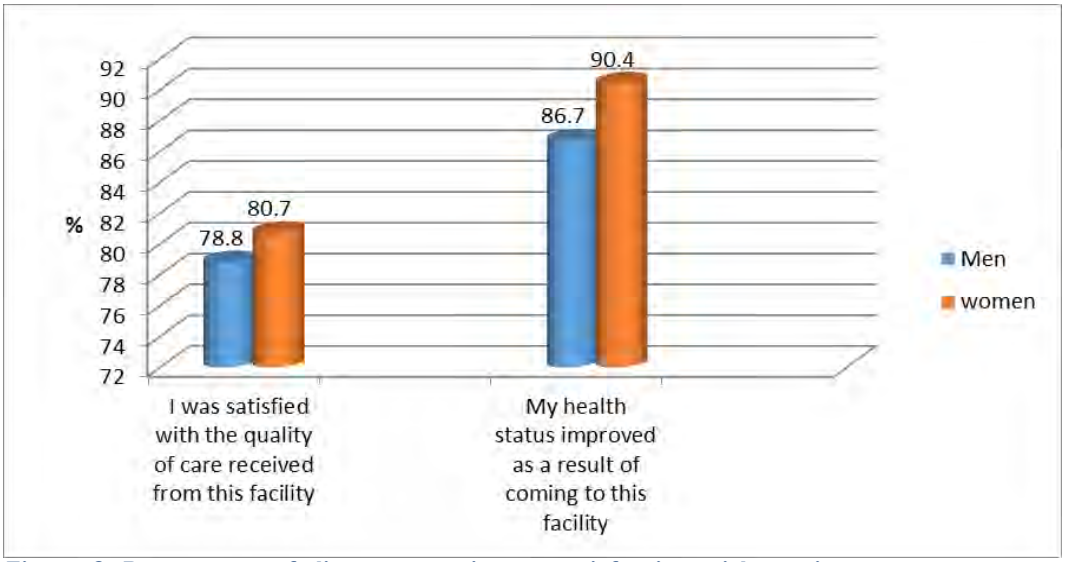


Figure 2: Percentage of clients reporting on satisfaction with services

1.2 Conclusions:

The above findings suggested the following conclusions with regards to the project's effect on the quality of care:

- Integration of health services reinforced by QA approaches and community empowerment are effective ways of improving quality of care at health facilities and community service delivery point
- Use of standards ensures quality service delivery
- Rewards for achieving standards is highly motivational to service providers
- Community mobilization and empowerment ensures quality services at facility level
- Client satisfaction has confirmed that quality of care has improved

1.3 Recommendations:

- DHMT should incorporate QA and community empowerment into the routine DIPs
- MOH and Partners should support the scale up of PQI/SBMR linked to PBI to more facilities

EVALUATION QUESTION 2

To what extent did SSDI-Services improve access to priority high impact EHP interventions in the target health facilities and community service delivery points?

2.1 Findings

SSDI-Services expanded coverage of EHP services and provided opportunities for greater access to clients.

The SSDI-Services Rapid Situational Analysis Report of 2011 determined that the health system faced several constraints. Nationally health centers were inadequately staffed with qualified service providers and lacked basic equipment to provide primary health care services. The facilities were overcrowded. To address these, SSDI-Services decided to expand the services delivered at the community by shifting some of the tasks to community based workers. HSAs were trained to provide DMPA injection while community based distribution agents (CBDA) provided condoms, pills and cycle beads.

Training, mentoring and supervision, provision of commodities, supplies and equipment improved the quality and availability of services at Health Facilities. SSDI-Services worked with staff at health facilities to re-organize the services, integrating them where applicable enabling clients to access as many services as possible in a single visit to the facility. This increased the range of services (a pregnant woman could access ANC services and also HIV testing services) provided at the facility level. For instance men were encouraged to accompany their wives to the antenatal clinic (ANC) reinforcing male involvement.

Similarly expansion of access to services occurred through the conduct of Open Days and Youth Clubs for Adolescents where Orientations to and uptake of sexual and reproductive health services enabled adolescents and the youth to take decisions to protect their health. The involvement of Care Groups and CAGs promoted by the SSDI-Services project ensured that the project reached out to multiple beneficiaries. The project supported the SUN activities in the communities through the Care Groups who worked in their cluster households to promote optimal nutritional practices, Family planning, Early ANC, malaria prevention, HIV/AIDS messages, cooking demonstration and principles of hand washing. As shown in figure 3 below the number of health facilities with established capacity to manage acute under-nutrition (CMAM) increased from 98 at baseline to 304 at end line. Care Groups contributed to CMAM objectives of focusing on maintaining the case outcomes above the sphere standard ->75% cure rate, <10% death rate and <15% default rate. Scale Up of Nutrition (SUN) intervention was scaled up from zero districts at inception to 11 districts. In addition the number of service delivery sites that offer Long acting and Permanent Methods (LAPM) has doubled from 129 sites at inception to 251 while access to EID Services measured by percent of HIV-exposed infants tested within 12 months increased from 7% in 2012 to 94% in 2016 as portrayed in figure 4, and the number of HF that provide BEmONC increased from 50 to 87.

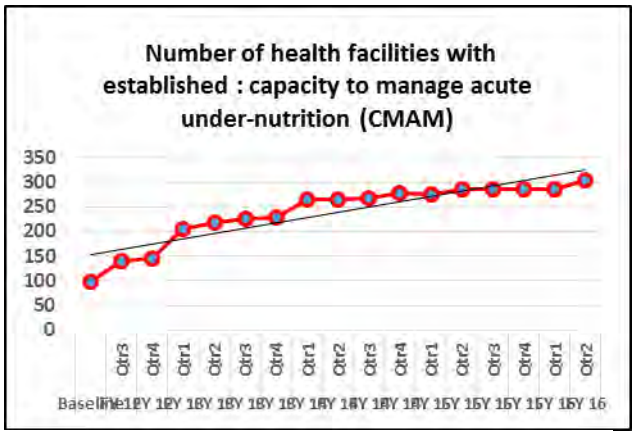


Figure 4: Trend of number of HF with established CMAM

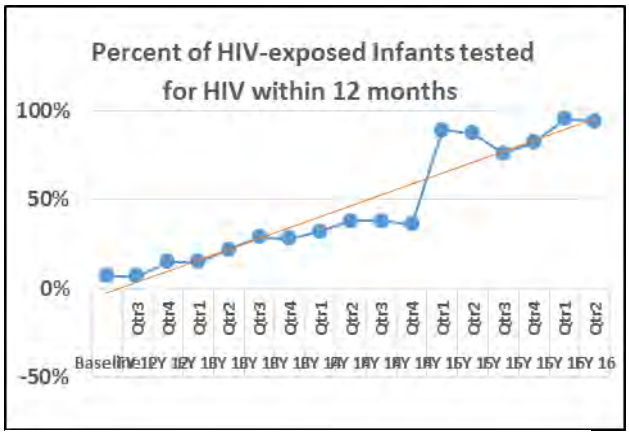


Figure 3: Trend of HIV-exposed infants tested for HIV within 12 months

Trained HSAs have improved communities access to CBMNH services through village clinics.

HSAs were trained in Community Based Maternal Neonatal Health (CBMNH) at the community level and man the village clinics. These have had a palpable impact on services at the community level. As shown in Figure 5 the number of functional village clinics providing iCCM increased significantly from 145 at baseline to 1721 at the end of the project providing greater access to health quarter during services in the communities.

However limited number of HSAs coupled with the lack of accommodation in the communities and adequate supervision remain challenges. These HSAs are expected to live in the communities where they work but often have no accommodation. This hampers access to services when they are away from the community. [Source: JHPIEGO Endline Report]

Besides, KII and GI respondents said that when there are staff shortages, some HSAs are often taken from the communities to work in the health facility further reducing access to services in the communities.

KII respondents also expressed concern about the challenges with supervising HSAs. Supervisors often had no means of transport to go on supervisory visits and mentors would rather call the HSAs to the Health center for the mentoring sessions which also leaves the communities without access to services.

> *"Increase health worker providers because they are few and are attending a huge number of people which is tiresome and it delays people from receiving help in time of which others thinks they are not well received at the facility, Government should train more HSAs to work in the communities"*—Woman client

SSDI services increased access in hard to reach facilities and communities but distances and transport are still major barriers to access in many places.

Integrated Family Health Outreach Clinics (IFHOC) were conducted in hard to reach areas. An average of 100 IFHOC was supported monthly. This significantly improved access to services in these hard to reach areas. However long distances for some communities and lack of transport to reach these areas limited access to referral and outreach services.

For instance 203 out of 304 have no ambulance of their own or have no access to ambulance in their immediate proximity. (*Source JHPIEGO database on facilities, utilities and interventions).* KIIs, GI participants said lack of transport has limited referral and outreach activities.

Family Planning Campaigns- this approach has improved access to FP services significantly especially for areas where there are no FP services e.g. in the Christian Health Association of Malawi (CHAM) catchment areas where health facilities do not provide FP service for religious reasons. KII respondents said this approach was used in Balaka district successfully.

LAPM at Health Posts: As part of getting services closer to clients SSDI-Services expanded delivery of Long Acting and Permanent family planning methods at community health post–the lowest level of the health. Couple Years of Protection for LAPM increased from 1,716 in the third quarter of 2012 to 70,969 at end of project March 2016.

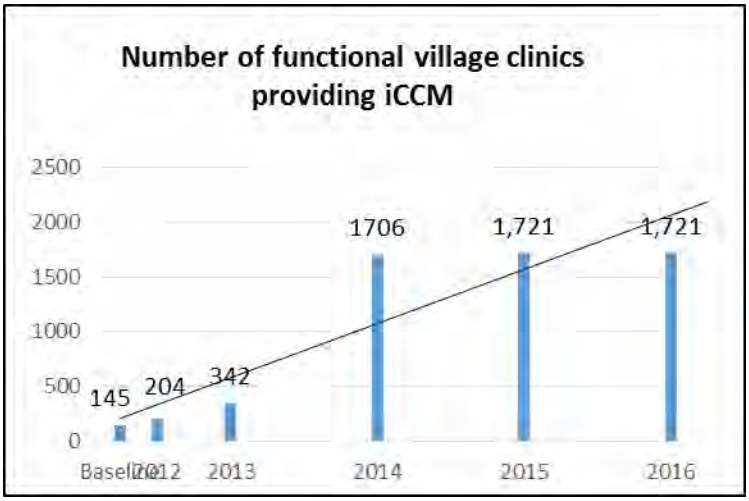


Figure 5: Trend of number of functional village clinics providing iCCM

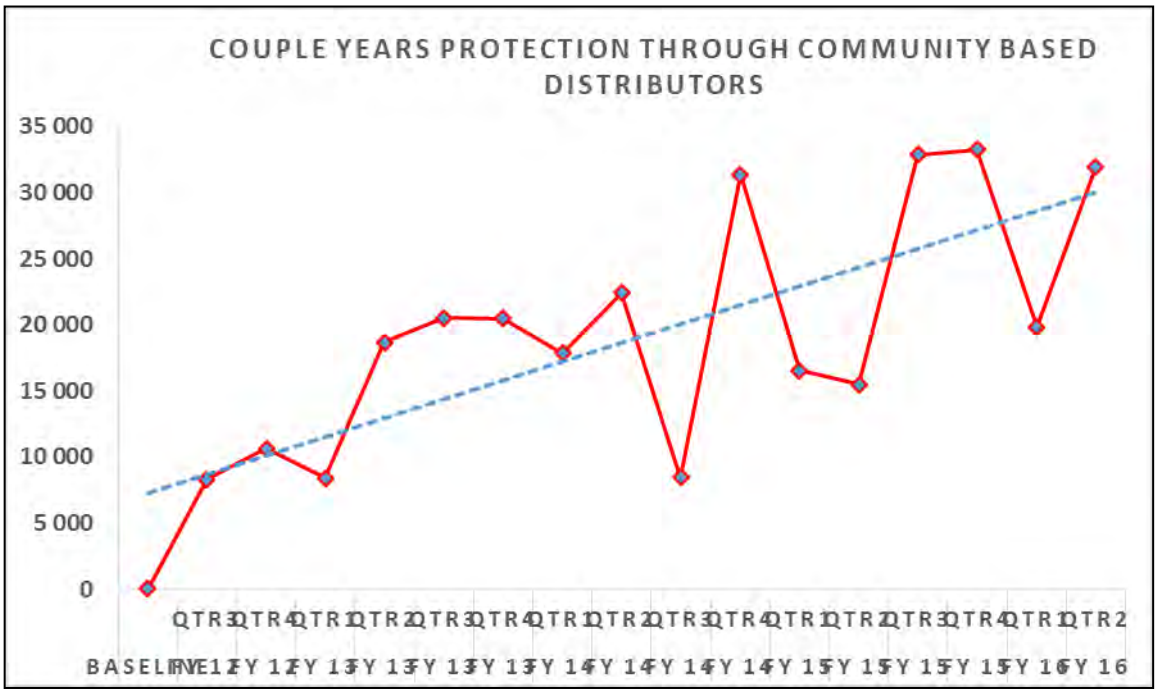


Figure 6: Trend of CYP through CBD

Performance Based Incentives (PBI) improved access to services.

PBI Scheme aims to increase access to and utilization of selected Essential Health Package (EHP) services by providing performance incentives to encourage health facilities to develop innovative approaches to achieving predetermined quality and utilization targets. Health facilities develop business plans that they implement over a defined period of time. As they implement they also assess their achievements against the set targets. An external team is also involved in the assessment of achievements and a bonus is awarded for meeting the predetermined service utilizations standards. This has had the motivational effect of making service providers work harder for their facility to earn the bonus. To ensure that they are on course to earning a bonus facilities have reached out to the communities in their catchment areas to provide services and encourage them to access services in their facilities showing the improvements in their services. Facilities participating in the PBI initiative also meet to share, ideas and experience and learn from each other what works and what does not work. This has generated a healthy competition to increase access to services and reach recognition status or earn bonus. When PBI was linked up with the Standards Based Management and Recognition (SBMR) program, many more facilities were able to attain the recognition status due to the motivation and accountability factors facilitated through the PBI process

However inadequate staff and staff turnover have negatively affected the implementation of the PBI scheme as trained staff move on. By the end of the project 12 facilities have so far achieved bonus status.

Community members agreed that SSD-I Services has increased their access to EHP services.

A review of the qualitative data shows that about 93% of respondents on the client score card agreed that access to a skilled provider for pregnancy and birthing services had improved (95.6% women and 90.9% men agreed). Similarly, about 95% of respondents agreed that people are able to access health services for their babies, infants and children better than before. Of these 96% of women and 93 % of men also agreed.

Ninety three percent of respondents agreed that people are able to access contraception, other family planning methods and abortion care services. Of these 96% of women agreed as opposed to 90% men. Most respondents 94% agreed that people are able to access HIV/AIDS and TB services in their community (women 94% and men 94%).

Health providers and key informants said men, women and people with disability had equal access to quality services. However the data from respondents on the score card shows that people with disability had less access to quality health care services than men and women

Figure 7: Access to quality services for men, women and people with disability

2.2 Conclusions:

Based on the findings above following conclusions are made:

- The approach of integration of services delivery, outreach clinics and CBS made it easier for communities to access high impact EHP interventions
- HSAs that were trained to provide CBMNH have made an impact on access to services in communities
- Irregular transport (vehicles and fuel) adversely affected Outreach clinics and referrals from health facility to District Hospital

2.3 Recommendations:

- Integrate outreach clinics and CBS into each district implementation plan, progressively extend outreach clinics and CBS to more hard to reach areas
- DHMTs should explore the possibility of Local government and / or communities supporting the construction of accommodation for HSAs
- MOH and Partners should ensure that more HSA's are trained in CBMNH for greater impact
- Partners and DHMT should integrate their activities and implementation schedules for more efficient use of transportation

EVALUATION QUESTION 3

To what extent did the direct involvement of MoH staff to facilitate the in-service training of health practitioners, on-the-job mentoring and quality assurance strengthen the MoH's capacity to institutionalize these components as part of routine delivery of high impact priority EHP services?

3.1 Findings:

The project built capacity for utilization of TOT, mentorship and supervision.

The integrated capacity building approach targeted change in skills, attitudes, and motivation of providers in order to improve service delivery to clients. The MOH and the DHMTs played a strategic role of identifying training gaps during planning and facilitating implementation of the capacity building process. The SSD-I Services training program effectively supported the MOH in establishing a critical mass of trainers and personnel qualified in mentorship and supervision of health services. A total of 1130 health

care providers were trained as Trainer of Trainers, mentors and supervisors. SSD-I Services also directly trained health providers in specific technical areas, including FP, CBDA, BEmONC, KMC, iCCM, CMAM and iPT2. The contribution of SSDI-Services to the capacity building also included development of curricula, for example, for trainings given to the MOH management level staff, and a series of provider level trainings that emphasized the importance of mentorship and supervision roles. Currently the positions of ToTs and mentors are well recognized and appreciated by the entire MOH system according to the KIIs.

Trainers were being utilized in mentorship, supervision and follow-up activities.

SSD-I Services positively affected the utilization of the ToT, mentorship and supervision initiatives by: 1) placing a strategic focus on addressing specific training needs at each tier of the health system; 2) aligning the capacity building to MoH Policies; and 3) revising and updating existing MOH curricula for service delivery as opposed to creating project-specific materials. Trainers were particularly effective at imparting knowledge and skills for keeping track of program indicators to program coordinators in various areas, such as Safe Motherhood, while at District and Facility levels mentorship and supervision benefitted service providers in EHP services.

> *"SSDI services introduced a number of capacity building activities like: mentorship on HBB, KMC, and antenatal, trainings for HMB and KMC and orientations on integrated management of maternal and neonatal care. Trainings in IP, five S training, BEmONC and CEmONC training, essential care of every newborn trainings, training HSAs in providing quality community based maternal and neonatal care."*—Health worker

GI interviews revealed that for those who received training, mentorship and supervision were highlighted as more effective instruments of change on quality of care as these approaches have more lasting impacts on the service providers' abilities. Although theoretical in-class lessons were appreciated, it was the long-term reinforcing and incentivized processes to go along with mentorship and supervision that had long lasting effects on the health workers. SSD-I Services provided the resources for mentorship and supervision to be conducted on an ongoing basis. Ironically this could also be the undoing of the recently created capacity as the MOH faces massive challenges in resourcing mentorship and supervision on a routine basis in the absence of partner funding. Staff movements and competing priorities of staff time due to multiple externally supported activities within facilities and community service delivery points are also perceived as major barriers to sustainability of these initiatives according to MOH KIIs.

Supervision of health facilities in SSD-I districts considerably increased.

As shown in Figure 8, supervision activities increased dramatically during implementation of SSD-I Services. The project sought to influence trainings, mentoring and introduction of specific performance management standards and checklists variably applicable to different programs and levels of service delivery. Zone and District level managers had a structured program for supervising facility and community level service delivery. These were reinforced by supportive resources including finances and transportation which consequently improved the number of supervision events across the districts. However, frequency and quality of supervision depends on a number of factors including district specific factors such as leadership and availability of vehicles. The HF was supervised by district team using integrated supervision checklist at least once per quarter through this capacity increased from 48 in 2011 to 225 in 2016. Concurrently, the number of districts supervised by zonal officers using integrated supervision checklist at least once in a quarter also increased from 10 to 15 over the life of project. This focus on supportive supervision suggests SSD-I Services made considerable investments to institutionalize routine quality assurance and quality improvement processes.

Major concerns voiced during interviews with MOH staff suggest that the capacity of MOH to institutionalize supervision at the current level remains very weak. All levels involved in supervision activities continue to face funding bottlenecks in the absence of support from partners. MOH staff at zonal and district levels may also benefit from prioritization and integration of their supervision activities.

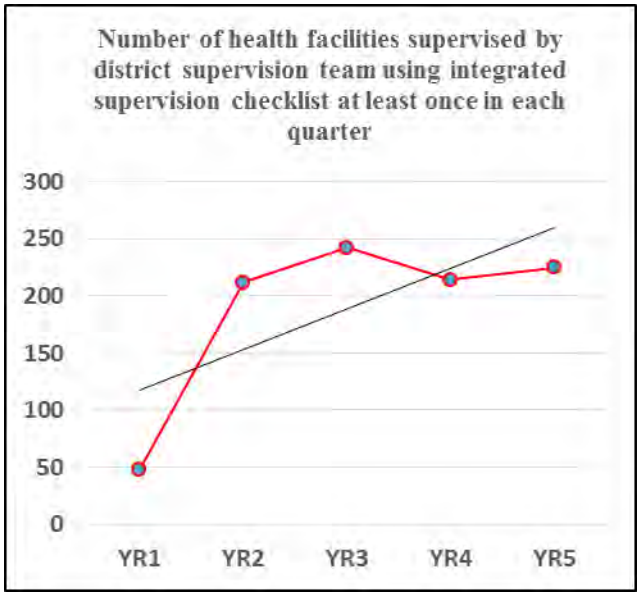


Figure 8: Trend in supervision from district to HF

Community score cards and community-based volunteers facilitated demand side contribution to improved quality of service delivery.

SSDI-Services used community score cards (CSC) to engage communities in situation analysis of their respective facilities and trigger corrective measures or improvements on service delivery. The scorecard specifically targeted demand-side influence on the facility. At the end of the project 42.6% of facilities are implementing CSC in the five Core Districts and 17.1% in other Districts. Some critical CSC achievements include the following:

Improved DHMT and CHAM commitment which lead to the deployment of staff in almost all facilities where CSC rolled out, the provision of ambulance where needed, greater collaboration and partnership with other sectors which contributed to the provision of water, electricity in some districts.

- Community involvement at facility has also induced infrastructure improvement like facility roofing, sanitation and contributed to providing electricity to some facilities
- Health worker attitude has greatly improved.
- New HACs were formed and trained and old ones revamped
- Ninety one percent of consumers reported that score cards have enabled health workers to better meet community needs in hard-to-reach areas

Community capacity comprising Community Action Groups (CAGs), Community-Based Distribution Agents (CBDA) volunteers and care groups working alongside the HSAs were empowered by the capacity building interventions to effect change in quality of service delivery. Care groups were particularly active in under nutrition assessments of under-5 children and greatly contributed to the effectiveness of the nutrition program interventions. These interventions enabled SSD-I Services to reach 498,759 children with nutrition-related activities.

Table 2: Community level capacity development for CBDAs

CBDAs trained in FP	Year 1	Year 2	Year 3	Year 4	Year 5
female	73	23	10	2	na
male	125	33	11	5	na
Grand Total	**198**	**56**	**21**	**7**	na

It is not easy to judge the potential for sustainability of the community voluntary processes but the immediate results of SSDI intervention in this dimension are encouraging. Stakeholder comments in both KIIs and FGDs, as well as secondary quantitative data gathered on specific indicators associated with community approaches such as FP, Maternal Mortality and CCM, indicate that the scorecards and

voluntary contributions have made a significant positive contribution to delivery of high quality services. For example training was given to the 108 female and 174 male CBDAs in the first four years of the intervention.

Capacity institutionalization is faced with funding challenges.

During the implementation phase of capacity building activities change in policy on allowances, change in operational strategy and a reduction in resources allocated to activities were the notable factors to limit capacity building. The policy on allowances had negative consequences such as low attendance or complete cancellation of some of the planned training sessions. Discussions with key MOH staff showed that frequent staff movements in the form of departures and transfers and inadequate staffs in key positions owing to government freeze on filling vacant positions has had both short term and long term effects on the project. The districts and facilities are also faced with perennial transport challenges in terms of fuel and vehicles required for supervision activities. The weak government funding environment and staffing shortages have long term effects on the momentum for institutionalization of the capacity created by SSDI.

3.2 Conclusions:

SSDI-Services had the following areas of influence on building capacity of MOH;

- Capacity was successfully created through training, mentorship and supervision
- The MOH currently has ample numbers of ToTs and mentors
- There was satisfactory utilization of the capacity in specific program areas. Phase out of SSDI project
- A poor government funding environment is the biggest threat to institutionalization of ToTs, Mentorship and supervision
- Supervision activities increased considerably over the life of the project.
- On the demand side, the scorecards and voluntary contributions have made a significant positive contribution to delivery of high quality services

3.3 Recommendations:

Recommendations to strengthen capacities are the following:

- MoH should decide whether mentoring approach to strengthen health personnel knowledge and skills should replace the classical training approach considering that mentorship appears to be more effective in improving staff skills
- MOH should ensure to create and update a database of the available TOTs and Mentors
- For routine utilization of the built capacity strategies, MoH and partners should ensure availability of supportive resources

EVALUATION QUESTION 4

To what extent did SSDI's investments in performance monitoring and Health Information Systems (HIS) improve the MoH's (national, district and facility) capacity to collect, access and utilize routine service delivery data for decision making?

4.1 Findings:

SSDI supported the migration from paper based reporting to DHIS 2; this included provision of equipment.

Performance monitoring and Health Information Systems strengthening is a core component of SSDI-Services interventions. Strategically SSDI- Services placed routine service delivery data collection and utilization for decision making as a priority issue for building the HMIS capacity of all the MoH, Zone, District, Health Facility levels. This included the introduction of new technologies such as DHIS2 and mobile phone reporting systems which induced the migration of paper based data reporting to an electronic and standardized one, the reinforcement of capacity of staff through training, the provision of adequate equipment and materials and on-going performance monitoring at all levels.

Staffs at different levels are more skilled, equipped and motivated to report routine data and use them to monitor performance and make decisions. This investment significantly improved the data processing chain from HF to District and up to the MoH. For example as shown in Table 3 below, data reporting from HF to District increased from 7 percent at the beginning to 83 percent at the end of the project.

HMIS has been strengthened at the national level.

At the national level, SSDI-Services invested heavily in the DHIS2 (e.g. training at Central, Zonal and District levels, equipment procurement and database management). DHIS2 which was originally housed by the Malawi College of Medicine became nationally accessible after the system was migrated to and rolled out under CMED in the MOH Headquarters. SSDI-Services' strengthening of the CMED (through staff training, technical and financial support to develop HIS Policy and Strategy documents, technical support for setting National Data Standards, Technical working groups and National data collaborative system, Technical support to review and print Registers and forms as well as provision of computers and routers) has enabled the MOH to conduct quarterly supportive supervision and quarterly data quality assessments at zonal level.

Some key informant interviews with CMED, Zone managers and some HMIS Officers suggested that the evolution of the DHIS2 had hitherto focused on data reporting for performance monitoring at HF, district and zonal levels and less so on than data quality and accuracy issues and strengthening the practice of making decisions based on data. There is no evidence that the system of routine DQA for the 15 supported districts established by SSDI- Services has yet improved the quality of the data and a study on this issue should be conducted.

The project built the capacity at district and HF levels for data collection, reporting, entry in DHIS2 and utilization.

Following a comprehensive needs assessment undertaken at various levels of the health system, SSD-I Services supported trainings of MOH staffs, including the DHMTs, HMIS personnel, program coordinators and health care providers on data collection, reporting and utilization. These trainings were integrated with broader elements of ToTs, mentorship, supervision, data entry into DHIS2 and application of tables and graphic analyses that would guide performance and decision making at all levels.

Apart from reinforcing knowledge and skills of health personnel, SSD-I Services also invested in equipment and materials to foster data utilization in the MOH. Resources were allocated to printing and distribution of registers, double reporting forms and booklets, acquisition of and setting up the DHIS2 system, as well as provision of airtime, computers, routers, stationery to district HMIS staff and mobile phones for rapid reporting by HSAs in hard to reach health facilities. This has contributed to change providers and DHMT attitude and practices towards data. At HF level, trained providers are able to use the registers and forms for reporting and also monitor their own performance. Health workers in hard to

> *"MOH capacity to collect and utilize data has been addressed, the issue of registers, tapes, graphs, hardboard, health passport books, and monthly reports maternity register has also been solved but submission to central server still a challenge. There is still some issues with quality of data which requires us to conduct quality assessments."*—District HMIS Officer

reach areas have been equipped with, and trained to use mobile phones to transmit their monthly reports. At District level DHOs, programs coordinators and other DHMT members have been granted access to the DHIS2 system data and be able to generate performance monitoring of interest.

Regular data collection and reporting are being institutionalized at district level.

In order to improve and sustain data reporting, DHMTs and SSDI-Services implementing partners at the districts supported monthly M&E Mentorship, reporting, filing, data completeness and analysis, data and charts displays by making vehicles, fuel and allowances available for these activities. HMIS staff and program coordinators were always central to the conduct of data handling and reporting. The district management teams also provided support that ensured continued functionality of the mobile health reporting system. In addition Data Quality Assessments taking place at district level were also done at zonal level albeit on a quarterly basis for the latter.

Generation of and access to data has been increased, and data review and analysis meetings are conducted every quarter.

In the SSDI-Services target districts, DHIS2 data reporting and completeness from health facilities to the district level has significantly improved from 7 percent in project year 1 to 83 percent in project year 3 and has been maintained at this level till the end of the project. Reporting from district to zone levels has also improved from 40 percent to 80 percent (see Table 3 below). There was clear evidence in the form of numbers and data charts on display in most HFs that data reviews were being conducted although the intervals at which these were being updated varied from one facility to another (*observation from HF visited during evaluation Aug – Sept 2016).*

Table 3: Data collection and reporting indicators

Area of data collection, reporting and use	BEFORE *April 2012*	AFTER *March 2016*
HFs meeting DHIS2 improved reporting requirements	7%	83%
DHIS2 establishment (DHIS2 mobile)	2 districts	10 districts
Improved reporting from district to zone level	40%	80%

Source: JHPIEGO, endline report August 2016

In terms of use, Group Interviews with facility staffs as well as KIIs with DHMT members indicated that HMIS staffs are mainly responsible for entry of the data in DHIS2 on a monthly basis while DHOs and program coordinators are the key staff that access DHIS2 for use.

Access to data has helped improvement of activities and identifying areas of poor performance of service delivery indicators that require corrective action. In addition to DHIS2 quarterly data review meetings, the evaluation found that the District Implementation Planning was another important process that used this data. During biannual DIP review DHMT used data to update, adjust or change activities being implemented.

Some challenges tend to undermine SSD-I Services effort to strengthen HMIS.

There is a shortage of statistical clerks at HFs and in most cases Senior HSAs are carrying out data collection roles and the setback is that they perceive data collection and reporting as something that only draws them away from their core activities. Lack of electricity and poor network connectivity are other barriers to access to DHIS2 on the one hand, and as well as preventing health providers in the hard to reach HF from sending data via mobile phones in time. In some cases staff have to use public

transportation to send data to the district level when feasible. Several districts reported of shortage of vehicles and/or fuel that resulted in HMIS Officer and program coordinators being unable to complete regular supportive supervision, mentorship and data quality assessments.

4.2 Conclusions:

- Investment in training and mentorship, appropriate equipment and technology as well as supportive supervision has contributed to create capacity to collect, access and utilize routine service delivery data and HF staffs are collecting routine data using registers.
- In most HF senior HSAs are carrying out data collection due to lack of statistical clerks.
- Data is being used at district and zone levels as data is being collected, processed and accessed by DHMT and also available on line through DHIS2 country wide.
- Data quality and utilization at national, district and HF levels are being challenged by lack of staff, and there is need for a lot more work to be done on addressing quality of data.
- Owing to the limited quality of the data being passed up the system, many potential program level users have been reluctant to use DHIS2. Consequently, data generation and management processes being supported by various partners running in partial or completely unintegrated mode with the DHIS2 are viewed to produce more reliable data outputs. The MOH and partners are aware of the effects of running various systems on the success of DHIS2 and efforts toward harmonization of the multiple systems are being slowly tackled and there is hope that the national DHIS2 will be transformed into a more useful HMIS.

4.3 Recommendations:

- DHMT should focus more on supervising data generating and utilization, and on data quality assessment at the facility level.
- MoH should provide each HF with a statistical clerks.
- MoH should integrate data quality assessment into supervision and mentoring activities.
- DHMT to increase providers and clerks' knowledge and skills on data quality through mentorship.
- MoH and Partners to improve integration of parallel health related data systems with DHIS2 for synergies e.g. Baobab system.

EVALUATION QUESTION 5

What are the most significant accomplishments, best practices, and lessons learned from the SSDI-services activity? Explicitly identify and document facilitating and inhibiting factors to positive performance for each of the above questions.

5.1 Accomplishments

Quality of Care:

- Quality of Care (QoC) has improved significantly at target HFs and community service delivery.
- Performance Quality Improvement approaches (e.g. PQI, AQ and PBI) have contributed to improve QoC.
- Community mobilization and empowerment through Score Card, CAGs and Care Groups have contributed to improve QoC.

Access to Care:

- More health services were offered as a result of SSDI which in turn provided opportunities for greater access to clients.

- Trained HSAs have improved communities access to CBMNC Services through Village Clinics, FP injectable method and CBD.
- SSDI services increased access in hard to reach facilities and communities but distances and transport are still major barriers to access in many places.
- The PBI scheme has increased access to and utilization of selected EHP services, improved the quality of health services by improving working conditions and recognition.

Capacity Building:

- The project built capacity for utilization of TOT, mentorship and supervision.
- Trainers are being utilized in mentorship, supervision and follow up activities.
- There is a substantial increase in number of health facilities in SSDI districts receiving one or more supervision visits per quarter.
- Community capacity through utilization of score cards and community based volunteers has facilitated demand side contribution to quality service delivery.

HMIS Reinforcement:

- SSDI supported the migration from paper based reporting to DHIS 2, this included provision of equipment.
- HMIS has been strengthened at the national level.
- The project built the capacity at district and HF levels for data collection, reporting, entry in DHIS2 and utilization.
- Regular data collection and reporting are being institutionalized at the district level.
- Generation and access to data has been increased, and data review and analysis meetings are being conducted every quarter.

These accomplishments have significantly improved SSDI-Services performance indicators in the 304 supported facilities within the 15 SSDI districts as presented and discussed in earlier sections. Table 4 shows how the interventions have impacted the 10 core performance indicators.

Table 4: Performance achievements on the 10 core indicators

Core Indicators (from 304 SSDI supported facilities)	**Before April 2012**	**After March 2016**
Number of service delivery sites offering LAPM	129	**251**
Number of sites/district providing BEmONC	50	87
Couple-years of protection • Through CBFP • Increasing CYP since inception (cumulative)	 8,298 41,383	 31,975 1,851,669
Percent of pregnant women attending ANC that were tested for HIV	66	92
Number of facilities with capacity to manage acute under-nutrition*	145	304
Malaria: Percent of pregnant women at ANC who received 2nd IPT**	12.6	64
HIV/AIDS: Percent of HIV positive pregnant women initiated on ART	89	95
Mentoring and PQI: percent of facilities receiving at least one supervisory visit per quarter.	-- (Not available)	225

Source: JHPIEGO: Endline Report, August 2016; * figures from USAID, 2016; ** source is the facility registers in SSDI-supported facilities

5.2 Contributing Factors

Several factors have facilitated these accomplishments. Among these factors are:

- The complementary and interactive design of the program which targeted the main pillars of the Health System and the presence of the communication for behavior change initiative.
- The focus of services delivery at lowest levels where the target population is present and the contribution of performance monitoring and evaluation activities involving multiple partners including those from other sectors.
- SSDI-Services was implemented within the MOH –HSSP. This let the MOH take leadership. Furthermore, SSDI-Services facilitated the operations with resources and reinforcing the DHMT leadership capacity at facility and community level, through provision of supplies, the empowerment of the community structures such as use of the score cards, outreach clinics, village health clinics.
- Integration of services and Outreach clinics: Providing services in an integrated manner ensure that clients receive services at one go. Outreach clinics bring services to the hard-to- reach areas that contributes to increases in access to services.
- Use of HSAs and Volunteers, Score Card Approach, Involvement of CAGs and Care Group: The use of community approaches like HSAs and care groups, CAGs provided an opportunity for leveraging community resources and also get input from the community about quality of services.
- CBDAs and other voluntary roles have contributed outstanding results in improving and extending access to quality care. For example an outstanding achievement was attained by Care Groups who were able to reach 4, 498,759 children with nutrition related activities.
- Incentive Schemes (Recognition/PBI): Rewards and recognition of facilities motivated services providers to achieve better outcomes.
- Provision of supportive resources by SSDI such as reporting booklets, Computers, Routers, Flash Disks, Air Time, fuel for transport and Phones with priority to hard-to-reach areas.
- Good awareness and adherence of Staff achieved through mentorship and supportive supervision have improved performance.
- DHMTs routinely financed internet connectivity.

5.3 Inhibiting Factors

Some factors have inhibited the performance of SSDI-Services or at least hampered the expected outcomes. Most of them are environmental factors that are embedded in the Malawi health system, such as:

- The weak government funding environment and staffing shortages have long term effects on the momentum for institutionalization of the capacity created by SSDI.
- High staff turnover, competing tasks and parallel implementing plans are highly affecting continuity of project activities.
- Change in policy on allowances, change in operational strategy and a reduction in resources allocated to activities were the notable factors during the implementation phase of capacity building activities limit capacity building.
- Lack of electricity hampered the quality of service delivery.
- Transportation for referrals: Transport for service delivery (outreach clinics) and referrals was inadequate due to lack of ambulance for referrals in some health facilities and road conditions all had negative influence on the quality of service delivery.

- Shortage of technical and clerical staff to operate DHIS2, frequent power outages, inadequate computers and unreliable internet connectivity undermined the potential of SSDI-Services Investment on data collecting, reporting and utilization.

Some of the inhibiting factors are inherent in the design of the SSDI-S strategy; in particular respondents to KII interviews pointed to SSDI being thinly spread to too many districts with a wide range of interventions (starting with 10 and extended to 15) as one of the main inhibiting factors. They observe that it is difficult to conclusively register immense impacts at population levels with such a spread, a model focusing on fewer districts with full coverage of those districts would be preferred. Respondents felt there was a missed opportunity to achieve the highest outcomes level in the project's theory of change due to the reduced funding in latter stages of implementation without a matching recourse on scale of operations.

5.4 Best Practices

The following were cited as best practices:

- Establishing 15 HFs that met specific quality standards as centers of excellence
- Using mentorship as a capacity building approach
- Using Standard Based Management and Recognition for improving quality of care
- Conducting facility data review meetings
- Camping 4-5 days in hard to reach areas for service delivery
- Use of Data Reporting Booklets
- Use of Phone Application
- Use of Community Score Cards, Community Action Groups (CAGs) and Care Groups
- Employing participatory approaches at designing activities and selected implementation stages.

As shown by Figure 9; "Capacity building (Training and Mentorship) in provision of quality care" was recognized as a best practice by 19% of all respondents to the self-assessment questionnaire , followed by "Improvements in all EHP services, (MNCH, FP, Male involvement in ANC, Malaria testing etc.)" 18%, "Improved data management and completeness of reporting" 12% (District level staff: 21,4%), "Follow ups and Quality supportive Supervision" 11% and "Planning and implementing together" 11% whereas successful and popular approaches as "Awards of excellence and PBI" scored 5%, "Comprehensiveness of Community based services and Community involvement" 3% and "Nutrition Assessments" 1%.

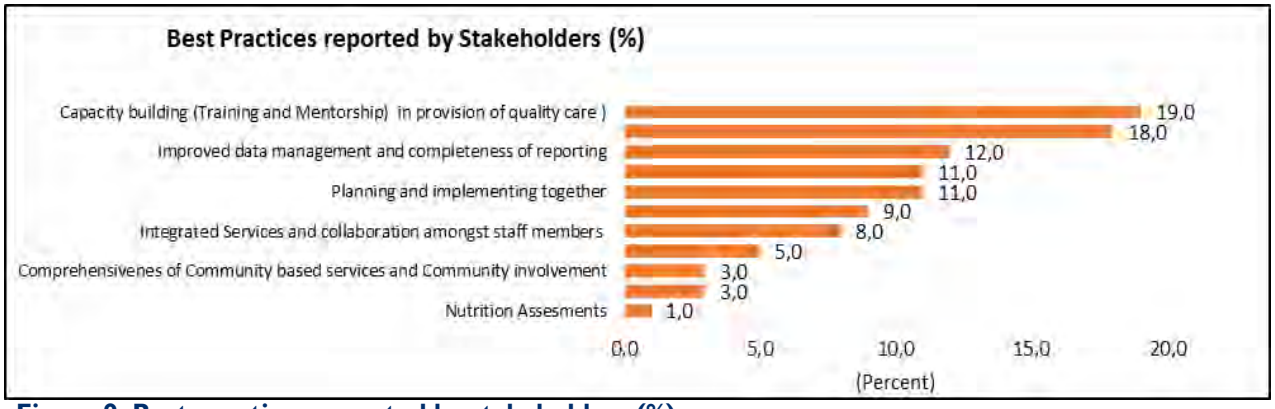


Figure 9: Best practices reported by stakeholders (%)

Figure 10 below shows best practices in different areas as attained by various HFs and how they were perceived by different categories of stakeholders.

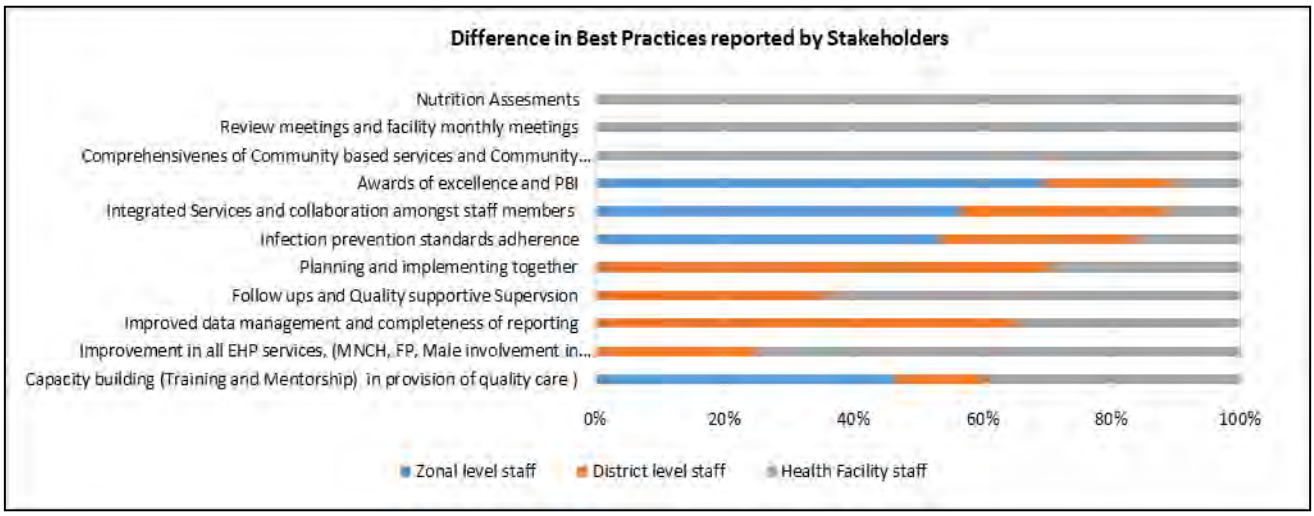


Figure 10: Difference in best practices reported by stakeholders

For example, Nutrition Assessment, Review meetings and facility monthly meetings, Comprehensiveness of Community based services and Community involvement, Follow ups and Quality supportive Supervision as well as improvement in all EHP services were fully acknowledged by Health Facility staff as Best Practices. District level staff appreciated integrated planning and implementation between partnerships, improved data management and completeness of reporting as best practices whereas Zonal staff recognized Award of excellence and PBI, integrated Services and collaboration among staff members as well as infection prevention standards adherence and capacity building as best practices.

These results provide insights into the level at which each category of best practices should be coordinated, sustained and institutionalized.

5.5 Lessons Learned

Central level:

- Investment in integrated service delivery in the National Health System has potential for reaching tremendous outcomes.
- Inclusive partnerships from initial design stages is conducive to successful implementation and outcomes.
- Coordination and harmonization of implementation for many partners is very difficult to achieve.
- The Malawi health system is not yet ready to independently sustain implementation of activities hitherto supported by SSDI after project phase-out.
- Service integration and PBI are effective approaches to improve quality.

District level:

- By focusing on data quality HFs are enabled to improve other technical domains too.
- PBI improves provider's confidence and increases participants program ownership and financial capacity to acquire and maintain equipment, infrastructure and supplies.

GENDER ANALYSIS

The evaluation critically looked at the potential positive or negative impacts of SSDI-Services activity on gender. Providers reported that there was no gender imbalance in the EHP interventions delivery at district hospital, health centers and village clinics. Health services are available and accessible to everyone regardless of gender even though health services have been designed and organized for women and children as the priority groups.

In addition the percentage of women is highest at service delivery level except for HSA cadre where men are predominant. Most of the RH officers were female while most DHOs and program coordinators were male, these are inherent systemic biases not necessarily a consequence of the SSDI-Service delivery interventions.

At community level more females have participated in community mobilization from score cards, CAGs and Care Groups during the first two years of the program implementation. Men came in later as a deliberate effort to lower female influence. Communication activities implemented by SSDI-Services targeted both men and women and increasing number of men involved in care provision, mainly in FP at HFs and village clinics. SSDI-Services had no impact nor did it intend to impact on issues related to disability.

ANNEXES

Annex 1: Evaluation Statement of Work

Annex 2: Summary Evaluation Methodology

Annex 3: Data Collection Instruments

Annex 4: People Consulted

Annex 5: Documents and Sources Reviewed

ANNEX 1. EVALUATION STATEMENT OF WORK

SECTION C DESCRIPTION/SPECIFICATION/STATEMENT OF WORK

C.1 SSDI ACTIVITIES EVALUATION-SERVICES

EXECUTIVE SUMMARY

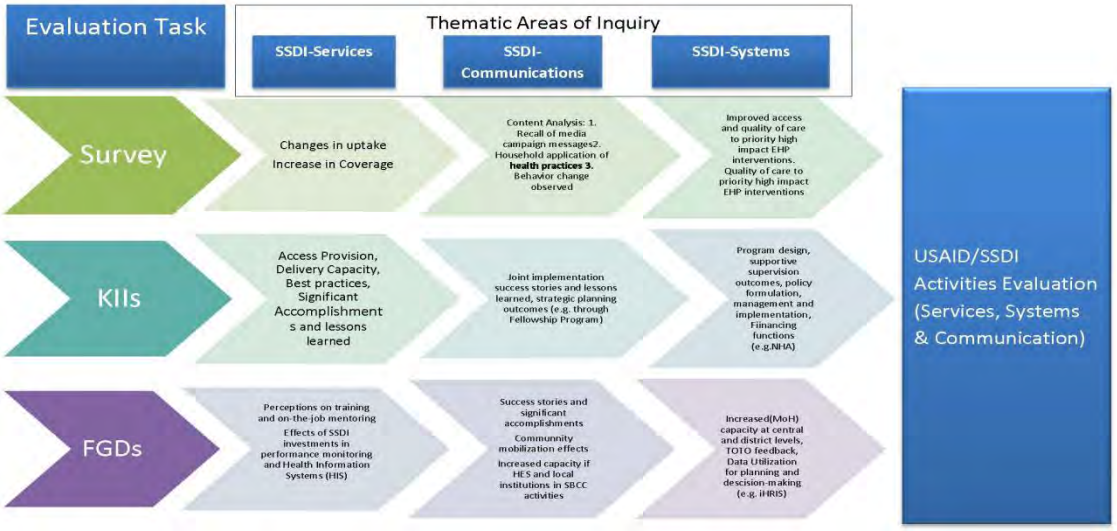
The Support for Service Delivery Integration (SSDI) is USAID/Malawi's flagship health activity to support the increased availability and quality of the Essential Health Package (EHP) services, reinforce health promotion and disease prevention among households, and strengthen elements of the health system to sustain effective EHP delivery throughout the 28 districts of Malawi.

SSDI consists of three interrelated sector activities: Services, Communications, and Systems. The Services activity provides an integrated service delivery program by improving the quality of priority EHP services at the community- and referral-levels. Communications is a social and behavior change communication (SBCC) activity to promote normative and individual behavior change in the priority areas of HIV and AIDS, maternal and child health (MCH), malaria, nutrition, water and sanitation, and family planning (FP). The mission of the Systems activity is to assist the Ministry of Health (MoH) to improve policies, management and leadership, and fiscal responsibility to advance Malawi's health system and the sustainable impact of the EHP. The integration of all three activities within one broad health initiative aims to achieve the USAID/Malawi Country Development Cooperation Strategy (CDCS) strategic goal to improve the quality of life for Malawians through the improvement of social development, the increase in sustainable livelihoods, and the exercising of citizen rights and responsibilities.

The following sections discuss in detail DevTech Systems' approach to conduct the final performance evaluation of the SSDI activity. DevTech's formula in developing effective approaches to obtain valid and reliable findings has been proven in more than 150 successful evaluations completed over 30 years. For the SSDI evaluation, DevTech's approach will be built from the following core foundations:

Extensive Experience in Health Systems. The DevTech Team consists of proven implementation and evaluation specialists in the areas of health systems strengthening and service delivery from the national- to community-levels in Malawi and other countries. Combining the strengths of each member brings a strong foundation of health systems qualifications in key functional areas including, but not limited to, policy formulation, program design, innovative service delivery, implementation and management, behavior change, and performance monitoring and evaluations. The DevTech Team also brings experiences in key health sectors such as HIV and AIDS, MCH, malaria, nutrition, water and sanitation, and FP. This rich set of qualifications will bring the needed depth and rigor to evaluate an expansive initiative such as SSDI.

Integrated Evaluation Approach for Valid and Reliable Findings. The SSDI consists of a broad range of interventions that are interrelated across the three components and are implemented from the zonal- to the district-levels. Thus, the overall evaluation approach will integrate one activity evaluation design with the other two where appropriate to have more accurate assessments of SSDI outcomes and results. Below represents our Thematic Areas of Inquiry.



One Team Approach for Technical and Management Efficiencies. Along with an integrated design, the DevTech evaluation team is structured along a "one team approach" that leverages complementarities among the members to form a cohesive evaluation unit. The DevTech Team for each activity will coordinate tasks closely and will be supported by research and logistics personnel who will work across the three evaluations. Additionally, all teams will be supported by DevTech HQ Senior Evaluation Advisor (STA), who will provide technical input throughout the evaluation and Program Manager who will provide operational support.

Local Understanding. The Malawi health sector is unique in its own circumstances and challenges. The country's need to expand coverage in all areas is a result of increasing demands for health services. At the same time, the quality of service delivery needs to be maintained, if not improved, to meet the stated development objectives. While the macro-level conditions are fairly evident, it is the knowledge of specific conditions at the district- and community-levels where evaluation findings of SSDI activities will be more useful and relevant. The DevTech evaluation team is heavily represented by proven Malawian health specialists and evaluators with extensive experience in conducting field work, even in remote (rural) locations of the country. Having previously worked with Invest in Knowledge a locally-based data collection firm, the DevTech Team will look to engage Invest in Knowledge to support all three evaluation activities.

Unequaled Management. DevTech Team is, a single integrated unit encompassing two very strong USAID partners with complementary skills, technical management expertise, logistical capability, geographic reach, and extended networks of local researchers. The Team offers an unequaled bench of Monitoring and Evaluation (M&E) expertise to successfully execute from day one.

Focus on Gender. Reinforcing health promotion and disease prevention among households cannot be effectively achieved without an awareness of relevant gender issues. Gender differences impact health practices such as the exposure to risk factors, access to services, attitudes towards personal health and maintenance, and perceptions of quality care. In all relevant aspects of the evaluation, the team will assess SSDI outcomes along gender lines not only to respond to the Mission's CDCS and the USAID Gender policy but also to determine if health practices are being applied throughout the project areas.

TECHNICAL APPROACH

Background on SSDI-Services

USAID/Malawi's flagship health activity, SSDI aims to strengthen health systems in Malawi through the implementation of three primary health sector activities: SSDI-Services, SSDI-Systems and SSDI-Communication. SSDI-Services specifically targets the provision of high quality EHP services to reduce fertility and population growth, lower the risk of HIV, and lower maternal, newborn, infant and under-five mortality and morbidity rates. The Mission and its partners focus on improving both access to and quality of care by building capacity at the ministry-, district-, and facility-level through 30 technical interventions including professional training, clinical mentorship, facility improvement, and community mobilization. Services aims to develop innovative community approaches to delivery such as care groups, while working in close collaboration with the Communications and Systems activities.

Objectives of the Evaluation:
The primary objective of the Services performance evaluation (PE) is, *"to measure and determine the extent to which SSDI Services interventions had on quality of and access to care; provide in-depth insights into the facilitating and limiting factors of increased service utilization at each level of service delivery; and document progress made towards building MoH capacity to deliver quality EHP services.*" The sections below detail our overall approach.

a. Overall Technical Approach

a.1 Evaluation Questions and Design
In order to assess the effect of SSDI Services activities on the quality of and access to services, the evaluation scope of work (SOW) outlined six evaluation questions. The DevTech Team proposes a mixed methods design that draws from existing data, project documents, and Health Information Systems (HIS) data on service provision and health outcomes, and calls for the collection of new qualitative and quantitative data through targeted surveys, key informant interviews (KIIs) and focus group discussions (FGDs). Table 1 summarizes the evaluation questions and describes the indicators and data sources used to answer the evaluation questions.

Table 1: Evaluation Design Summary Table

EQ #	Evaluation Question	Theme	Indicator	Data Source
Q1	To what extent did SSDI improve quality of care for priority EHP interventions at targeted health facilities and community service delivery points? Were there any adverse or unexpected results on the quality of care?	Quality of Services	Changes in output and outcome indicators Perceptions of care	Existing program output and outcome data Baseline and endline data gathered by SSDI FGDs with healthcare providers and community members Qualitative Score Card (during FGDs) Healthcare provider and consumer surveys KII with MoH officials Document review Other secondary data
Q2	To what extent did SSDI-Services improve access to priority high impact EHP interventions in the target health facilities and community service delivery points?	Access to Services	Change in uptake of services Coverage increase (mapping) Increase in community based provision of care Perceptions of access	Existing program output and outcome data GIS data Baseline and endline data gathered by SSDI FGDs with healthcare providers and community members Qualitative Score Card (during FGDs) Healthcare provider and consumer surveys KIIs with MoH officials Other secondary data
Q3	To what extent did the direct involvement of MoH staff to facilitate the in-service training of health practitioners, on-the-job mentoring and quality assurance strengthen the MoH's capacity to institutionalize these components as part of routine delivery of high impact priority EHP services?	Capacity for Service Delivery	Number of practitioners trained Changes in MoH capacity described by MoH staff and trainers (beneficiaries of Trainer-of-Trainer programs) Perceptions of training received	Existing program data on number trained KIIs with MoH officials FGDs with trainers Qualitative Score Card (during FGDs)
Q4	To what extent did SSDI's investments in performance monitoring and Health Information Systems (HIS) improve the MoH's (national,	Capacity for Data-Driven Decision-Making	Number of individuals trained in HIS usage Usage of HIS data Perceptions of data usage	Existing program data on number trained Baseline and endline HIS data on usage (number of times accessed, reports generated, etc) KIIs with MoH officials

EQ #	Evaluation Question	Theme	Indicator	Data Source
	district and facility) capacity to collect, access and utilize routine service delivery data for decision making?			Document review
Q5	What are the most significant accomplishments, best practices, and lessons learned from the SSDI-services activity? Explicitly identify and document facilitating and inhibiting factors to positive performance for each of the above questions.	Successes/Lessons Learned/ Enabling and Inhibiting Factors	Change in targeted health outcomes Perceptions of SSDI-Services activities	Self-assessment questionnaire Baseline and endline data gathered by SSDI KIIs with MoH and IP FGDs with community members and healthcare workers Qualitative Score Cards (during FGDs) Healthcare provider and consumer surveys

a.2 Evaluation Activities

In order to meet the evaluation objectives and ensure timely submission of key deliverables, the following key activities are proposed:

Post-Award Meeting and Internal Planning Meeting (IPM). Following award, the DevTech Team will meet with Mission stakeholders via phone to clarify roles and responsibilities and to finalize the workplan, timeline, and relevant SSDI documents and secondary data to review and analyze.

Document Review and Secondary Data Analysis. The DevTech Team will review program reports, performance monitoring plan (PMP) data, baseline and endline data collected by SSDI, and other relevant secondary data identified together with the Mission, to assess changes in access, quality, and effectiveness of SSDI-Services interventions. The analysis will also be used to identify best- and least-improved healthcare sites that will be the focus of qualitative data collection.

Field Data Collection. A team of data collectors will be retained to conduct data collection at a sample of health facilities across the 15 districts where SSDI activities are implemented. The Team Leader (TL) and Evaluation Specialist (ES) will provide training and oversight of data collectors.

Ongoing Data Analysis. The Research Analyst (RA) will analyze quantitative and qualitative data collected on an ongoing basis to facilitate discovery of preliminary results and report writing. The DevTech Team will meet weekly via phone to discuss progress, data collection issues, and discuss preliminary findings.

Bi-weekly Debriefing Meetings with USAID. The TL and HQ STA, will provide regular updates to USAID during the bi-weekly meetings that will also include the Communications and Systems meetings for more efficient management.

USAID/Malawi Presentation. The TL and team members will deliver an oral presentation to USAID on preliminary findings, conclusions, and recommendations.

Findings Workshop. In consultation with USAID, the DevTech Team will organize findings workshops in Lilongwe to present the main findings, conclusions, and recommendations to key stakeholders across the three SSDI evaluations.

A.3 Integration of Gender and Other Disadvantged Groups

In the process of developing its current CDCS, the Mission undertook a gender assessment to identify approaches to improve health outcomes of some of Malawi's most vulnerable citizens — women and children under the age of five. Several of these approaches are central to the design of SSDI Services, including building capacity at the local level in order to implement community-based services and delivering integrated services that take gender and social norms into consideration. Therefore, as part of its analysis of the effectiveness of SSDI-Services in improving the level of access to, and quality of, services, the DevTech Team will consider how quality and services may differ by gender and other social and economic factors. Additionally, the sampling strategy will take into account gender and age differences.

b. Evaluation Plan

This section describes a detailed plan the team will take to evaluate the SSDI Services evaluation.

b.1 Data Sources

Existing Data. The Devtech Team will leverage a number of existing data including: baseline and endline data gathered at the household level by SSDI Services and SSDI Communication, respectively; PMP data; GIS data gathered by the Mission; HIS data; program quarterly reports; and potentially data gathered through the 2010 DHS and other relevant national surveys.

Primary Qualitative and Quantitative Data. While the team will capitalize on opportunities to draw from existing data, the evaluation design requires that the DevTech Team also collects new information from a variety of stakeholders to obtain direct perspectives on the outcomes of SSDI-Services' activities. Devtech proposes five distinct data collection activities as part of the SSDI-Services evaluation: 1) self-assessment questionnaire of Services implementers, 2) survey of healthcare providers; 3) survey of individuals who have received services from an SSDI-supported facility (consumers); 40 KIIs with MoH officials, district health officers, representatives from IPs; and 5) focus group discussions (FGDs), including qualitative score cards, with community residents, healthcare providers, and trainers benefiting from MoH Trainer-of-Trainer (ToT) programs. The sections below provide more details about each of the data collection activities.

b.2 Data Collection Approach

Quantitative Data Collection

Healthcare Provider and Consumer Surveys. The DevTech Team will carry out two brief surveys — one with representatives from healthcare facilities and a second with healthcare consumers — at 49 healthcare facilities, chosen through a stratified random sampling approach in all 15 districts. Each survey will take approximately 15-20 minutes to complete. In addition to demographic questions, the surveys will consist of items to gauge both healthcare workers' and consumers' perceptions of the quality of services (Q1) and access to health care (Q2). The survey will also include items that specifically target female respondents, especially those of childbearing age and those with children under five.

Self-Assessment Questionnaire. At the conclusion of KIIs with implementers and other partners, the team will administer a short self-assessment questionnaire to objectively assess stakeholder performance in implementing SSDI-Services, and to identify successes, challenges, and enabling factors of their performance.

Qualitative Data Collection

While the survey data will give us a broad understanding of providers' and consumers' perceptions on access to care and the quality of care, KIIs and FGDs provide depth of understanding of the factors that determine quality of, and access to, care, as well as the role SSDI-Services has played, especially in terms of increasing capacity and the use of data to improve outcomes.

Key Informant Interviews. In addition to supplementing information gathered through provider and consumer surveys to address Q1 and Q2, KIIs will be used to understand changes in the MOH's capacity to gather and analyze HIS data and increase the quality and reach of services (Q3 and Q4). Furthermore, the DevTech Team will ask interviewees about significant accomplishments, best practices and lessons learned, personal experiences, and other factors that may have inhibited or promoted success (Q5).

Focus Group Discussions and Score Cards. The DevTech Team will adapt a qualitative data collection technique used in the baseline study of the USAID/Malawi CDCS (see box 1) — a Rural Score Card — to examine healthcare providers' and community members' perceptions of care with respect to both quality (Q1) and access (Q2). FGD participants will be asked to vote on whether or not there were positive or negative changes in their community related to various issues around access and quality of healthcare, and to discuss their responses. The DevTech Team will use a similar technique with individuals who participated in ToT programs to examine the quality of the training (Q3) and help flush out successes, best practices, and lessons learned (Q5).

Instrument Development and Training. Prior to fieldwork, survey instruments and semi-structured FGD and KII guides will be vetted with USAID staff, translated into local languages,

and piloted. All data will be collected in the respondent's preferred language. Each data collection team will include local language speakers as either interviewers or translators. The data collection team will be trained under the supervision of the TL with the assistance of the ES, particularly on using interviewing and facilitation techniques that encourage robust responses from respondents.

Survey Sample

The DevTech Team will follow a stratified random sampling approach at the district level to select a random sample of healthcare facilities in the 15 SSDI districts. Using this approach, the Team will conduct quantitative data collection in 49 healthcare facilities, with the goal of collecting two healthcare provider surveys per site for a total of 98 provider surveys, and a total of 385 healthcare consumer surveys across sites. Collecting two healthcare provider surveys per site from representatives with different roles, tenure, level, or gender minimizes the potential for response bias due to confounding factors. This sampling approach allows the DevTech Team to generalize conclusions, at a 95% confidence level, about perceptions of care quality and access to all healthcare facilities and catchment population within the 15 districts. This approach assumes that service delivery is more similar between healthcare facilities within, than between districts.

The DevTech Team will consult with USAID/Malawi to finalize the sample sizes and sample facilities selected, with the goal of targeting healthcare facilities that offer all three SSDI sector activities and that are representative of urban and rural facilities and length of SSDI support, among other criteria.

Qualitative Sample: The team's qualitative sampling approach is purposive in nature. The team anticipates collecting qualitative data in eight districts, including Balaka, Machinga, and Lilongwe Rural to target the three districts in which most activities have focused. The remaining five districts will be determined in collaboration with the teams for the Communication and Systems evaluations. The team will aim to collect data in an equal number of urban and rural sites and in locations where all three SSDI activities overlap. Two facilities will be visited in each district, for a total of 16 facilities. A total of 38 KIIs and FGDs with 64 people will be conducted, targeting a range of MoH district/zonal and central representatives, implementers, USAID representatives and male and female community members.

b. 3 Data Analysis Plan

Survey and secondary data will be cleaned, processed, and analyzed on an ongoing basis throughout the evaluation. Results and trends will be discussed during weekly team check-ins. The Team will analyze survey data to assess changes in both quality of and access to healthcare over time at the level of healthcare providers and consumers, and to extract patterns in the data that point to key enabling and/or inhibiting factors to the objectives of SSDI-Services. The DevTech Team will systematically investigate differences attributable to gender and/or other disadvantaged group status particularly in terms of perceptions of healthcare access and quality, and to understand if and how SSDI-Services are effectively and equally reaching women, children, and men. The Team will draw upon existing quantitative data and use GIS tools to

construct maps that illustrates SSDI-Services' coverage, including where this coverage overlaps with SSDI-Systems and SSDI-Communications. Qualitative data collected will be digitally recorded whenever possible and transcribed and translated from local languages to English as needed. The team will then code the data using qualitative data analysis software to identify themes and build a narrative that responds to the primary evaluation questions. Through quantitative data, the evaluation offers a discrete assessment of the level of care quality, access, and effectiveness of SSDI-Services, enriched and validated by narrative themes from the qualitative data collected.

Challenges and Limitations. Based on the DevTech Team's past experience in Malawi, we anticipate some potential challenges and present solutions in Table 2.

Table 2. Anticipated Challenges and Potential Solutions.

Challenges	Mitigating Solutions
Geographic distance. The time it takes to travel between sites, especially during the rainy season (December-March).	Identify a reputable local data collection firm to oversee logistics, and conduct data collection, transcription, and data entry.
Language differences. The variety of local languages spoken, e.g., Chechewa, Chisena, Tumbuka, Yao.	The local data collection firm will include team members fluent in the wide diversity of local languages spoken by respondents.
Respondent fatigue. Malawi is heavily saturated by programming, and as a result, evaluations. Many Malawians are experiencing respondent fatigue.	The DevTech Team aims to mitigate this burden by coordinating data collection activities across the three PEs.
Condensed evaluation timeline. The RFP requests a high-level of rigor in technical approach, which the current proposal seeks to fulfill. However, the condensed timeline may not provide sufficient time to extensively codify and analyze data to form robust findings and recommendations.	The Team will conduct data analysis on an ongoing basis, utilizing an efficient data analysis plan that focuses on answering the specified evaluation questions. While in-depth results may not be possible within the evaluation timeframe, the dearth and quality of the qualitative and quantitative data the Team will provide as a product of the evaluation will allow the Mission to revisit the data or request additional analysis through subsequent task orders.

[END OF SECTION C]

ANNEX 2. SUMMARY EVALUATION METHODOLOGY

Data Collection Method	Stakeholder	Number
KIIs	USAID, IP, MOH	34
Self-Assessment Questionnaire	USAID, IP, MOH, health providers	112
Group Interviews	Health Providers	26
FGDs/Community Scorecards	Community members	38 (13 men only; 26 women only)
Consumer Questionnaires	Health Consumers	490
13 out of 15 districts sampled		
26 health facilities visited (2 per district)		

ANNEX 3. DATA COLLECTION INSTRUMENTS

A-Instrument: Key Informant Instrument Interview Guide

Stakeholder**:** MoH managers (central, zonal, DHO)

Hello! My name is_____, I am an interviewer for DEV TECH which is doing a study for the Ministry of Health and its partners. We are here to ask questions about health and hope you can help us. All answers will remain confidential. It should take about an hour. Please be advised that you are not in any way obliged to participate in this interview, and you can discontinue the interview at any time without any penalty. You can also refuse to answer any question and move on to the next one.

At the end of this interview we would like to ask you to fill out a short self-assessment questionnaire about SSDI's performance. Please answer « yes » if you agree to participate.

For the evaluation team to fill out:		
Site:	Respondent Sex (M/F):	Respondent ID/Number:

Stakeholder Group: Management Level

Title/Stakeholder Group:		
National:	Zone:	District:

Evaluation Question 1: To what extent did SSDI improve quality of care for priority EHP interventions at targeted health facilities and community service delivery points? Were there any adverse or unexpected results on quality of care?

1. Kindly explain what you know about how the SSDI Services program is organized and how you fit in? *(Note: It may be known by another name)*.
2. To your understanding, what are the major health issues that SSDI services has addressed?
3. How have SSDI services activities influenced the *quality of care* for these health issues at health delivery sites?
4. Which of these activities/approaches were successful/unsuccessful? Please explain and give examples.
5. Do men and women <u>equally</u> have good quality of care, or is the quality of care different for men versus women? Please explain. What about people with disabilities? Please explain.
6. Were there any unexpected results (good or bad) on the quality of care as a result of SSDI services activities? Any surprises in general? Please explain.
7. What are your suggestions on how SSD-I Services could have been implemented differently to have a stronger effect on the quality of health services? Please clarify

Evaluation Question 2: To what extent did SSDI-Services improve access to priority high impact EHP interventions in the target health facilities and community service delivery points?

1. What are the challenges that have affected patient and community access to EHP services in your unit and/or Malawi?
2. How has SSDI Services addressed these access challenges through its support and activities? Kindly explain and provide examples.
3. Which of these activities/approach were successful/unsuccessful? Please explain and give examples.
4. In your opinion, how has the equality in access to care changed for 1) women, 2) disabled and 3) marginalized groups as a result of SSD-I Services
5. In your opinion, how has SSDI services affected the access to care for men versus women? Do they have equal access? Why, why not? What about people with disabilities?
6. What are your suggestions on how SSDI Services could have been implemented differently to have a stronger effect on access to health services at the community level? Please clarify.

Evaluation Question 3: To what extent did the direct involvement of MoH staff to facilitate the in-service training of health practitioners, on-the-job mentoring and quality assurance strengthen the MOH's capacity to institutionalize these components as part of routine delivery of high impact priority EHP services?

1. Please describe the SSD-I Services capacity building activities of which you are aware.
2. Have these activities addressed the capacity needs existing before SSDI services began at MOH? Please explain.
3. Have TOTs/Mentors/PBI-Q been used within the system or elsewhere besides SSDI?

   Have there been any bottlenecks to full utilization of TOTs/mentors/supervision?
4. What have been the most successful/unsuccessful components? Please give examples
5. In your opinion, how could the institutionalization and sustainability of the TOTs/mentors/supervision be improved?

Evaluation Question 4: To what extent did SSDI's investments in performance monitoring and Health Information Systems improve the MoH's (national, district and facility) capacity to collect, access and utilize routine service delivery data for decision-making?

1. Please describe the *HMIS* capacity gaps being targeted by SSDI Services.
2. In what manner have the performance monitoring activities affected the capacity of MOH to collect and utilize data? Can you provide a concrete example?
3. Is the HMIS and its data being used on a routine basis? Who is using them, and how? If not, why not?
4. Please describe the successes or improvements you have seen from this investment and the main factors contributing to its success?
5. What have been the main bottlenecks in establishing this system and in its actual utilization?
6. What will you recommend to improve the usefulness of HMIS and performance management in your area of responsibility?

Question 5: What are the most significant accomplishments, best practices, and lessons learned from the SSDI-Services activity? Explicitly identify and document the facilitating and inhibiting factors to positive performance for each of the above questions.

1. Overall did the SSDI project activities meet your expectations? Why or why not?
2. Would you please describe the SSDI Services accomplishments/lessons learned/ best practices? What are the main factors that contributed to these outcomes?
3. Do you have any final remarks or questions?

Thank you very for your participation.

B-Instrument: Key Informant Instrument Interview Guide

Stakeholder**:** Program coordinators, HMIS, and facility in-charge/health provider

Hello! My name is_____, I am an interviewer for DEV TECH which is doing a study for the Ministry of Health and its partners. We are here to ask questions about health and hope you can help us. All answers will remain confidential. It should take about an hour. Please be advised that you are not in any way obliged to participate in this interview, and you can discontinue the interview at any time without any penalty. You can also refuse to answer any question and move on to the next one.

At the end of this interview we would like to ask you to fill out a short self-assessment questionnaire about SSDI's performance. Please answer « yes » if you agree to participate.

For the evaluation team to fill out:		
Site:	Respondent Sex (M/F):	Respondent ID/Number:

Stakeholder Group: Management Level

Title/Stakeholder Group:		
National:	Zone:	District:

Evaluation Question 1: To what extent did SSDI improve quality of care for priority EHP interventions at targeted health facilities and community service delivery points? Were there any adverse or unexpected results on quality of care?

1. Kindly explain what you know about how the SSDI Services program is organized and how you fit in? (Note: It may be known by another name).
2. To your understanding, what are the major health issues that SSDI services has addressed?
3. How have SSDI services activities influenced the quality of care for these health issues at health delivery sites?
4. Can you kindly specify the activities/ approaches used to improve the quality of care within specific health services or categories of services?

5. Which of these activities/approaches were successful/unsuccessful? Please explain and give examples.
6. Do men and women equally have good quality of care, or is the quality of care different for men versus women? Please explain. What about people with disabilities? Please explain.
7. Were there any unexpected results (good or bad) on the quality of care as a result of SSDI services activities? Any surprises in general? Please explain
8. What is your opinion on the overall effect of SSD-I Services on the quality of care in your area of responsibility? Please explain, give examples
9. What are your suggestions on how SSDI Services could have been implemented differently to have a stronger effect on the quality of health services? Please clarify.

Evaluation Question 2: To what extent did SSDI-Services improve access to priority high impact EHP interventions in the target health facilities and community service delivery points?

1. What are the challenges that have affected patient and community access to EHP services in your unit?
2. Can you kindly specify the activities/approaches used by SSDI Services to help improve access to health care within specific health services or categories of services?
3. Which of these activities/approach were successful/unsuccessful? Please explain and give examples.
4. In your opinion, how has SSDI services affected the access to care for men versus women? Do they have equal access? Why, why not? What about people with disabilities?
5. In your opinion, what are the key factors that facilitated the positive achievements that you have observed?
6. What have been the main bottlenecks for SSDI Services in improving access to service? Please explain.
7. What are your suggestions on how SSDI Services could have been implemented differently to have a stronger effect on access to health services at the community level? Please clarify.

Evaluation Question 3: To what extent did the direct involvement of MoH staff to facilitate the in-service training of health practitioners, on-the-job mentoring and quality assurance strengthen the MOH's capacity to institutionalize these components as part of routine delivery of high impact priority EHP services?

1. Please describe the SSD-I Services capacity building activities of which you are aware.
2. In your opinion, have these activities addressed the capacity needs existing before SSD-I began in your/District/Facility/unit? Please explain.
3. What changes has TOT program brought in addressing capacity building needs? How has this improve health access and quality? Please explain
4. Kindly describe how TOT were utilized within your area of responsibility. What specific health areas or responsibilities were they used for? Please give examples.
5. Do you continue to use the TOTs? If so, how often and for what purposes? If not why?
6. Have the TOTs in your area of responsibilities trained other individuals or groups outside your area?

7. What have been the greatest bottlenecks to routine utilization of TOTs?
8. Are you aware of or been involved in the SSDI Services mentorship and supervision activities? In your opinion, what has been the outcome of this process?
9. What are the contributing factors of the successful/unsuccessful components?
10. Have there been improvements in the quality of or access to health service indicators because of SSD-I capacity building activities?
11. In your opinion, how could the institutionalization of the TOTs/mentorship/supervision be improved?

Evaluation Question 4: To what extent did SSDI's investments in performance monitoring and Health Information Systems improve the MoH's (national, district and facility) capacity to collect, access and utilize routine service delivery data for decision-making?

1. Please describe the HMIS capacity gaps being targeted by SSD-I Services within your area of responsibility.
2. What performance monitoring systems did the SSD-I services activity introduce into your area of responsibility? Please describe.
3. In what manner have the performance monitoring activities affected the capacity of your district/facility/unit to collect and utilize data?
4. Is the utilization of these systems and activities routine? Who is using them, and how? If not, why not?
5. Please describe the successes or improvements you have seen from this investment?

   What are the main factors contributing to these successes?
6. What have been the main bottlenecks in 1) establishing this system and 2) in its actual utilization?
7. What would you recommend to improve the usefulness of HMIS and performance management in your area of responsibility?

Evaluation Question 5: What are the most significant accomplishments, best practices, and lessons learned from the SSDI-Services activity? Explicitly identify and document the facilitating and inhibiting factors to positive performance for each of the above questions.

1. Overall did the SSDI services project activities meet your expectations? Why or why not?

2. Would you please describe any best practices or lessons learned from SSDI Services?

3. Do you have any final remarks or questions?

Thank you very for your participation, etc.

C-Instrument: Key Informant Instrument Interview Guide

Stakeholder: Implementing partners, USAID

Hello! My name is_____, I am an interviewer for DEV TECH which is doing a study for the Ministry of Health and its partners. We are here to ask questions about health and hope you can help us. All answers will remain confidential. It should take about an hour. Please be advised that you are not in any way

obliged to participate in this interview, and you can discontinue the interview at any time without any penalty. You can also refuse to answer any question and move on to the next one.

At the end of this interview we would like to ask you to fill out a short self-assessment questionnaire about SSDI's performance. Please answer « yes » if you agree to participate.

For the evaluation team to fill out:		
Site:	Respondent Sex (M/F):	Respondent ID/Number:

Stakeholder Group: Management Level

Title/Stakeholder Group:		
National:	Zone:	District:

Evaluation Question 1: To what extent did SSDI improve quality of care for priority EHP interventions at targeted health facilities and community service delivery points? Were there any adverse or unexpected results on quality of care?

10. Kindly explain what you know about how the SSDI Services program is organized and how you fit in? (Note: It may be known by another name).
11. To your understanding, what are the major health issues that SSDI services has addressed?
12. How have SSDI activities influenced the quality of care for these health issues at health delivery sites?
13. Can you kindly specify the approaches used to improve the quality of care within specific health services or categories of services?
14. Which of these activities/approaches were successful/unsuccessful? Please explain and give examples.
15. Do men and women equally have good quality of care, or is the quality of care different for men versus women? Please explain. What about people with disabilities? Please explain.
16. Were there any unexpected results (good or bad) on the quality of care as a result of SSDI services activities? Any surprises in general? Please explain.
17. What is your opinion on the overall effect of SSD-I Services on the quality of care in your area of responsibility and in Malawi? Please explain, give examples
18. What are your suggestions on how SSDI Services could have been implemented differently to have a stronger effect on the quality of health services? Please clarify

Evaluation Question 2: To what extent did SSDI-Services improve access to priority high impact EHP interventions in the target health facilities and community service delivery points?

8. What are the challenges that have affected patient and community access to EHP services in your unit and/or Malawi?
9. Can you kindly specify the approaches used by SSD-I Services to help improve access to health care within specific health services or categories of services?
10. In your opinion, how did these approaches actually influence access to care at heath delivery sites?
11. Which of these activities/approach were successful/unsuccessful? Please explain and give examples.
12. In your opinion, how has SSDI services affected the access to care for men versus women? (Please explain). Do they have equal access? Why, why not? What about people with disabilities?
13. In your opinion, what are the key factors that facilitated the positive achievements that you have observed?
14. What have been the main bottlenecks for SSDI Services in improving access to service? Please explain.
15. What are your suggestions on how SSDI Services could have been implemented differently to have a stronger effect on access to health services at the community level? Please clarify.

Evaluation Question 3: To what extent did the direct involvement of MoH staff to facilitate the in-service training of health practitioners, on-the-job mentoring and quality assurance strengthen the MOH's capacity to institutionalize these components as part of routine delivery of high impact priority EHP services?

1. Please describe the SSD-I Services capacity building activities of which you are aware?
2. In your opinion, have these activities addressed the capacity needs existing before SSD-I services began? Please explain.
3. Which of these activities were successful/unsuccessful? Why?
4. To your understanding, has the MOH continued to utilize TOTs, mentoring, or supervision? How so?
5. What have been the greatest bottlenecks to routine utilization of TOTs? Please explain
6. How have SSDI services capacity building activities affected the quality of and access to health services, if at all?
7. In your opinion, how could the institutionalization and sustainability of the TOTs/mentorship/supervision be improved?

Evaluation Question 4: To what extent did SSDI's investments in performance monitoring and Health Information Systems improve the MoH's (national, district and facility) capacity to collect, access and utilize routine service delivery data for decision-making?

1. Please describe the HMIS capacity gaps being targeted by SSD-I Services for the entire system or within your area of responsibility?
2. What performance monitoring systems did the SSD-I services activity introduce?
3. In what manner have the performance monitoring activities affected the capacity of MOH to collect and utilize data?

4. Please provide example of concrete products/successful results of investments in performance management and HMIS?

   Please provide examples of concrete unsuccessful results of investments in performance management and HMIS?

5. Is the utilization of these systems and activities routine? Who is using them, and how? If not, why not?

6. What would you recommend to improve the usefulness of HMIS and performance management in your area of responsibility?

Evaluation Question 5: What are the most significant accomplishments, best practices, and lessons learned from the SSDI-Services activity? Explicitly identify and document the facilitating and inhibiting factors to positive performance for each of the above questions.

1. Overall did the SSDI service project activities meet your expectations? Why (explain)? or why not (explain)?

2. Would you please describe any best practices or lessons learned from SSDI Services?

3. Do you have any final remarks or questions?

Thank you very much for your participation, etc.

D-Instrument: Self-Assessment Questionnaire (Likert)
Stakeholder**:** SSDI implementers and partners

For the evaluation team to fill out:		
Site:	Respondent Sex (M/F):	Respondent ID/Number:

****

PART A: Please circle the number of the stakeholder group that you belong to:

SSDI staff (JHPIEGO, CARE, PLAN, Save the Children)	1
Health Care Provider	2
Trainer of Trainer, Trainer, Mentor, or Supervisor	3
HMIS Staff	4
Donor (USAID)	5
Ministry of Health Official/Administrator	6
Other (Please write) :	7

PART B: For each question, please circle the number that best matches your answer (1, 2, 3, 4 or "I don't know"):

Topic: Quality of Care (Evaluation Question 1)

Within the last 5 years, to what extent has SSDI services improved the **quality** of care for family planning services at targeted health facilities?

1	2	3	4	5
"not at all"	"a little"	"moderately"	"a lot"	"I Don't Know"

1. Within the last 5 years, to what extent has SSDI services improved the **quality** of care for maternal and neonatal health at targeted health facilities?

1	2	3	4	5
"not at all"	"a little"	"moderately"	"a lot"	"I Don't Know"

2. Within the last 5 years, to what extent has SSDI services improved the quality of care child health services at targeted health facilities?

1	2	3	4	5
"not at all"	"a little"	"moderately"	"a lot"	"I Don't Know"

4. Within the last 5 years, to what extent has SSDI services improved the **quality** of care for nutrition services at targeted health facilities?

1	2	3	4	5
"not at all"	"a little"	"moderately"	"a lot"	"I Don't Know"

5. Within the last 5 years, to what extent has SSDI services improved the **quality** of care for malaria services at targeted health facilities?

1	2	3	4	5
"not at all"	"a little"	"moderately"	"a lot"	"I Don't Know"

6. Within the last 5 years, to what extent has SSDI services improved the **quality** of care for HIV/AIDS services at targeted health facilities?

1	2	3	4	5
"not at all"	"a little"	"moderately"	"a lot"	"I Don't Know"

Topic: Access to Care (Evaluation Question 2)

7. Within the last 5 years, to what extent has SSDI services improved **access** to family planning in the target health facilities?

1	2	3	4	5
"not at all"	"a little"	"moderately"	"a lot"	"I Don't Know"

8. Within the last 5 years, to what extent has SSDI services improved **access** to maternal and neonatal health in the target health facilities?

1	2	3	4	5
"not at all"	"a little"	"moderately"	"a lot"	"I Don't Know"

9. Within the last 5 years, to what extent has SSDI services improved **access** to child health in the target health facilities?

1	2	3	4	5
"not at all"	"a little"	"moderately"	"a lot"	"I Don't Know"

10. Within the last 5 years, to what extent has SSDI services improved **access** to child health services in the target health facilities?

1	2	3	4	5
"not at all"	"a little"	"moderately"	"a lot"	"I Don't Know"

11. Within the last 5 years, to what extent has SSDI services improved **access** to nutrition services in the target health facilities?

1	2	3	4	5
"not at all"	"a little"	"moderately"	"a lot"	"I Don't Know"

12. Within the last 5 years, to what extent has SSDI services improved **access** to malaria services in the target health facilities?

1	2	3	4	5
"not at all"	"a little"	"moderately"	"a lot"	"I Don't Know"

13. Within the last 5 years, to what extent has SSDI services improved **access** to HIV/AIDS services in the target health facilities?

1	2	3	4	5
"not at all"	"a little"	"moderately"	"a lot"	"I Don't Know"

Topic: Capacity for Service Delivery (Evaluation Question 3)

14. As a result of SSDI-Services, to what extent does the MOH routinely use the Training-of-Trainers as part of ensuring quality service delivery for EHP (Essential Health Package)?

1	2	3	4	5
"not at all"	"a little"	"moderately"	"a lot"	"I Don't Know"

15. As a result of SSDI-Services, to what extent does the MOH routinely use Mentoring as part of ensuring quality service delivery for EHP (Essential Health Package)?

1	2	3	4	5
"not at all"	"a little"	"moderately"	"a lot"	"I Don't Know"

16. As a result of SSDI-Services, to what extent does the MOH routinely use the Quality Assurance Supervision as part of ensuring quality service delivery for EHP (Essential Health Package)?

1	2	3	4	5
"not at all"	"a little"	"moderately"	"a lot"	"I Don't Know"

Topic: Capacity for data-driven decision making (Evaluation Question 4)

17. As a result of SSDI-Services, to what extent does the MOH now collect and utilize routine service delivery data to make decisions?

1	2	3	4	5
"not at all"	"a little"	"moderately"	"a lot"	"I Don't Know"

PART C: Please answer in your own words the following questions:

18. What were the biggest achievements and the best practices of SSDI-Services?

Achievements:_____
_____
_____

Best practices_____
_____

19. What were the biggest challenges of designing, implementing, and managing SSDI-Services activities?

_____
_____
_____
_____

E-Instrument: Perceptions of Care Survey

Stakeholder: Consumers

*SCRIPT: We would like your personal opinion on **changes** in various health services in Malawi since the SSDI Services program began. There are three parts to this survey and it should take about 30 minutes to complete.*

Your personal observations and perceptions are anonymous and you can never be associated with them because they will be entered into a large database with many other opinions. We will only ask your sex and age.

Participating in this survey is voluntary. You will not receive any compensation for participating in the survey. You will also not be punished if you decline to participate. At any time you can refuse to answer a question or stop participating altogether.

Your personal opinion is extremely valuable for evaluating SSDI's services performance over time. Kindly be as frank as you can so that health services for all Malawians can be its very best. Please say "yes" if you would like to take part in this survey.

Zikomo kwambiri!

For the evaluation team to fill out:			
Site District:	Respondent Sex (M/F):	Age:	Respondent ID/Number:

PART A (Service Usage):

1. Please indicate which of the following health services you or your family have ever received from this facility:

=1 Malaria

=2 Maternal, Neonatal and Child Health

=3 Family Planning

=4 HIV/AIDS

=5 Nutrition

=6 Water, hygiene and sanitation

=7 Infant vaccinations

=8 Bed nets for malaria

=9 Malaria treatment

=10 Birth outside the home with medical assistance

=11 Prenatal care

=12 Postnatal care

=13 Water and sanitation: soap/protection of water and food/latrines

=14 Nutrition education

=15 Vitamin A

=16 Other (Please name)

2. In the last 5 visits, were you able to receive the service you came for each time? Say "yes" or "no."

Yes	No

PART B (Likert Scale): *SCRIPT: Think about the services that you receive from this facility, or from the community based workers from this facility. Based on your last visit, please indicate how much you agree with the statements.*

Quality of Care

3. The people I went to for services spent enough time with me.

1	2	3	4

"not at all"	"a little"	"moderately"	"a lot"

4. I was given information about different services that were available to me.

1 "not at all"	2 "a little"	3 "moderately"	4 "a lot"

5. I was given enough information to effectively handle my problems.

1 "not at all"	2 "a little"	3 "moderately"	4 "a lot"

6. In general, I was satisfied with the quality of care that I received from this facility.

1 "not at all"	2 "a little"	3 "moderately"	4 "a lot"

7. My health status has improved as a result of coming to this facility.

1 "not at all"	2 "a little"	3 "moderately"	4 "a lot"

8. In general, this health facility is able to meet the needs of women in my community.

1 "not at all"	2 "a little"	3 "moderately"	4 "a lot"

9. In general, this health facility is able to meet the needs of men in my community.

1 "not at all"	2 "a little"	3 "moderately"	4 "a lot"

10. In general, this health facility is able to meet the needs of people with disabilities in my community.

1 "not at all"	2 "a little"	3 "moderately"	4 "a lot"

Access to Care

11. It is easy for me to get to this facility to receive quality care.

1	2	3	4
"not at all"	"a little"	"moderately"	"a lot"

12. It is easy for me to access a health worker in my community.

1	2	3	4
"not at all"	"a little"	"moderately"	"a lot"

13. The staff at this facility explained things to me in a way that was easy for me to understand.

1	2	3	4
"not at all"	"a little"	"moderately"	"a lot"

14. It is easy for men from my community to access quality care at this facility.

1	2	3	4
"not at all"	"a little"	"moderately"	"a lot"

15. It is easy for women from my community to access quality care at this facility.

1	2	3	4
"not at all"	"a little"	"moderately"	"a lot"

16. It is easy for people from my community with disabilities to access quality care at this facility.

1	2	3	4
"not at all"	"a little"	"moderately"	"a lot"

PART C (Scorecard)

SCRIPT: In this part, we would like to know about how things used to be, compared to how things are now. Please think about when you used to go to a health facility 5 years ago. Now think about going to this health facility now. I am going to say some statements. For each status, please say whether you think things have become better, stayed the same, or become worse than five years ago. You can also say that you don't know.

No.	Question	BETTER	SAME	WORSE	Don't know
1	People are aware of when they should go to a health center.				
2	People are able to get to the hospital or health center when needed.				
	How is the quality of this care compared to				

	before?				
3	This health facility is able to meet the needs of the community.				
4	Community health workers are meeting the needs of the community, especially for women of childbearing age, or women with children less than 5 years of age				
	How is the quality of this care compared to before?				
5	People are able to access pregnancy and birthing support (e.g. midwife attendant when needed).				
	How is the quality of this care compared to before?				
6	People are able to access health services for their babies, infants and young children when needed.				
	How is the quality of this care compared to before?				
7	People are able to access contraception, other family planning methods and post-abortion services.				
	How is the quality of this care compared to before?				
8	People are able to access HIV/AIDS and TB services in their community.				
	How is the quality of this care compared to before?				
9	Women and men have equal access to good quality health services.				
	How is the quality of care for women compared to before?				
	How is the quality of care for men compared to before?				

10	People with disabilities have access to care. How is the quality of this care compared to before?				

F-Instrument: Focus Group Discussion using Participatory Scorecard

Stakeholder**:** Consumers, Community Action Groups (CAGs)

Consent Script

Thank you very much for coming today. My name is _[fill in]__ and I am working with an American company named DevTech. We are conducting a study to assess the impact of the ***SSDI program*** *[mention SSDI, Jhpiego, or other possible names by which participants may know the name]. We are gathering information about how the program has affected your community in order to make improvements to the program.*

You have been invited to participate in this group discussion because you may be able to provide information about changes in health in this community in the past 5 years. This interview will take about 1.5 hours of discussion.

Your participation is completely voluntary. You can choose not to participate now, or at any time. There is no penalty or problem if you choose not to participate. There are no known risks of participating in this activity, other than losing the time it will take. Should you feel uncomfortable with any question, you may refuse to answer it. You will not be paid to participate, and there are no direct benefits to you other than knowing your information may help the Malawian Government to improve its services in Malawi and to your community.

I encourage everyone to keep the conversation confidential out of respect for your neighbors here. We will not ask your name and so your answers will be anonymous to outsiders. We will only ask for your age because we need to reflect at the different age group needs. I also request your permission to record our conversation so that I can remember what was said.

Do you have any questions?

Do you agree to participate in the study? **(everyone must give a verbal answer) Yes No**

(if any say no, allow them to leave before proceeding)

Do you agree to let me record our conversation? **(everyone must give a verbal answer) Yes No**

(if anyone says no, allow them to leave, or do not record if large consensus to not record)

For the evaluation team to fill out:	
Community Name:	Name of Nearest Health Facility:

	FGD Participants Log		
#	Sex (M/F)	Age	Verbal Consent (Y/N)
1			

2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

Introductions:

SCRIPT: First, let's get to know each other… [facilitate group greetings, including name, number of years living in community, and any leadership positions held]

Instructions:

SCRIPT: I am going to ask about certain topics, and for each one, please tell me whether you feel the situation has gotten ***worse,*** *gotten* ***better****, or* ***stayed almost the same*** *as in the last 5 years. I expect that some of you may not fully agree on each thing, and that is OK. These questions ask for your own personal perceptions, and there are no right or wrong answers. Each person's perspective is valuable to us, so please feel free to speak your mind.*

PART 1: GENERAL DISCUSSION (45 minutes) *SCRIPT: I'd like us to discuss the quality of health services and health information in your community in the last 5 years.* Note to facilitator: lead a discussion that hits some of the following topics. Probe only if necessary. Do not ask too many questions, rather allow the participants to discuss among themselves.

1. What health services do you receive from your health facility and/or the community health worker?
2. Do you know of any changes in recent years to community practices of visiting health centers when one is feeling unwell? Please explain the changes
    a. Probe: Would you say that the positive/negative changes are peculiar to specific health services only? What would be the explanation for that?
    b. Have you experienced any changes in how the facilities attend to community members when you visit them? Please explain
3. How did the changes positive/negative come about?
    a. Probe: Are there any elements at the community level responsible for the positive/negative changes you have mentioned?

4. Do you think that there are specific groups of people that have been mainly affected by the positive/negative services? Would you explain?

5. What improvements would you still make going forward to reach a satisfactory level of receiving care from the health facilities?

PART B: SCORECARD EXERCISE (45 minutes)

The below questions are asked and voted upon using the flipchart. Draw a happy face to mean "better," a neutral face to mean "same," and a sad face to mean "worse."

No.	Question	BETTER	SAME	WORSE
1	People are aware of when they should go to a health center.			
2	People are able to get to the hospital or health center when needed.			
	How is the quality of this care compared to before?			
3	This health facility is able to meet the needs of the community.			
4	Community health workers are meeting the needs of the community, especially for women of childbearing age, or women with children less than 5 years of age			
	How is the quality of this care compared to before?			
5	People are able to access pregnancy and birthing support (e.g. midwife attendant when needed).			
	How is the quality of this care compared to before?			
6	People are able to access health services for their babies, infants and young children when needed.			
	How is the quality of this care compared to before?			
7	People are able to access contraception, other family planning methods and post-abortion services.			
	How is the quality of this care compared to before?			
8	People are able to access HIV/AIDS and TB services in their community.			
	How is the quality of this care compared to before?			
9	Women and men have equal access to good quality health services.			
	How is the quality of care for women compared to before?			
	How is the quality of care for men compared to before?			
10	People with disabilities have access to care.			
	How is the quality of this care compared to before?			

TIPS FOR FACILITATOR: Probes to promote general discussion:

- ✓ Do you agree with this view?
- ✓ Why do you think so?
- ✓ Can you give an example of why you think this?
- ✓ Is there any part that has improved? Has become worse?
- ✓ Ending question for each item ask: Is there consensus on which category I should use? Mark the number of votes for each topic on the flipchart.

Thank and end here.

ANNEX 4. PEOPLE CONSULTED

Key Informant Interviews at Zonal and District levels
North Zone
Dr. Owen Musopole, Zonal Supervisor Northern Zone
Chitipa DHO-HMIS
Chitipa DHMIS Officer
Chitipa FP Coordinator
Chitipa Plan Representative
Chitipa District Family Planning Programme Officer
Mr. Selemani, Chitipa District Nursing Officer
Karonga: Health care provider and HMIS staff
Samuel Longwe North Zonal M&E Officer Ministry of Health Mzuzu
Central East Zone
Dr. Sosten Lankhulani, DHO Nkhotakota
Tifa Ngoma, NASO Executive Director, Nkhotakota
NASO Programme Officer, Nkhotakota
Nkhotakota: District HMIS Officer
Nkhotakota District Malaria Programme Officer
Happy Manda, Nkhotakota District Quality Assurance/ PBI Programme Officer
Salima: Lab Technician
Mezuwa Banda, Nutrition Coordinator Nkhotakota
Maclean Mphenzi, District Malaria Coordinator, Nkhotakota
Central East Zonal HMIS officer MoH
Central West Zone
Stella Misomali, HMIS Officer Lilongwe DHO
Dr. Evelyn Chitsa Banda Central West Zonal Supervisor, Lilongwe
Bwaila Hospital Nursing Officer
Dowa: DHO
District HMIS /M&E Officer for Lilongwe
Kasungu HMIS Officer
South East Zone
Dr. Dickson Mabulu, DMO-Balaka
Alinafe Mangulenje Zonal Nursing Officer–Zomba
Andrew Nkhoma, Programme Coordinator Safe Motherhood
Sabola. HMIS-Balaka
SE Zonal supervisor-Zomba
Christabel Namondwe SSDI-S team leader for Balaka
Thoko Bema, Zonal manager for Save the Children

South West Zone
Dr. Alexander Chijuwa DHO Nsanje
Dr. Malangizo Mbewe, Zonal Officer-Blantyre
Stony Makunganya District Community Coordinator–Nsanje
District HMIS Officer–Nsanje
Coordinator–Safe motherhood Nsanje
District Nursing officer Nsanje
Felix Monia Health service Administrator Nsanje
Safe-Motherhood Coordinator Nsanje
South West Zone Office
Dr. A Majidu, DHO-Chikwawa

Group Interviews with HF providers, Consumers Survey, FBGs and Community Score Cards
North Zone
Chitipa District
Kapenda health centre staff
Nthalire health centre staff
Karongo District
Kapenda health centre staff
Fulira health centre staff
Wiliro health centre staff
Central East Zone
Nkhota Kota District
Dwambadzi health centre staff
Ngala health centre staff
Salima District
Thavite health centre staff
Maganga health centre staff
Dowa District
Bowe health centre staff
Kasese health centre staff
Central West Zone
Kasungu District
Bua health centre staff
Simulemba health centre staff
Lilongwe District
Mitundu rural hospital staff
Khongoni health centre staff
South East Zone

Phalombe District
Nambazo health centre staff
Gogo Nazombe health centre staff
Mangochi District
Nankumba
Katula
Machinga District
Nyambi
Mkwepele
Balaka
Mbela health centre staff
Kalembo health centre staff
South West Zone
Nsanje District
Nsanje DH staff
Masenjere health centre staff
Chikwawa District
Chapananga health centre staff
Ndakwera health centre staff

Key Informant Interview–Stakeholders and Implementing Partners at Central Level
Ministry of Health
Maganizo Monawe, CMED, Technical Advisor MoH
Felix Pensulo, Director of Nutrition, Department of Nutrition, HIV and AIDS
Dr. Henry Ndindi, Deputy Director of Clinical Services-Curative
Mrs. Rose Nyirenda, Director of HIV/ AIDS Department
Rhino Mchenga, CMED, Acting Head (MoH)
Egley Chirwa, Central East Deputy Zonal Supervisor MoH
Senior Nursing Officer, MoH, Lilongwe
Safe Motherhood Coordinator, MoH, Lilongwe
Dr. Jane Namasasu, Central Zonal Supervisor, MoH, Lilongwe
USAID
Peter Halpert, Health Office Director
Chimwemwe Chitsulo, M&E Specialist USAID Malawi
Ms. Evelyne Zimba, AOR SSDI-Services
Violet Orchardson, Nutrition Advisor, USAID
JHPIEGO
Dan Wendo, Chief of Party
Deliwe Malema, Deputy Chief of Party

Lolade OSENI, M&E M&E Director
William Twahirwa, PBI advisor
SAVE THE CHILDREN
Catherine Mkangama, Snr. Technical Nutrition Advisor
PLAN
Chitipa, Plan Representative
CARE
Rose Tchwenko, Assistant Country Director CARE.
DEVTECH
Carol Shepard, TL Communication Component Evaluation
Iain McLellan, Community Mobilization Specialist, Communication Component Evaluation
Franck, SSDI System Component Evaluation

ANNEX 5. DOCUMENTS AND SOURCES REVIEWED

1. Government of Malawi, SSDE Quarterly Progress Report FY 2012: Quarter 1: October 1, 2011–December 31, 2011: USAID and Ministry of Health, Lilongwe.
2. Government of Malawi, SSDI- PBI Program Updates USAID/Ministry of Health. March 31, 2015. Lilongwe.
3. Government of Malawi. SSDE-Quarterly Progress Report FY 2013 Year 2 Quarter 3 Progress Report (April 1, 2012–June 30, 2012). USAID and Ministry of Health, Lilongwe.
4. Government of Malawi. SSDE-Quarterly Progress Report, SSD-E Quarterly Report, FY 2013 Year 2 Quarter 3 Progress Report (April- June 2013), USAID and Ministry of Health, Lilongwe.
5. Government of Malawi. Support for Service Delivery Integration-Services (SSDI-Services), Quarterly Progress Report, FY 2012-Quarter 2: January1, 2012–March 31, 2012, USAID and Ministry of Health, Lilongwe.
6. Jhpiego Database for Selected Best and Poor performing facilities in 13 SSDI Districts.
7. Jhpiego, SSDI Services Evaluation, List of Facilities with utilities and interventions.
8. Jhpiego, SSDI Services Evaluation, List of Key Stakeholders National.
9. Jhpiego, SSDI Services Evaluation, List of Key Stakeholders, Central East Zone.
10. Jhpiego, SSDI Services Evaluation, List of Key Stakeholders, Northern Zone.
11. Jhpiego, SSDI Services Evaluation, List of Key Stakeholders, South East Zone.
12. Jhpiego, SSDI Services Evaluation, List of Key Stakeholders, South West Zone_Rev.
13. Jhpiego, SSDI Services Evaluation, List of Other Trainers of Trainers.
14. Jhpiego, SSDI Services Evaluation, List of Trainers of Trainers, Central West Zone.
15. SSDI End of Project Final Report 2014.
16. SSDI Performance Monitoring and Evaluation Plan for support for Service Delivery Integration-(SSDI-Services) Project; Malawi USG Partner: Jhpiego, Time Period Covered: November 2011–September 2016.
17. SSDI-Performance Monitoring and Evaluation Plan For Support for Service Delivery Integration-Services (SSDI-Services) Project, Malawi USG Partner: Jhpiego, Time Period Covered: November 2011 to September 2016.
18. SSDI-Services FY 2013 PMP Indicators and Targets.
19. SSDI-Services FY2013 Annual Progress Report (October 2012-September 2013).
20. SSDI-Services Results on Key Indicators; M&E Monthly Bulletin (FY 2012 Issue No.3, USAID–SSDI, April 2012–September 2012).
21. SSDI-Services Results on Key Indicators; M&E Monthly Bulletin (FY 2013: Issue No.4, USAID–SSDI, October 2012).
22. SSDI-Services Results on Key Indicators; M&E Monthly Bulletin (FY 2015 Issue No.5, USAID–SSDI, October 2012–November 2012).
23. SSDI-Services Results on Key Indicators; M&E Monthly Bulletin (FY 2013 Issue No.6, USAID–SSDI, October 2012–December 2012).
24. SSDI-Services Results on Key Indicators; M&E Monthly Bulletin (FY 2013 Issue No.7, USAID–SSDI, October 2012–January 2013).
25. SSDI-Services Results on Key Indicators; M&E Monthly Bulletin (FY 2013 Issue No.10, USAID–SSDI, October 2012–April 2013).

26. SSDI-Services Results on Key Indicators; M&E Monthly Bulletin (FY 2013 Issue No.12, USAID–SSDI, October 2012–June 2013).
27. SSDI-Services Results on Key Indicators; M&E Monthly Bulletin (FY 2013 Issue No.13, USAID–SSDI, October 2012–July 2013).
28. SSDI-Services Results on Key Indicators; M&E Monthly Bulletin (FY 2013 Issue No.14, USAID–SSDI, October 2012–August 2013).
29. SSDI-Services Results on Key Indicators; M&E Monthly Bulletin (FY 2013 Issue No.15, USAID–SSDI, October 2012–September 2013).
30. SSDI-Services Results on Key Indicators; M&E Monthly Bulletin, (FY 2012 Issue No. 2, USAID–SSDI, April 2012–August 2012).
31. SSDI-Services Results on Key Indicators; M&E Monthly Bulletin, FY 2012 Issue No. 1, USAID–SSDI, July 2012.
32. SSDI-Services Self-Assessment and Rapid Situation Analysis Report, MOH, USAID, SSDI, June 2012.
33. SSDI-Support for Service Delivery Excellence (SSD-E) Program Description-ATTACHMENT B.
34. USAID Inception Report AID 612-TO-16-00003 SSDI Activities (Services) Evaluation, Submitted by: DevTech Systems, Inc., July 19, 2016.
35. USAID, Request for Applications (RFA) Number 674-10-0051 Support for Integrated Service Delivery: Southern Africa, August 2010.
36. USAID. Support for Service Delivery Integration Services Program Year Three Work Plan October 2013-September 2014 October 2013-September 2014.
37. USAID. Support for Service Delivery Integration SSDI-Services, Progress Report FY2013 Year 2: Quarter 2 (January–March 2013).
38. USAID/Malawi, Support for Service Delivery Integration Services Program, Year Two Work Plan October 2012-September 2013, (Submitted August 31, 2012-Resubmitted November 15, 2012).
39. USAID/Malawi, Support for Service Delivery Integration Services Program, Year Three Work Plan October 2013-September 2014 (Submitted October 23, 2013).
40. USAID/Malawi, Support for Service Delivery–Excellence (SSD-E) Program, Year One Work Plan, October 2011-September 2012 (Submitted February 8, 2012).