Evaluation of the Health Institution Capacity Assessment Process (HICAP)

For: Concern Worldwide

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Contents

Table of figures

Acronyms

ADC	Area Development Committee
AEC	Area Executive Committee
CCPW	Community Child Protection Worker
CDA	Community Development Assistant
CDO	Community Development Officer
DCDO	District Community Development Officer
DEC	District Executive Committee
DHO	District Health Office
EHO	Environmental Health Officer
FBO	Faith Based Organisation
FGD	Focus Group Discussion
FIM	Food Income Markets
GVHM	Group Village Headman
HICAP	Health Institution Capacity Assessment Process
MIS	Management Information System
MoGCSW	Ministry of Gender, Child and Social Welfare
MoH	Ministry of Health
MoLG	Ministry of Local Government
MP	Member of Parliament
MRH	Maternal and Reproductive Health
NAC	National AIDS Commission
NASO	Nkhotakota AIDS Support Organisation
NGO	Non-Governmental Organisation
SSI	Semi Structured Interview
SWAM	Society for Women and AIDS in Malawi
SWOT	Strengths, Weaknesses, Opportunities, Threats
TA	Traditional Authority
TLC	Total Land Care
ToR	Terms of Reference
U5	Under Five
VDC	Village Development Committee
VHC	Village Health Committee
VHM	Village Headman

Executive Summary

The purpose of this consultancy was to review the effectiveness, efficiency, relevance, accuracy and sustainability of the Health Institution Capacity Assessment Process (HICAP), a self-assessment tool based on the appreciative inquiry process.

In three Traditional Authorities of Nkhotakota District, Concern Worldwide implements the HICAP with 58 Village Development Committees (VDC), a community governance structure mandated by Malawi's 1998 Decentralisation Policy to oversee all community development initiatives. HICAP is used to both strengthen their capacity to improve community health outcomes, and to promote greater community participation and empowerment in order to support inclusive development activities.

After an initial 3-day training from Concern, VDCs conduct self-assessments every 6 months, scoring themselves on five main capacity areas and their sub-components, all of which are based on their prescribed roles in Government policy. These scores are collated by Concern into a central database (the HICAP database). Capacity building is then provided by Concern staff during six-monthly review meetings or, ideally, on an on-going basis by Government extension workers from the Ministry of Health or Ministry of Gender Child and Social Welfare.

For this assignment, a literature review was conducted as was an analysis of the HICAP database, prior to primary and predominantly qualitative data collection. The latter included 32 interviews with Concern staff, Government officials, extension workers, VDC members, community leaders and community members.

Overall, the response to the HICAP was positive from all parties. It is considered relevant and useful to the work of the VDCs, and specific examples were given of its positive impact on community health outcomes as well as its role in reinforcing more representative participation of community members and in reinforcing the Government's decentralisation agenda. However, some key areas for reform were identified, notably the need to support the VDCs through election cycles (VDC members are elected by their communities every 3 years, according to Government policy); and the need to enable them to secure sustainable funding to finance their plans and activities. Furthermore, the heavy reliance on extension workers to conduct the majority of capacity building and support to the VDCs is a concern, given their resource and time constraints.

With the MRH programme due to end in March 2016, Concern is developing an exit strategy to ensure the sustainability of gains made to date, including those resulting from the HICAP process. The recommendations in this report therefore address the questions in the ToR, with particular emphasis on securing a sustainable and efficient handover of the HICAP.

For an effective handover of the HICAP, these include:

- Engagement with key line ministries as early as possible, particularly at district level to define roles and responsibilities;
- Using the next round of self-assessments and review meetings (scheduled for November/December 2015) as part of the handover process;
- Easing resource constraints for implementation by Government, potentially through a 'waterfall' training of trainers approach, and involving better performing VDCs in training provision;
- Considering a third party, potentially and NGO or CBO to ensure resources for continued implementation.

To enable the HICAP to better support VDCs fulfil their roles:

- An additional component should be added to the HICAP around proposal writing and lobbying for resources and on post-election handover procedures;
- An additional field in the HICAP database should be added to capture dates of assessments and thereby enable more detailed analysis;
- Consideration should be given to the expansion of the HICAP to Village Health Committees and how this would be resourced;
- Capacity areas 1 and 2 could be amended to make explicit mention of the inclusion of the extreme poor, disabled, elderly and other vulnerable or marginalised groups.

1 Introduction

1.1 Programme Context

The Health Institution Capacity Assessment Process (HICAP) is implemented as one component of the Maternal and Reproductive Health (MRH) Programme (2013-2016). The programme is designed to reduce maternal morbidity and mortality through the following strategic objectives, of which the HICAP falls under the third:

1. Improved utilization of high quality MRH services through increased availability and accessibility of services;
2. Improved utilization of high quality community-based family planning services, including youth friendly reproductive health through increased availability and accessibility of services;
3. Improved Government and traditional leadership structures and community members to plan, manage, support and monitor key maternal and reproductive health activities.

The programme is implemented in three of Nkhotakota's seven Traditional Authorities (TA): Mwansambo, Malengachanzi and Mwadzama. In total, Concern implements the HICAP (and other programme components) with 58 Village Development Committees (VDC) in these TAs.

With the MRH programme due to end in March 2016, Concern is developing an exit strategy to ensure the sustainability of gains made to date, including those resulting from the HICAP process.

1.2 Introduction to VDCs and their role in Malawi

Under the 1998 Decentralisation Policy, VDCs are mandated to coordinate community-based development activities and represent their communities and their needs at Area Development Committees (ADC), a district level governance structure. Their membership, elected every 3 years by community members, consists of a prescribed number of community members, ward representatives and extension workers, with Chiefs taking an advisory role and minimum quotas for women's membership. Annex 7.4 details the functions and membership of the VDC in more detail.

1.2.1 VDCs and the decentralisation process

Malawi's Constitution and the 1998 Local Government Act devolves political and administrative authorities to Local Government units, with democratic oversight from elected local councils and popular participation in development planning processes. However, in 2005 the decentralisation process effectively stalled when Local Council elections were cancelled. Political authority was re-centralised over

the next decade or so while administrative functions were deconcentrated to Local Government, with limited supervision or oversight.

VDCs became relatively weak structures in terms of their ability to impact community development, and were chaired by Chiefs with limited community participation (contravening Government policy).

Over the past few years, Government has revived the decentralisation process and, as such, VDC elections were held in Nkhotakota district in 2014 and 2015. A process of community sensitisation took place first, to ensure that the expected membership and mandate of the VDCs was understood, and to encourage people to vote and to stand for election.

The VDCs (including those with whom Concern works) are therefore pre-existing committees, who fall under the mandate of the Ministry of Local Government (MoLG). It should be noted that in the TAs in which Concern works, there are more than the 58 VDCs with whom they work. Many are newly formed since the 2014/2015 elections: it was decided in many cases that the geographical areas covered by VDCs were too large and therefore they sub-divided.

1.2.2 VDCs and community health

With a mandate for all community development activities, VDCs engage in and instigate initiatives to improve community health outcomes. VDCs oversee sector-specific sub-committees for the villages which they cover. In the case of the health sector, this is the Village Health Committee (VHC) and, as such, there are usually multiple VHCs under one VDC. Their activities overlap in practice but the decision to implement the HICAP with VDCs is largely a practical one, given the volume of VHCs and time and resource limitations to effectively work with them all.

Ministry of Health (MoH) extension workers, namely Health Surveillance Assistants (HSAs) work both with VDCs and VHCs, and effectively use their members as another layer of extension workers, in the sense that they can reach further into a greater number of villages than just one HSA. Their work tends to focus on surveillance for malnutrition and the incidence of disease, health messaging and education on the importance of using health services, and sanitation and nutrition. Much of this focusses on maternal and child health.

[i] In some cases, VDCs (and reportedly Area Development Committees (ADC)), are reinforcing Government/MoH messages by passing by laws and fining those who don't comply – such as women who stay at home for their delivery against Government advice to deliver in a clinic.[ii]

1.2.3 Support for VDCs, aside from the HICAP

Concern provides technical training to VDC members on key health issues, including nutrition and maternal and under 5 health. It has also supported some VDCs to open bank accounts to hold maintenance funds as a pre-condition for the donation of bicycle ambulances that the VDCs manage (the demand for this has been so high that it is being extended to more VDCs as funding becomes available).

Support from Government is primarily provided through extension workers. In the case of the health sector, these are mostly from the Ministry of Gender Child and Social Welfare (MoGCSW) and the Ministry of Health (MoH) and include Community Child Protection Workers (CCPW), Community Development Assistants/Officers (CDA/CDO) and Health Extension workers (HSAs) respectively.

Extension workers carry out the mandate of their line Ministries, disseminating messaging and implementing programmes at the community level, often through the VDCs and their sector-specific sub-committees. In theory, they should provide regular trainings and capacity building, and support VDCs prepare, resource and implement their plans for community development activities. However, as will be discussed in more detail below, there are many limitations to this support due to a lack of funds and staffing gaps.

From observations and the responses of interviewees, there seems to be no other systematic support from Government or non-Government sources to build the capacity of VDCs or support the implementation of their plans.

1.2.4 Financing VDC activities

Financing of VDCs is mostly done through community fundraising, organised in collaboration with Chiefs and Village Headmen (VHM), or members' own contributions. In theory, VDCs can lobby for funding from the Area Development

[i] Nkhandwe VDC Chair and Secretary to the Village Headman during SSI

[ii] Malawi has a plural system of law, in which a common law system exists alongside the more informal customary law adjudicated by local chiefs. Customary laws are unwritten laws that are not strictly legally binding but are enforceable at the community level. Family and land law adjudication in rural areas is often left in the hands of Chiefs, while the legislature is responsible for criminal law and human rights matters. It is not clear if VDCs are fully mandated to autonomously pass and enforce customary laws of the kind described here.

Committee (ADC), Councillors and Members of Parliament (MP), and should be able to lobby for funds through sources such as:

- Malawi Social Action Fund (MASAF)[iii];
- Community Development Funds (controlled by MPs);
- Local Development Fund (although this is mainly used to pay salaries for piece-work, such as road and bridge maintenance);
- Existing transfers from line ministries.

In practice, this does not seem to be happening, as discussed in Section 3, below.

1.3 Overview of the HICAP tool

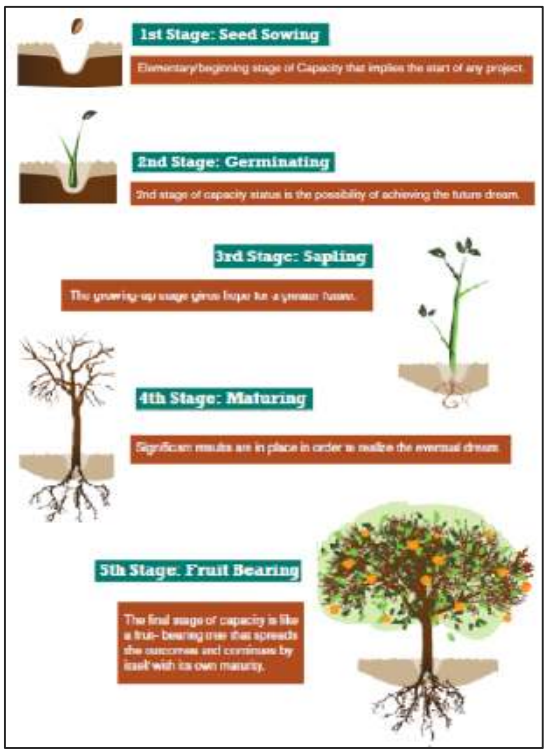
The HICAP is a self-assessment tool based on the appreciative inquiry process. It is used to both strengthen the capacity of community governance structures, and to promote greater community participation and empowerment in order to support inclusive development activities.

The application of the HICAP has expanded from Bangladesh, where it was first implemented as part of Concern's Child Survival Programme, starting in 2000. It was adapted for capacity building among Village Development Committees in Malawi in 2009 and implemented in 2010-2013 under a community health and nutrition programme in Nkhotakota district (the predecessor to the current MRH programme). It is also being implemented with Health Management and Ward Development Committees in Sierra Leone.

The HICAP tool consists of five capacity areas, based on the roles and responsibilities established in the Decentralisation Policy: Participatory planning; Leadership (governance); Resource mobilisation and management; Collaboration and coordination, and Monitoring and evaluation.

[iii] The Malawi Social Action Fund (MASAF) is a social investment programme (SIF) that provides funds for District government and communities to invest in roads, health centres, schools, and income-earning activities. - See more at: http://www.itad.com/projects/masaf-iii-third-social-action-fund-impact-evaluation/#sthash.NuXkDUzC.dpuf

FIGURE 1: AN ANALOGY OF THE HICAP TOOL'S 5 LEVELS OF CAPACITY TO THE STAGES OF A GROWING TREE[iv]



Each capacity area has two or three sub-components, the scores for which are between one (lowest) and five (highest) and are defined by possibility statements in the Self-Assessment Tool, a matrix provided to all VDCs to use in the self-assessments. This leads to an average score for each capacity area, and for the Committee overall.

An analogy of the five levels is made to a growing tree, as depicted in Figure 1, to help participants relate to the new 'scoring' concept.

The subcomponents of each capacity area are summarised in Annex 7.5 and the self-assessment tool is provided in Annex 7.6.

1.4 Implementation of the HICAP in Malawi

An initial three-day training by Concern introduces the HICAP to VDCs (including extension workers) and teaches them to conduct self-assessments. It may also be attended by representatives of the TA and district authorities, if it is thought helpful for them to understand the process and/or if they can usefully contribute. The initial training also covers broader areas, such as the importance of health in the community, how VDCs can promote better health through their work and their position and role within the decentralised governance structure.

At the end of these three days, the VDCs conduct their first self-assessments, scoring themselves on each sub-component of the five capacity areas, yielding an average for each capacity area and the VDC overall. From then on, the VDCs should conduct self-assessments independently every six months, to be followed by a review meeting with Concern to discuss and verify the scores. These scores are recorded in a central database, held and updated by Concern.

In the six-monthly review meetings, VDCs' plans and challenges are also discussed and support and advice is given by Concern staff, including on other aspects of the MRH programme. If any capacity needs are identified that require more time than just the review meeting to address, these are passed on to extension workers, particularly Community Development Assistants (CDAs), for

[iv] Adapted from Concern Worldwide, US, 2011. Breaking the Mould: A Toolkit for the Replication of an Effective Urban Health Model. New York.

follow up (an extension worker should be present at the review meeting, as per the VDC membership guidelines provided in Annex 7.4).

Under each VDC are a number of sub-committees, including the Village Health Committees (VHC). In theory there is one VHC for each village that the VDC covers although this is not always the case. Approximately three VHC members for each VDC are invited to attend the six-monthly assessments and review meetings. They are encouraged to share the findings from the meetings and to implement the HICAP with their Committee members, although Concern does not actively support or supervise them in this.

1.5 Purpose of the consultancy

The purpose of this consultancy was to review the effectiveness, relevance, and sustainability of the HICAP, and particularly its impact in strengthening health capacity and coordination of VDCs. This evaluation therefore answers the following questions, set out in the terms of reference (ToR), provided in Annex 7.1:

1. Process: What are the overall strengths and weaknesses of the HICAP process as perceived by VDCs and other stakeholders?
2. Accuracy: Are the HICAP self-assessment scores accurate reflections of increases in capacity? To what extent do the scores actually correlate to improvements in real-life capacity?
3. Relevance: Are the capacity areas measured relevant to VDCs' capacity-building needs?
4. Effectiveness: To what extent has the HICAP tool served to strengthen community capacity to plan and manage community health initiatives, and how has it done so?
    a. Is there evidence of improved VDC leadership capacity on health?
    b. Is there evidence of improved linkages between communities and the health system?
    c. What changes have community members, VDCs, or other stakeholders identified as a result of the HICAP process?
    d. Has the process been inclusive of the needs of the extreme poor, how are women's voices/ needs represented in the process?
    e. Has the process of capacity building of VDCs impacted on women's voice and representation at a community level?
5. Efficiency: Are resources used well? What needs to be done differently?
6. Sustainability:
    a. Are the improvements in capacity attained by the VDCs sustained over time, as members come and go through election cycles?
    b. What is the potential for the HICAP tool to be incorporated into Ministry of Local Government procedures within Nkhotakota District?
    c. While the evaluation will take place within the context of Concern Malawi's Nkhotakota district health programme, the evaluation will

generate learning that may be applied to other country programmes implementing the HICAP approach.

2 Methodology

2.1 Desk review and analysis of HICAP self-assessment scores

A desk review was first conducted in Lilongwe, including Concern project documents from both Malawi and Bangladesh; the HICAP tool and training guide; project reports and evaluations; literature on decentralised structures and capacities; Government policy relating to decentralisation and Local Government procedures and responsibilities; and literature on regional and international best practice to build capacity at the community level, particularly in the health sector. The findings of this review informed the development of the data collection tools, and the conclusions and recommendations of this report.

The HICAP database (which contains all VDCs' verified self-assessment scores for all components/sub-components) was then analysed to identify trends. The results of the analysis were triangulated with the findings from the primary data collection process to assess the accuracy and reliability of scores.

2.2 Primary data collection

The consultant spent 10 days in Nkhotakota conducting primary (mostly qualitative) data collection through a total of 32 interviews. Interviewees were selected by Concern staff, with locations selected randomly and a mix of VDC members, community members, Local Government representatives and extension workers chosen purposively within those location. The consultant was also able to request additional interviews to ensure there were no gaps.

Interviews were conducted in a mixture of English and Chichewa, depending on interviewees' preferences, with a transcriber present for both and a translator present in the case of the latter. Generally, focus group discussions were conducted in Chichewa and interviews with extension workers or Government officials were conducted in English.

The list of interviewees, including names, locations, job titles and institutions, as well as gender distribution within group interviews, are provided in Annex 7.3. The following list provides a summary:

- 2 semi structured interviews (SSI) with Concern staff
- 9 SSIs with Local Government staff (including extension workers)
- 3 SSIs with VDC/VHC chairs
- 2 focus group discussions (FGD) with village chiefs (a male and a female group)
- 6 FGDs with community members (1 of which was a female only group)
- 7 FGDs with 6 VDCs that had used the HICAP, including some VHC members (1 of which was female only, and one male only)
- 2 FGDs with VDCs that had not used the HICAP
- 1 FGD with a VHC member only group

[v], [vi]

The information from the desk review, database analysis and primary data collection were triangulated and analysed to develop the Findings, Conclusions and Recommendations Sections.

2.3 Limitations

During the primary data collection process, a number of limitations relating to the interpretation of the data became apparent:

1. In some group interviews, it was discovered that not all participants were from the expected demographic – e.g. in one VDC FGD a local chief (who was not a VDC member) also attended; in another, there seemed to be more than one VDC represented; and one community group included VHC members. This may have influenced people's responses;
2. Despite repeating the purpose of the evaluation and that it was not an assessment of any individuals or institutions, there was clearly still some nervousness. In some cases, answers given seemed to be what people thought were the "right" answers, rather than the most accurate. There were indications that this was influenced by an understanding (or a fear) that the MRH programme was coming to an end;

[v] Mankhwazi VDC Chairman and Vice Chairwoman 11th August 2015
[vi] Participatory Ranking Method with Chia VDC, 15th August 2015

3. Similarly, and particularly among groups not receiving the HICAP, some groups seemed to tailor their responses to show a need for more or continued support; and
4. Finally, given the integrated nature of Concern's work, it was very difficult for participants to distinguish the impact of HICAP from other aspects of the MRH programme or, indeed, from other Government or NGO interventions in the health sector.

To mitigate these factors, findings were triangulated and verified between various groups and careful note was taken where responses may have been influenced by such factors so that their responses could be analysed in light of this.

3 Findings

This section answers the questions set out in the ToR, as detailed above in Section 1.5 and Annex 7.1. Findings are based on the literature review, analysis of data in the HICAP database and primary data collection. Given that the responses to the ToR questions are interlinked, the findings are structured as follows:

- HICAP's role in strengthening VDCs' capacity to address community health needs;
- A discussion on the scoring process and self-assessment scores;
- The relevance of HICAP's capacity areas;
- The efficiency of resource allocation; and
- The sustainability of the HICAP after March 2016.

3.1 HICAP's role in strengthening VDCs' capacity to address community health needs

Almost unanimously, communities, local leaders and extension workers reported improvements in VDC leadership capacity and linked it to community health improvements since the introduction of the HICAP. A clear example that was repeated many times was that VDCs had previously understood development to mean infrastructure development, whereas since using the HICAP they are more aware of the need to support 'softer' (and more affordable/realistic) initiatives, such as health education. One HSA reported a reduction in the incidence of U5 diarrheal diseases and an increase in immunisation coverage, as supported by HMIS data trends since approximately 2012, and attributed this to VDC health educational activities.

VDCs were said to be more active and, in particular, more supportive of initiatives to improve maternal and child health by community members, extension workers and Concern staff. Since working with Concern, three VDCs have built an U5 shelter and one has built a house for the HSA as it realised that the previous HSAs left because of poor housing.

When compared with VDCs that were not using the HICAP, the VDCs with whom Concern works were far more conversant and knowledgeable about the health needs of their communities, whereas non-HICAP VDCs tended to respond by referring to the VHCs' role. Reinforcing this, when communities were asked what their health needs were during the data collection process, their answers tended to match what committee members reported in separate interviews to be VDC priorities.

In terms of their links with Village Health Committees (VHC), one extension worker stated that since the HICAP, VDCs were engaging more with VHCs, coordinating their plans and activities and meeting regularly which may strengthen the VHCs' role in providing leadership on community health issues, although this was not examined closely.

3.1.1 Support to and inclusion of vulnerable and marginalised groups by VDCs [vii]

Capacity areas 1 and 2 include aspects of inclusion of both community and committee members in decision making and planning. However, they do not make explicit mention of the extreme poor, disabled, or elderly, for example.

The HICAP reinforces gender balance, particularly in the initial three-day training in which the Government guidelines on VDC membership are covered. Interviewees, including extension workers and Concern staff, consistently responded that more women held VDC positions as a result of the elections and HICAP and that they were active in their roles. Women reported that by virtue of being elected, they felt that they had the respect of their male and female peers.

However, it was observed that women's participation varied greatly between VDCs during data collection. In the above picture, women are shown leading the voting process during a FGD participatory ranking exercise. However, in most FGDs, men dominated discussions, as per cultural norms, and women had to be prompted to contribute.

The clearest indication that the HICAP is supporting a better gender balance is given through comparison with non-HICAP VDCs, where fewer women were

[vii] Nkhongo FGD participatory ranking exercise on community health needs

seen in senior positions and none were reported to attend ADC meetings, as is the responsibility of the Chair and Vice Chair (of which at least one should be female).

In terms of the activities VDCs were conducting, some VDCs mentioned working with the elderly and HIV+ community members, but none mentioned the disabled or extreme poor without prompting. Maternal and child health interventions were usually given priority.

From a top-down perspective, though, it was reported by extension workers and Committee members that there is now a better flow of information on Government initiatives to the community level (e.g. reports on ADC meetings and policy) as VDCs are more transparent in communicating such things than the Chiefs/Village Headmen (VHM) were.

3.1.2 Maintaining VDC capacity gains through elections

Although not all members of the VDCs were replaced in the 2014/2015 elections, they did bring in a significant number of new members (and therefore the removal of old members). There were no reports of formal handovers, although the continued terms of some members mitigated the impact of this to an extent. Extension workers and Concern project staff both noted that they had to 'start again' with many VDCs in terms of capacity building.

While it was reported by some extension workers that the Government has developed training courses designed to induct new VDC members, a lack of funding and manpower meant these were not delivered. The topics covered under these trainings includes many aspects similar to the HICAP, such as:

- Decentralisation system;
- Leadership skills;
- Community participation in public works;
- Stages of the project cycle;
- HIV/AIDS and its impact on development; and
- Gender mainstreaming.

A handover meeting after elections, involving both old and new VDC members and a joint self-assessment, could mitigate the loss in capacity or at least speed up capacity gains. A handover process could also be incorporated into Capacity Area II: Leadership (Governance)

3.2 A discussion on the scoring process and the self-assessment scores

3.2.1 VDC's understanding and implementation of the scoring process

Almost all respondents, including VDCs' members and extension workers, said that the scoring process was relatively easy and that scores were accurate reflections of capacity. Most VDCs reported that they could do the entire assessment in 30 minutes to one hour. This seems very quick, considering that there are 14 sub-areas to score, each with a choice of five fairly detailed definitions of capacity (see Annex HICAP self-assessment tool7.6); it would allow only two to four minutes per discussion on each capacity sub-area and therefore may be an indication that the process isn't being conducted thoroughly or precisely.

When asked about the weaknesses of the HICAP, some interviewees (VDCs and extension workers) did say that scoring was a little complicated and that, at least in the first few assessments, people struggled with the tool. Considering that less than half of the VDCs have conducted four or more assessment, this is a significant period of time (see below, Section 3.2.3).

In some cases, sub-groups of VDCs were interviewed who contradicted their most recent assessment scores of just the previous week, which may be an indication that the scoring process was not fully inclusive (the final scoring is supposed to be a unanimous decision).

Finally, when questioned on the definition of their scores and the difference between this and, for example, the score they were aiming for, almost no respondents could provide a detailed or accurate response as to what the difference would be, i.e. they didn't know what improvements they were working towards. This brings into question how they identify and achieve capacity improvements reflected in VDCs' overall increasing scores.

3.2.2 Scores from the first assessments

All of the VDCs without exception scored themselves "1" in all capacity areas, including for all the sub-components, in their first (baseline) assessment. This is the lowest score and, broadly speaking, can be summarised as the VDC not fulfilling any of its core functions (for more detail, see the self-assessment tool in Annex 7.6).

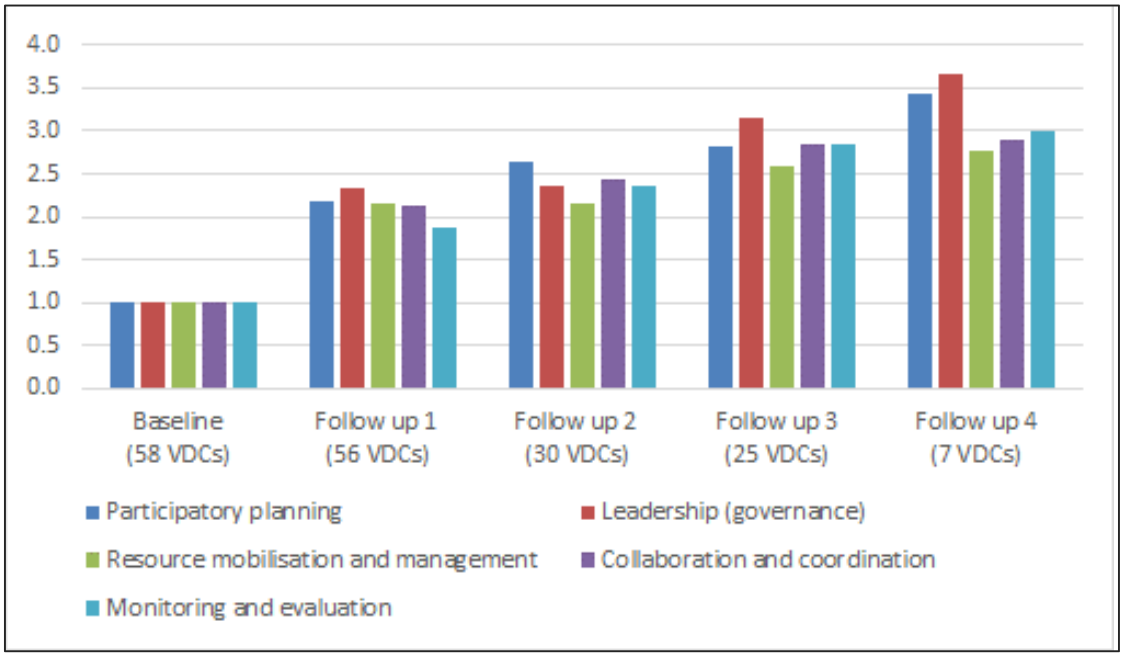
During the data collection for this report, VDCs who had never used the HICAP and were not receiving external support from Concern or any other agencies, were interviewed. Using these as a control group brings the unanimously low baseline scores into question. Those VDCs with no external support were clearly not as functional as those who had received support, but would not have scored 1. For example, they were able to produce annual plans, to articulate their roles and the needs of their communities, to share some examples of coordination with other

VDCs, and reported meeting regularly all of which would have scored them above 1, according to this HICAP definitions.

The baseline scores bring into question the VDCs' understanding of the scoring definitions and, further, whether there was an expectation on the part of the VDCs that they should start at the beginning (i.e. 1, in their understanding) and progress through to 5.

3.2.3 The trend in capacity improvements[viii]

FIGURE 2: AVERAGE SCORES OF EACH CAPACITY AREA OVER 5 ASSESSMENTS (BASELINE = 1ST ASSESSMENT)



As the above graph shows, the trend is generally of increasing capacity scores although it should be noted that the sample size decreases with each assessment. This is partly due to resource and time constraints faced by Concern staff, who are unable to visit all 58 VDCs every six months (each assessment can take up to one day). There may also be some bias towards more active groups maintaining engagement.

Capacity area 2: Leadership (governance) shows the greatest increases, with the average score increasing from 1 at the baseline, to 3.7 at the fourth follow up. There is no clear trend in terms of which of the sub-components scores highest, although the only score of 5 under this area is recorded for participatory decision making.

Capacity area 3: Resource mobilisation and management tends to lag behind the other areas slightly, with the average score increasing from 1 at the baseline, to 2.8 at the 4th follow up. Despite all VDCs stating that a lack of funds is their biggest

[viii] During the data collection process, some VDCs presented scores from assessments conducted in July and August. These are not included in the above analysis and they are not yet in the Database

challenge (sometimes expressed as a lack of means of transport, or another capital item), the sub-components of 'fundraising in annual plan' and 'other resource mobilisation' both score an average of 3 at the 4th follow up, with the capacity areas' overall average score being brought down by the sub-component on 'financial documentation and transparency'. This could be explained by the language in the scoring matrix focussing on the planning and preparation for fundraising, rather than the adequacy of funds raised.

Capacity areas 1, 4 and 5: Participatory planning; Collaboration and coordination, and Monitoring and evaluation all show steady upward trends. Collaboration and Coordination shows the slowest signs of progress amongst these, which may be related to a lack of funds (in this case manifesting as lack of transport), as it requires coordination with other bodies, such as other VDCs, VHCs, health extension workers (HSAs) and health clinics.[ix]

Although some VDCs do show ups and downs in their scores, on average all five capacity areas show an upward trend. It is certainly not infeasible that VDCs' capacities have increased over the period, however:

i. Despite seeming to be positive overall for the capacity and performance of the VDCs, the elections were reported to have been initially disruptive, with newly elected members not fully understanding their roles. In line with this, it would not be surprising to see some VDCs' scores dip immediately after elections. A calendar for the elections was not available - it is only known that they took place over approximately 12 months between 2014 and 2015. Assessment dates are similarly not listed in the database and therefore it was not possible to correlate the timing of elections with changes in capacity scores.

ii. There is a lack of clarity as to how exactly the capacity of VDCs is built to the extent shown by the data (and not just assessed) under the HICAP. Concern only provides minimal capacity building in the six-monthly review meetings and relies on extension workers to conduct training and follow up for any further needs. However, many extension workers commented that in observing FGDs or SSIs with VDCs, they were hearing the VDCs' needs for the first time. They also repeatedly discussed their own lack of funds and

[ix] The above speculation as to the causes behind changes in scores is based on observations of the VDCs sampled for primary data collection. It was beyond the scope of this consultancy to interview and review documentation from all 58 VDCs to identify the most/least common causes for changes among them.

resources as an impediment to providing more support and, those asked, reported that they were unable to implement any kind of systematic capacity building initiatives. [x]

iii. The upward trend, at least in the initial follow ups, could be partially attributed to overly-low baseline scores, as discussed above.

Despite these concerns, there certainly is value in the scores as well as in the process of self-assessment and the opportunities it yields for further interaction (e.g. as an entry point to working with VDCs), but this evaluation does not recommend that the VDC capacity at any one point in time is assumed to be rigidly defined by the corresponding HICAP scores. Rather, the scores and trends in the scores should be considered indicative.

3.3 The relevance of HICAP's capacity areas

The current areas assessed under the HICAP are seen as both useful and relevant to building VDC capacity. In no case did any respondent express a wish to remove any areas or sub-areas from the assessment.

However, it seems clear that capacity building alone will not enable VDCs to fully exercise their mandate if they are not also properly resourced. The HICAP could provide practical support in this area by including a sixth component (or another sub-component under Capacity Area III: Resource Mobilisation and Management) that focuses on the process of raising funds: i.e. proposal writing; understanding the decentralisation structure and funding mechanisms; understanding the amount of funds available at District and TA levels and familiarity with institutions responsible for allocating those funds.

Similarly, there is potential for VDCs to be weakened through election processes without clear protocols for comprehensive hand overs between old and new members. Indeed, this was temporarily the case after the 2014/2015 elections. This is another relevant area in which the HICAP could provide additional support through a new capacity area, or a new sub-component under Capacity Area II: Leadership (Governance).

Of course, the introduction of a new component, must be supported by the resources for training in order to be useful and effective for VDCs.

3.3.1 HICAP and the Government's decentralisation agenda

Extension workers and Concern staff in Nkhotakota in particular noted changes in the VDCs and their capacity since the implementation of the HICAP. For example, since the Chiefs are no longer Chairs of the VDCs, as mandated by the Decentralisation Policy, some extension workers said VDCs were easier to mobilise and more cooperative and active in general. This should have resulted

[x] Community Development Officer with unused motorbike due to lack of budget for fuel and maintenance

solely from the elections (i.e. the renewed effort for proper enforcement of Government guidelines on VDC membership) but in those VDCs where the HICAP was not being implemented, it was noted that Chiefs still tended to hold leadership roles.

However, some VDCs reported that they felt their role was sometimes undermined and this seemed to be a sign that the decentralised governance structure at the community level isn't fully embedded yet. For example, they referred to a lack of consultation or involvement in some Government and NGO projects in their area. They complained of an inability to raise funds to enable them to implement their own plans whilst Government/NGO projects, which they (or the community) didn't consider priority, were going ahead.

In almost all cases, VDCs said they would go to Concern as the most reliable source of support and resources when needed, rather than local Government structures.

3.3.2 VHCs and the HICAP

It should be noted that whilst the HICAP is relevant to the work of the VDCs, if the ultimate aim is improved community health outcomes, then VHCs, with their specific mandate to oversee community health initiatives, would seem to be a (additional) clear target for HICAP's implementation. The exponentially larger number of VHCs makes the resourcing of this a major constraint.

The VHCs interviewed during data collection did express a strong interest in the HICAP although none were attempting to implement it.

3.4 The efficiency of resource allocation

3.4.1 VDCs' resources

 [xi]

[xi] Chiefs sitting outside Chia Primary School, in front of Chia VDC's bicycle from Concern Worldwide

With very limited means, VDCs were seen to be implementing some of their plans, although often not larger projects, such as building housing for HSAs or U5 clinics, or building and maintaining boreholes. Unfortunately, these things were also often mentioned as priority planned activities by both VDCs and community members.

There were indications though that VDCs could manage budgets for projects of this size. Some had already implemented small infrastructure projects and others were able to produce paperwork related to the management of bicycle ambulances (shown in the above photo), including bank account papers, and a logbook listing all uses of the ambulance.

However, in some areas the VDCs find financial transparency with community members difficult. One VDC reported that they did not share information on their finances with the community because the demands were so numerous as soon as it was known that they had any funding. Instead, the VDC decided how to use their funds according to priorities previously agreed with the community, which is perhaps a practical compromise. This was reinforced by a meeting with village Chiefs who said their role was easier now that they were not VDC chairs, as the community pressured the VDCs more for their health needs

3.4.2 Programme resources

Whilst a cost-benefit analysis was beyond the scope of this work (and would be very challenging considering the difficulties in isolating the impact of the HICAP from other programme components), it is clear that the impact of the HICAP is positive overall. It is not clear, however, whether this is the most efficient use of resources.

Time, personnel and resource constraints undermine Concern's ability to actively support and supervise all 58 VDCs, as exemplified by the falling numbers of VDCs completing six-monthly assessments. Whilst ideally VHCs would also be involved in the initiative (given their mandate for overseeing community health initiative) their even larger numbers currently negate this possibility.

The HICAP does seem to act as a 'gateway' for Concern staff and extension workers to engage with VDCs and some VHC representatives, especially during the six-monthly review meetings, which enables other topics to be discussed and addressed. This can yield significant benefits for other aspects of Concern's programming.

Similarly, the improvement in VDCs' capacity will inevitably impact on other initiatives in a positive (but as yet unquantified) way.

3.5 The sustainability of HICAP after March 2016

3.5.1 Considerations for handover of HICAP to Government counterparts

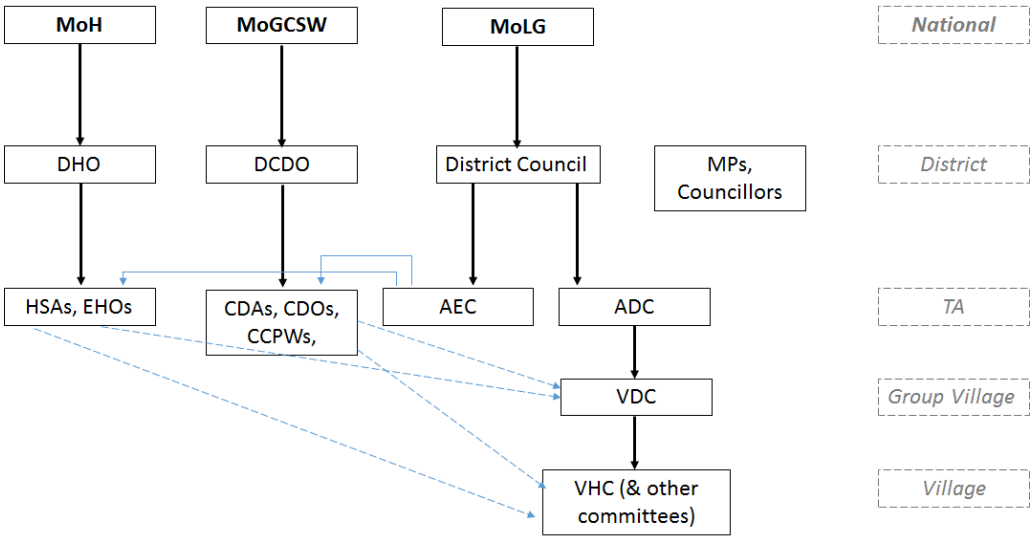
All extension workers and Government officials interviewed were positive in their assessment of the HICAP and its impact, and wanted to see it continue. Given that the burden of responsibility for implementing the HICAP will fall to extension workers if it is handed over to Government, an understanding of their position is essential.

Whilst extension workers may fall under the MoH or MoGCSW, on a day to day basis they can be managed by and report to the Area Extension Committee (AEC), under the Ministry of Local Government (MoLG). These complex links will need to be fully understood to ensure:

- The ultimate responsibility for the implementation of HICAP falls to the right ministry at the right level of Government;
- The HICAP is given sufficient political and financial support to enable implementation (particularly through extension workers); and
- All relevant parties are coordinated and sufficiently participating to ensure successful implementation.

Figure 3: Simplified depiction of the decentralised structures relevant to the implementatoin of the HICAP, below, is a simplified depiction of Government institutions that in some way contribute to the implementation of the HICAP in the health sector

FIGURE 3: SIMPLIFIED DEPICTION OF THE DECENTRALISED STRUCTURES RELEVANT TO THE IMPLEMENTATOIN OF THE HICAP [xii]



[xii] This diagram is based on discussions with Concern staff and Government staff in Nkhotakota

Whilst extension workers certainly have the capability to sustain the HICAP's implementation, they will be constrained by a lack of resources, particularly means of transport. It should be noted that this does not seem to be an immediate impact of the post-'Cashgate' zero-aid budget, as some extension workers noted that trainings for VDCs and VHCs had been suspended for ten years or more. In either case, the fact that Government was unable to provide initial trainings to new VDC members after the elections is a worrying indication of their capacity to finance the HICAP's implementation to the current standard.

Another constraint will be time, given that extension workers tend to cover large areas, which can include dozens of VDCs and VHCs (more since sub-divisions following the elections). Exacerbating this is the high turnover of staff within Government; frequent transfers, study leave and extension workers leaving to seek better remuneration can affect continuity, as has been seen in Nkhotakota during the MRH programme.

Finally, there may be an issue to do with the motivation of extension workers, as many of those interviewed expressed frustration with a lack of career progression and earning potential. It should be expected that extension workers will at least try to request additional allowances for the 'extra' work of supporting the HICAP. Many extension workers stated during data collection that they were given the same allowances as VDC members for any current engagement in the HICAP, and complained that their position (and inferred higher level of capacity and training) should afford them higher compensation.

If additional resources are needed, other parties worth considering in the handover could include Community Based Organisations, which are reported to be very strong and active in Nkhotakota in particular, or other stakeholders (NGOs/FBOs) already working in the area and familiar with community capacity building approaches.[xiii]

3.5.2 Timing considerations for handover

With the MRH project ending in March 2016, only one more round of HICAP self-assessments will take place, in November/December 2015. This is shown in Figure 4: Key dates and milestones for the sustainability of, below, which highlights the need for the formulation of an exit strategy as soon as possible, particularly if handover to Government is the preferred option. The November/December HICAP assessments and review meetings could then serve as a handover between Concern and Government.

[xiii] Organisations and projects mentioned included: NASO, SWAM, TLC, NAC, Land O Lakes, Foundation for Community Capacity Development, St Anne's Hospital, Maikhanda

FIGURE 4: KEY DATES AND MILESTONES FOR THE SUSTAINABILITY OF THE HICAP TOOL

Key dates / Milestones	2015							2016	2017
	Sept	Oct	Nov	Dec	Jan	Feb	Mar	July (approx)	Sept (approx)
HICAP evaluation report finalised									
Planning meeting intended to take place between Concern staff and District Council as part of exit strategy									
HICAP self assessments by VDCs (only opportunity for Concern to jointly conduct review meetings by way of handover to another party)									
End of Concern's MRH programme									
HICAP self assessments by VDCs due									
VDC elections begin									

3.5.3 Application of the HICAP to other sectors

Given the positive response to the HICAP from all stakeholders interviewed and the cross-cutting nature of the capacity areas it includes, there is much potential to expand its application to other sectors, programmes or locations (resources permitting). The main requirements for the HICAP to be of use are that a VDC-type structure exists (i.e. a committee, cooperative or community level group) and is in need of capacity building to better fulfil its role and support its community.

For example, in Concern's Food, Incomes and Markets (FIM) programme, also operating in Nkhotakota District, farmer groups and women's groups would be potential candidates for the HICAP.

4 Conclusions

In general, there was an overwhelmingly positive response to the HICAP. Whilst it is almost impossible to isolate and quantify the impact of the HICAP on VDCs' capacity and correlate this to improved health outcomes, VDC members valued being able to define their status and progress. It also seems to be a useful tool to instigate interaction between the VDC and extension workers, as well as Concern, and to then open discussions on related topics. The fact that it involved regular reviews helps to maintain a level of momentum and productivity within the VDCs.

There also seems to be a virtuous circle developing, in which the VDCs' improved performance is increasing expectations amongst the community, who can now voice their opinions through the election process. The election process and government policy was seen to be more effectively implemented among VDCs

who are supported by the HICAP, and this in turn gives them the necessary confidence and structure to respond to community demands.

Table 1: SWOT AnalysisTable 1, below, summarises the findings from Section 3, into strengths, weaknesses, opportunities and threats (SWOT).

TABLE 1: SWOT ANALYSIS

Strengths	Weaknesses
• The self-assessment process empowers and motivates VDCs more than external assessments would • HICAP supports the Government's decentralisation process, thereby empowering communities • It is a very useful and strategic means of engagement/ entry point for other work with VDCs • The five capacity areas are all relevant and important to the VDCs' functionality • It helps VDCs to be more independent through building their capacity and confidence • It ensures core functions are being completed by VDC, particularly for improved health outcomes • The capacity gains are beneficial to all other VDC activities • It encourages participation by all VDC members and community members • It identifies and helps VDCs understand weaknesses in their capacity, which gives them direction • The tree analogy helps people understand the scoring system	• It relies on extension workers, who are time and resource constrained, to provide capacity building • Key tasks are not included, such as proposal writing and lobbying, and post-election handover • Baseline scores are not necessarily reflective of initial capacities, which may indicate that expectation drives scoring to some extent and/or a lack of understanding persists after the initial 3-day training • Strong indications that the scoring system and definitions of capacity levels are not fully understood, but rather loosely followed by VDCs therefore definitions of capacity according to scores cannot be assumed to rigidly define capacity • Many VDC members are not confident with the tool after the initial three-day training, and need extra time to practice under supervision • No explicit mention of the poor, disabled, elderly or other vulnerable groups in the self-assessment tool • Dates of self-assessments/review meetings are not included in the HICAP database, making it difficult to track engagement, time between changes in scores, and correlation with elections • Self-assessments require a certain level of education, particularly literacy, for each member to be able to use the scoring matrix without relying on others to read to them, given the detail involved • For some VDCs, six months between assessments and review meetings is too long and momentum can be lost
Opportunities	**Threats**
• To use extension workers and members of the best-performing VDCs in a 'Training of Trainers waterfall': i.e. reducing the travel burden and number of VDCs that each trainer/supervisor needs to support. This could also include VDCs peer-reviewing and supporting each other's assessments • To enable VDCs to be more self-sufficient by adding components on proposal writing, lobbying and post-election hand-overs • Engaging with ADCs and District Councils (or national ministries) to engender support and resource allocation • Resources permitting, to expand to VHCs more systematically, complimenting their basic technical training, to have a potentially greater impact on community health outcomes • Resources permitting, to extend to other sectors, including agriculture, where comparable community structures exist (e.g. farmer groups and cooperatives)	• Without adequate funding (or the means to request and lobby for funding) to implement plans, VDCs and VHCs could become demotivated and lose community support • Government counterparts, specifically extension workers tasked with capacity building, are under-resourced and may not be able to maintain implementation standards after handover (March 2016) • The lack of a handover process (particularly around elections) threatens consistency in VDC performance • Despite the mandate of the VHCs to improve community health, VDCs are currently receiving more support, which could cause tension (although not observed in this evaluation)

5 Recommendations

The recommendations below focus on 2 themes, structured by the ToR questions:

1. Sustainability, Process and Efficiency: Whether or not, and how, the HICAP can be sustained after Concern's MRH programme ends in March 2016 (assuming that handover will ideally be to Government); and
2. Accuracy, Effectiveness and Relevance: Whether the HICAP supports VDCs to better fulfil their role.

5.1 Sustainability, process and efficiency

1. In order for handover of the HICAP to Government to be successful and sustainable, Concern should engage as soon as possible with the key line ministries: MoLG, MoGCSW and MoH particularly at District level, and the ADC and AEC, to define clear roles and responsibilities for funding, staffing and overseeing the implementation of the HICAP.
    i. This should also be taken as an opportunity to understand how the HICAP aligns to Government initiatives to support VDCs (and their implementation status) and their relative cost-effectiveness.
2. The next round of assessments and review meetings (scheduled for November/December 2015) should be attended by the party who will take over the HICAP's implementation, by way of handover from Concern.
3. Careful consideration should be given to the availability of resources post-handover to support the HICAP, particularly for extension workers if it is to be handed over to Government.
    i. A 'waterfall' model for training and supervision could be considered, whereby extension workers train better-performing VDC members to train and supervise neighbouring VDCs on the HICAP, to mitigate resource constraints.
4. If necessary, Concern may need to consider joint handover to Government and a third party (such as a CBO or NGO) to ensure resources are availed.

5.2 Accuracy, effectiveness and relevance

1. To ensure proper funding of the VDCs (and VHCs), the HICAP should incorporate components that enable them to understand and access financing streams, preferably Government streams. This should include further training on the decentralisation structure with particular emphasis on entities that are mandated to support community development; Government financing streams for local development and their management; and proposal writing.
2. To ensure the HICAP's approach is harmonised with the Government's decentralisation agenda, it should include a component on handovers between old and new members, possibly also with the requirement that the first

VDC/VHC meeting after elections includes a verbal and written handover from old members to new.

3. The inclusion of assessment dates/ review meetings should be made in the HICAP database to facilitate more detailed analysis of VDCs' engagement, the time between changes in scores and correlation of changes in scores with election processes.
4. If the HICAP is to continue to focus on health, consideration should be given to the expansion to VHCs and how this would be resourced.
5. To strengthen inclusion of all community members, capacity areas 1 and 2 should be amended to make explicit mention of the inclusion of the extreme poor, disabled, elderly and other vulnerable or marginalised groups.

6 Acknowledgements

Thank you to all those who shared their valuable time and knowledge to contribute to this report, including members of VDCs and VHCs, Local Government officials and community members and leaders. Particular thanks go to the staff of Concern's Lilongwe and Nkhotakota offices who facilitated my data collection, notably Jennifer Weiss (Health Adviser, Lilongwe) and (left to right in the photo): Allain Joram, (Project Manager, Nkhotakota); Davis Makhoza (Community Outreach Officer, Nkhotakota); Peter Nyirenda (Driver, Nkhotakota); Felix Chinseu (Transcriber, Nkhotakota), and Priscilla Tchete (Translator, Nkhotakota).

7 Annexes

7.1 Terms of reference

1. Background

For nearly 20 years, Concern Worldwide has implemented community health initiatives designed to expand access to services, foster healthy practices at the household level, and strengthen community health systems. Central to all of these programs is the commitment to building the capacity of local governance structures responsible for the provision and/or oversight of community health services.

Responding to a need to measure and monitor local organizational capacity and create actions plans to foster change at the community level, Concern Worldwide developed and refined the Health Institution Capacity Assessment Process (HICAP), under a USAID-funded Child Survival grant in Bangladesh (1998-2008). The HICAP is a participatory, capacity building approach that assists local governance structures to fulfil their roles and responsibilities with regards to health issues in their community. The assessment focuses on crucial issues of health service delivery, while maintaining a continued focus on the capacity development process of the local structures.

The application of the HICAP with local governance structures in the Bangladesh program was identified as a critical element of the program's sustained success, by transforming Concern's relationship with municipal health committees and increasing the role of Local Government in coordination health promotion and services in their area.

2. Introduction

In Malawi, Concern has been implementing a health and nutrition programme in Nkhotakota District since 2010. From 2010 to 2013, Concern implemented a programme to reduce morbidity and mortality among children under five. From 2013, Concern began implementing a maternal and reproductive health project with funding from Merck for Mothers and the Scottish Government.

A key strategy of both programmes has been strengthening of local governance structures such as Village Development Committees and Village Health Committees, with an objective of improved capacity of government and traditional leadership structures to plan, manage, support and monitor key health activities.

Beginning in 2010, Concern Malawi applied the HICAP tool to assess the specific functions of the Village Development Committee (VDC), which is the lowest level of formal governance structure under Malawi's Decentralization Policy. After a short orientation on VDC roles and responsibilities, Concern facilitators use the HICAP tool to guide the VDC in assessing their own level of capacity on indicators under five key capacity areas: leadership and governance, collaboration and coordination, resource mobilization, participatory planning, and monitoring and evaluation.

Every six months, Concern staff, in partnership with local government counterparts, follow up with VDCs to reassess their progress. The self-generated capacity scores are recorded in a database for tracking over time. There are currently 58 VDCs in Nkhotakota that have gone through the HICAP process. Concern is now replicating the HICAP approach with 36 VDCs under an integrated agriculture and nutrition programme in Mchinji district, and Concern is also implementing the HICAP as a key element of its child survival programme in Sierra Leone.

3. Purpose of Evaluation:

The HICAP has provided Concern with a key method to engage with local governance structures around community health. As the application of the tool continues to expand within the organization, not only within the health sector, but also within the Food, Income and Markets and potentially other sectors, Concern seeks to review the effectiveness, relevance, and sustainability of the HICAP process in strengthening health capacity and coordination at community level. Specifically, the evaluation seeks to understand:

1. Process: What are the overall strengths and weaknesses of the HICAP process as perceived by VDCs and other stakeholders?
2. Accuracy: Are the HICAP self-assessment scores accurate reflections of increases in capacity? To what extent do the scores actually correlate to improvements in real-life capacity?
3. Relevance: Are the capacity areas measured relevant to VDCs' capacity-building needs?
4. Effectiveness: To what extent has the HICAP tool served to strengthen community capacity to plan and manage community health initiatives, and how has it done so?
    - Is there evidence of improved VDC leadership capacity on health?
    - Is there evidence of improved linkages between communities and the health system?
    - What changes have community members, VDCs, or other stakeholders identified as a result of the HICAP process?
    - Has the process been inclusive of the needs of the extreme poor, how are women's voices/ needs represented in the process?
    - Has the process of capacity building of VDCs impacted on women's voice and representation at a community level?
5. Efficiency: Are resources used well? What needs to be done differently?
6. Sustainability:
    - Are the improvements in capacity attained by the VDCs sustained over time, as members come and go through election cycles?
    - What is the potential for the HICAP tool to be incorporated into Ministry of Local Government procedures within Nkhotakota District?

While the evaluation will take place within the context of Concern Malawi's Nkhotakota district health programme, the evaluation will generate learning that may be applied to other country programmes implementing the HICAP approach.

4. Methodology

The evaluation will focus primarily on qualitative data collection through key informant interviews, but will also review existing secondary data, such as the bi-annual HICAP assessment scores, and collect comparative information on VDC capacity. The evaluation will primarily involve stakeholders at the community level, such as community members, VDC members, and extension workers. In addition, Concern staff and district stakeholders will be included in the assessment. Preferably, the evaluation will compare communities where VDCs have been through the HICAP process with those that have not.

The evaluation will be informed by the following data sources:

- Review of project documents including the HICAP tool and training guide, HICAP database, and project reports; as well as relevant documents from the original HICAP in Bangladesh
- Interviews with community level stakeholders including VDC members, community members, and extension workers
- Key informant interviews with local leaders, staff from the District Community Development office, District Health Office, and Concern Worldwide project staff

5. Specific Tasks

1. Develop evaluation tools and methodology:
2. Review project documents and resources to understand the project
3. Draft evaluation methodology and schedule (including the proposed number of and type of key informant interviews or focus groups discussions, and/or activity observations)
4. With Concern Worldwide, identify VDCs, communities, and key stakeholders to be included in the assessment
5. Develop questionnaires, interview guides, and other data collection tools as needed
6. Carry out data collection:
7. Review and analyse HICAP database data for key trends
8. Conduct interviews and focus group discussions, and lead other data collection methods as needed
9. Synthesize findings:
10. Interpret results, draw conclusions, and make specific recommendations for future uses of the HICAP tool
11. Prepare report on the findings of the evaluation, including recommendations for strengthening, scaling up, replicating,
12. and handing over (if indicated) the HICAP process to district stakeholders

6. Outputs

- Evaluation report, with an executive summary (2-3 pages), to be submitted at the end of the assignment. Report should summarize findings against each of the evaluation questions, and provide specific recommendations for the future use of the HICAP tool.
- Presentation on key findings to be shared with senior management and other national-level stakeholders

7.2 Bibliography

1 CLGF, 2013, 'The local government system in Malawi'
2 Concern Worldwide Bangladesh, 2004, 'Child Survival Programme: Midterm evaluation report'
3 Concern Worldwide Bangladesh, 2004, 'Child Survival Programme: USAID – Concern – Municipality Partnership: Final Evaluation Report'
4 Concern Worldwide Bangladesh, 2008, 'Municipal Health Partnership Programme: Building on experiences in Saidpur and Parbatipur for urban health in Radshahi Division, Bangladesh, October 2004 – September 2009: Fourth Annual Report'
5 Concern Worldwide Bangladesh, 2008, 'The end of magical thinking: Sustainability evaluation three years after the end of the Saidpur and Parbatipur Urban Health Project'
6 Concern Worldwide Bangladesh, 2011, 'Breaking the Mould: A toolkit for the replication of an effective urban health model'
7 Concern Worldwide Malawi, 2011, 'Health and Nutrition Program Capacity Assessment Tool For Village Development/Health Committees (VDC/VHC) in Malawi'
8 Concern Worldwide Malawi, 2014, 'Malawi Country Strategic Plan 2014-2018'
9 Concern Worldwide Malawi, 2014, 'Merck for Mothers Case Study: Nkhala Village Development Committee (VDC) improving health outcomes together'
10 Concern Worldwide Malawi, 2015, 'Capacity Assessment Tracking Table'
11 Concern Worldwide Malawi, 2015, 'End of year report to Scottish Government Malawi Development Programme 2013-2016'
12 Concern Worldwide Malawi, 2015, 'Year 3 Mid-term report to the Merck for Mothers Global Giving Programme'
13 Concern Worldwide, 2010, 'VDC/VHC Capacity assessment workshop facilitator's guide'
14 Concern Worldwide, 2011, 'A community capacity building approach to health and nutrition'
15 Concern Worldwide, 2012, 'Irish Aid funded programme results frameworks'
16 Cooperrider & Whitney, 2010, 'A positive revolution in change: Appreciative Inquiry'
17 Crisp et al, 2000, 'Four approaches to capacity building in health: consequences for measurement and accountability', Health Promotion International
18 Fotso, 2015, 'Mid Term Evaluation Report: Concern Worldwide Malawi's Maternal and Reproductive Health Project Nkhotakota District (2013- 2016)'
19 GTZ, 1998, 'National Decentralisation Policy 1998 Summary'
20 Makaula et al., 2012, 'Primary health care in rural Malawi - a qualitative assessment exploring the relevance of the community-directed interventions approach', BMC Health Services Research
21 Malawi Government, 1998, 'Local Government Act, 1998'
22 Malawi Voice, 1st November 2014, 'DC, Councillors, Chiefs tussles over VDC election allowances'
23 Malengasanga VDC, 2015, 'July 2015 Work plan' (document photographed during field work)

24 Mankhwazi VDC and VHC, 2015, 'Joint Annual Action Plan 2015' (document photographed during field work)
25 Mankhwazi VDC and VHC, 2015, 'Joint presentation to ADC' (document photographed during field work)
26 Ministry of Health, 2011, 'Malawi Health Sector Strategic Plan 2011-2016'
27 MoGCSW, 2004, 'Community Leaders Training Manual for Community Development Workers' (document photographed during field work)
28 MoGCSW, 2015, 'A brief: Local Governance and The Decentralisation Process in Malawi' (document photographed during field work)
29 Ntanga VDC, 2014,'2014-2015 Workplan' (document photographed during field work)
30 Ntanga VDC, 2015, 'Bicycle ambulance register and log book' (document photographed during field work)
31 ODI, 2014, 'Fragmented governance and local service delivery in Malawi'
32 Office of the President and Cabinet Affairs, 2001, 'Development planning system handbook for district assemblies'
33 Pfeiffer et al, 2008, 'Strengthening health systems in poor countries: A code of conduct for nongovernmental organisations', Health Policy and Ethics
34 Sarriot et al, 2014, 'Advancing the application of systems thinking in health: sustainability evaluation as learning and sense-making in a complex urban health system in Northern Bangladesh', Health Research Policy and Systems
35 Tilitonse, 2013, 'Report for a political economy analysis of local governance in Malawi'

7.3 List of people met

Interviewee name	Institution	Job title	TA	# Participants	
				M	F
Immanuel IC Mvula	MoGCSW	Community Development Officer	Mwansambo	1	0
Enea Mfipa	MoH/ District Health Office	Assistant Environmental Health Officer	Mwansambo	1	0
Khuni VDC - Female Community Members		-	Mwansambo	0	11
Khuni VDC - Mixed Community Members		-	Mwansambo	6	6
Khuni VDC - Mixed VDC members and Village Headman		-	Mwansambo	11	6
Allain Joram & Davis Makhoza	Concern Worldwide	Project Manager & Community outreach Officer	Nkhotakota town	2	0
Mankwazi VDC and VHC - Mixed		-	Mwadzama	4	6
Mankhwazi VDC - Chair and Vice Chair		-	Mwadzama	1	1
Mankhwazi VHC - Mixed VHC members		-	Mwadzama	2	3
Issah Jaffih	Kapiri Healthcentre	EHSA	Mwadzama	1	0
Nkhongo VDC - Mixed Community Members		-	Mwadzama	4	4
Nkhongo VDC - Mixed VDC members		-	Mwadzama	4	3
Mtanga VDC - Mixed VDC members		-	Malengachanzi	6	6
Mtanga VDC - Mixed VHC members		-	Malengachanzi	1	3
Mtanga VDC - Mixed Community members		-	Malengachanzi	3	8
Nkhandwe VDC - Mixed VDC members		-	Malengachanzi	3	7
Nkhandwe VDC - Mixed Community members		-	Malengachanzi	2	6
Nkhandwe VDC - VDC Chair and Village Headman's Secretary		-	Malengachanzi	2	0
Bentry Brown Balakasi	MoGCSW	Community Development Officer	Malengachanzi	1	0
Misheck Katudza	MoGCSW	Community Development Officer	Mwadzama	1	0
Mervis Katanula	MoGCSW	CCPW	Mwadzama	0	1
Frank Chipalasa	Malowa Health Centre	Supervisor of HSAs	Mwadzama	1	0
Malengasanga VDC - Female VDC members		-	Malengachanzi	0	4
Malengasanga VDC - Male VDC members		-	Malengachanzi	9	0
Malengasanga VDC - Mixed Community members		-	Malengachanzi	4	8
Kanyenda VDC - Mixed VDC members		-	Kanyenda	7	4
Chia VDC - Mixed VDC members		-	Chia	6	7
Mtanga VDC - Male Chiefs and Village Headman		-	Malengachanzi	5	0
Mtanga VDC - Female Chiefs and Village Headwomen		-	Malengachanzi	0	4
Corenelius R Kalipirde	MoGCSW	Community Development Assistant	Malengachanzi	1	0
Paul Butai	MoGCSW	Nkhotakota District Community Development Officer	Nkhotakota town	1	0

7.4 Membership and functions of VDCs

7.4.1 Membership

- Membership of the VDC is made up of:
  - An Elected member from each village within the VDC
  - Ward Representative (s) as member(s)
  - Four women representatives nominated by people within the VDC
  - An elected extension worker representative
- Total membership to the VDC should not exceed 16 persons
  - Where that is not possible or representation from villages is affected, AEC members should discuss with the GVH to have the VDC split into two or more VDCs.
- Members of the VDC should elect among themselves a Chairperson, Vice-Chairperson, Secretary, and Treasurer.
  - If a man is elected Chairperson of the committee, the Vice-Chairperson should be elected from among the women members and vice-versa.
- The Group Village Headman/woman (GVH) cannot chair a VDC but supervises the VDCs and all other committees within his/her jurisdiction. The VDC(s) report to the GVH after every meeting to keep him/her informed of development matters discussed by the committee. The GVH shall continue to perform his primary role as Chief that is settling disputes in the constituency.
- Extension workers based within the VDC should elect among themselves a representative to sit in the VDC and AEC. The representative could not vie for an elected position in the VDC. He/She should be elected on his ability to lead others effectively and good relations with the community.
- The term of office of VDC members shall be three years unless otherwise replaced. Ward Representatives are the only exception as permanent members.

7.4.2 Functions

The functions of the VDC are as follows:

- Coordinate community-based issues with the ADC and DEC and communicate messages from the ADC and DEC to the communities;
- Mobilise community resources for participation in self-help activities;
- Assist in identifying, prioritizing, and preparing community needs and submit the same to the ADC;
- Supervise, monitor, evaluate implementation of village development activities;
- Solicit external funding for prioritized community-based projects;
- Initiate locally funded self-help activities; and
- Report to the GVH all activities and discussions of the committee.

7.5 Summary of the HICAP tool capacity areas

Capacity Area 1: Participatory planning
1) Meeting Attendance (% of committee members present at every meeting.)
2) Regular Meetings with an Agenda Are there meetings held on a regular basis with a prepared agenda?
3) Written Annual Plan Is there a written annual plan based on community priorities?
Capacity Area 2: Leadership (Governance)
1) Membership Replacement Process Is the process of replacing members fair and transparent?
2) Secondary leader (vice-chairperson) and other committee roles assigned and understood? Are committee roles (chairperson, vice-chairperson, secretary, treasurer), well defined, assigned and understood by those selected for the positions?
3) Participatory Decision Making Do all members participate equally in decision-making?
Capacity Area 3: Resource mobilization and management
1) Fundraising in Annual Plan Are fundraising activities included in the annual plan?
2) Financial Documentation and Transparency Are proper financial records kept and shared with the committee and the public?
3) Other Resource Mobilization Are VDC/VHC members aware of local resources and utilize them to implement activities?
Capacity Area 4: Collaboration and coordination
1) Collaboration and Coordination with other VDC/VHCs Does the VDC/VHC collaborate and coordination with other VDC/VHCs?
2) Collaboration and Coordination with Health Service Providing Institutions Does the VDC/VHC collaborate and coordinate with healthcare facilities?
3) VDC/VHC Support to CHVs and TBAs Does the VDC/VHC support HSAs and other extension workers in their work?
Capacity Area 5: Monitoring and evaluation
1) Review of Annual Plan Is the annual plan regularly followed and reviewed at the end of every year? Are annual review results used in creating the next year's annual plan and long term plans?
2) VDC/VHC Use of Health Information in Planning Does the VDC/VHC ensure data quality control in health data collection and consider health information in planning?

7.6 HICAP self-assessment tool

Capacity sub-components and indicator	1st Stage	2nd Stage	3rd Stage	4th Stage	Final Stage
Capacity Area I: Participatory Planning **Definition:** The systems in place to ensure VDC/VHC activities are planned in advance, with proper division of responsibilities, phases of implementation, and input from all VDC/VHC members.					
1) Meeting Attendance (% of committee members present at every meeting.)	Very Poor (Less than 40% present)	Poor (41-55% present)	Moderate (56-70% present)	Good (71-85% present)	Excellent (86-100% present)
2) Regular Meetings with an Agenda Are there meetings held on a regular basis with a prepared agenda?	- VDC/VHC meetings are held ad hoc, often planned last minute. - There is no prepared agenda. - Action points are not assigned to individuals nor due dates set.	- Meetings are held a few times a year but the day and time are not fixed and not much advanced notice is given. - There is no prepared agenda. - Action points are not assigned to individuals nor due dates set.	- There is a fixed day and time for monthly meetings. But changes occur often and giving proper advanced notice is not a priority. - An agenda is prepared before the meeting but is not based on last meeting's action points. - Some action points are assigned to individuals with due dates set.	- Meetings are held every month on a fixed day and time. Effort is made to give proper advance notice when there are changes. - An agenda is prepared before the meeting based on prior meeting's action points. - Most action points are assigned to individuals with due dates set.	- Members given annual schedule of meetings. Minimizing changes and giving proper advance notice when there are changes is a priority. - A prioritized agenda is prepared before the meeting based on prior meeting's action points. - All action points are assigned to individuals with due dates set.
3) Written Annual Plan Is there a written annual plan based on community priorities?	- There is no written annual plan.	- A simple annual plan (i.e. no activity leaders assigned) is written with few committee members having input.	- An annual plan is written with set targets and committee members assigned leaders. - Some but not all committee members participate in planning discussions.	- An annual plan is written with set targets, activity leaders assigned. Some consideration for plans beyond current year. - All committee members contribute to shared discussions and decision making for annual plan.	- An annual plan is written with set targets and activity leaders assigned. A simple long term plan (beyond the current year) is written as well. - Committee members get input from the community and sector they represent in preparation for annual planning process.

Capacity sub-components and indicator	1st Stage	2nd Stage	3rd Stage	4th Stage	Final Stage
Capacity Area II: Leadership (Governance) **Definition:** The processes followed to ensure the VDC/VHC remains representative of and responsible to the community, through proper internal management ensuring all members understand their responsibilities and fully participate in decision making.					
1) Membership Replacement Process Is the process of replacing members fair and transparent?	- Members are not replaced after 3 year term is finished. - Replacement process is not participatory. Some members or outside entities have special influence. - There is no consideration for ensuring new members meet specified criteria (i.e. represent same group of member leaving, commitment to serving community, etc.)	- There is little consideration for ensuring new members meet specified criteria. - The full committee votes on selection of new member but the nominations and votes are often unfairly influenced by a few individuals.	- There is some effort to ensure new members meet specified criteria. - The full committee votes on selection of new members but sometimes nominations and/or votes are unfairly influenced by a few individuals.	- A transparent selection process has been defined with specific rules (number of members must be present, rules for a tie). Special influence is minimal. - Ensuring new members meet specified criteria is a priority.	- Members are replaced every three years according to guidelines. There is a well defined, transparent member replacement process in place. - First priority is to ensure those nominated meet all criteria and are the most qualified from their representative group.
2) Secondary leader (vice-chairperson) and other committee roles assigned and understood Are committee roles (chairperson, vice-chairperson, secretary, treasurer), well defined, assigned and understood by those selected for the positions?	- No roles are defined or assigned other than the leader (Chairperson). - The role of chairperson is filled by someone not eligible for the responsibility	- Secondary leader is assigned (vice-chairperson). - Roles are not well defined, the person does not have proper understanding of it, and/or people in roles do not meet criteria (e.g. gender balance).	- Secondary leader and a few other roles are assigned. - Most roles and responsibilities are well defined., and are filled by eligible people - Some individuals assigned a role do not have proper understanding of their responsibilities.	- All roles are assigned. - All roles and responsibilities are well defined and are filled by eligible people. - All individuals assigned a role have a good understanding of their responsibilities.	- All roles are assigned - All responsibilities are well defined, filled by eligible people, and in writing. - All individuals assigned a role have a good understanding of their responsibilities.
3) Participatory Decision Making	- Chairperson makes decisions without	- Chairperson sometimes consults with a few members for some	- Chairperson regularly consults with a few members to make	- Discussions include most committee members, and	- All decisions made by full committee vote and/or input from those directly

Capacity sub-components and indicator	1st Stage	2nd Stage	3rd Stage	4th Stage	Final Stage
Do all members participate equally in decision-making?	consultation without members' input/vote.	decisions but always has final say.	decisions but full committee rarely approached for input.	Chairperson brings important decisions to the full committee for input/vote.	impacted. Discussions include all committee members.
Capacity Area III: Resource Mobilization and Management **Definition:** The VDC/VHC's ability to raise funds, locate and utilize local resources and maintain proper financial records available to the public.					
1) Fundraising in Annual Plan Are fundraising activities included in the annual plan?	- There is no mention of fundraising activities in the annual plan (if there is an annual plan).	- Fundraising has been done occasionally (e.g. proposal-writing), but any fundraising activities implemented are ad hoc.	- There is at least one fundraising activity included in the annual plan. - An area/s is identified for use of the funds raised (i.e. vaccination campaign, emergency fund for community members, etc). - Other potential sources and methods of fundraising are discussed.	- There are several fundraising activities included in the annual plan. - An area/s is identified for use of the funds raised for most of the fundraising activity with full committee input. - There is some diversification of sources and methods.	- Fundraising is a priority. - Several fundraising activities are included in annual plan involving diverse sources and methods. - An area/s is identified for use of the funds raised for all fundraising activity with full committee input.
2) Financial Documentation and Transparency Are proper financial records kept and shared with the committee and the public?	- There are no financial records kept. - Funding updates are not shared with full committee or the public.	- There are some financial records but proper bookkeeping methods are not used. - Financial records are not easily accessible to committee members and rarely shared at meetings. - Financial records are not shared with the public.	- Financial records are being kept using proper bookkeeping methods. - Financial records are shared at meetings but a regular schedule of updates and reviews is not followed. - Financial information is rarely shared with the public.	- Proper financial records are kept and analyzed using basic tools. - A regular schedule of updates/review (quarterly balance, semi-annual budget review, annual report) is mostly followed. - Selected financial information (i.e. good news only) is annually shared with the public.	- Detailed financial records are being kept and being analyzed using more advanced tools/methods. - The regular schedule of updates/reviews is always followed. - The annual financial report is shared with the public.

Capacity sub-components and indicator	1st Stage	2nd Stage	3rd Stage	4th Stage	Final Stage
3) Other Resource Mobilization Are VDC/VHC members aware of local resources and utilize them to implement activities?	- VDC/VHC does not have a regular meeting place within the ward, a bank account, nor seal and pad. - - VDC/VHC members do not utilize local resources to implement activities.	- VDC/VHC has a temporary meeting place. -Utilizing local resources to implement activities is minimal.	- The VDC/VHC has a permanent meeting space but it is not a convenient space (i.e. bad location, too small, etc.). - Local resources are occasionally utilized.	- The VDC/VHC has a proper permanent meeting space. - Members are very familiar with local resources available. - Local resources are often utilized but documentation of resources is poor.	- VDC/VHC has an established meeting place in a central location that is well known throughout the ward. - Utilizing local resources is an institutionalized practice and a list of available resources is created and updated annually.
Capacity Area IV: Collaboration and Coordination **Definition:** The VDC/VHCs ability to establish relationships with key local, regional and national institutions, resulting in a greater scope of services in support of the community.					
1) Collaboration and Coordination with other VDC/VHCs Does the VDC/VHC collaborate and coordination with other VDC/VHCs?	- VDC/VHC has no communication with other VDC/VHCs.	- VDC/VHC realizes the benefit of establishing relationships with other VDC/VHCs. - VDC/VHC has taken some steps towards this.	- VDC/VHC has regular meetings with 2-3 VDC/VHCs to share lessons learned and coordinate activities.	- VDC/VHC is in contact with more than 3 other VDC/VHCs. - The process of starting an annual meeting between all VDC/VHCs in the municipality has begun.	- VDC/VHC collaborates with several VDC/VHCs. -In addition to meetings between neighboring VDC/VHCs, there is an annual meeting of all VDC/VHCs in the municipality.
2) Collaboration and Coordination with Health Service Providing Institutions Does the VDC/VHC collaborate and coordinate with healthcare facilities?	- VDC/VHC has no established relationship with health service providing institutions.	- VDC/VHC has reached out to some health service providing institutions. - Collaboration is rare.	- VDC/VHC has established a formal relationship with the major local health service providing institutions servicing its ward. - VDC/VHC collaborates with these institutions for special occasions only (i.e. NIDs).	- VDC/VHCs relationship with local health service institutions servicing its ward have become institutionalized. - VDC/VHC collaborates with these institutions on short and long term initiatives (NIDS, CIMCI, etc.) and continuously seeks	- VDC/VHC has established a formal relationship with all health service institutions servicing its ward and some regional/national institutions. - The institutions and the VDC/VHC continuously rely on each other to improve their quality of service.

Capacity sub-components and indicator	1st Stage	2nd Stage	3rd Stage	4th Stage	Final Stage
				further opportunities for collaboration.	- There are ongoing collaborations with many of institutions.
3) VDC/VHC Support to CHVs and TBAs Does the VDC/VHC support HSAs and other extension workers in their work?	- Extension worker representatives are not active in VDC/VHC and do not liaise with HSAs in the community regarding VDC/VHC activities. - The VDC/VHC does not support HSAs in their work.	- Extension worker reps occasionally participate in discussions and share the views of HSAs and VDC/VHCs. - VDC/VHC rarely supports HSAs in their work.	- Extension worker reps are active in VDC/VHC and make some effort to inform HSAs in the community regarding VDC/VHC activities. - VDC/VHC sometimes supports HSAs by helping with collection of information or overseeing health volunteer activities.	- Extension worker reps are very active in the VDC/VHC and regularly liaise with HSAs in the community regarding VDC/VHC activities. - The VDC/VHC has begun establishing a system to help HSAs with activities such as identifying patients, collecting health information, and supervising volunteers.	- Extension worker reps are some of the most active members in the VDC/VHC and successfully engage HSAs in VDC/VHC activities. - The HSA support system is institutionalized, including efforts to maximize VDC/VHC involvement in all health activities in the area.
Capacity Area V: Monitoring and Evaluation **Definition**: The VDC/VHC's ability to systematically document the results of its activities and ensure this information is regularly reviewed and used as the basis for future planning. The VDC/VHC actively supports the collection of community health data and uses relevant information to inform its planning process.					
1) Review of Annual Plan Is the annual plan regularly followed and reviewed at the end of every year? Are annual review results used in creating the next year's annual plan and long term plans?	- The Committee does not look at the annual plan throughout the year to check its progress. - There is no year end review. - Annual review results and recommendations do not exist or are not referred to in planning or other decisions.	- The Committee rarely looks at the annual plan to check its progress and for further planning. - At the end of the year, the Committee holds a meeting to review the year's accomplishments but the results are not written. - Annual review results and recommendations are rarely considered in creating new annual plan	- The Committee looks at the annual plan to check its progress and for further planning a few times a year but not at set intervals. - A year-end review meeting is held and the results are recorded. - A basic evaluation report is prepared and shared with the Committee.	- The Committee looks at the annual plan quarterly to check its progress and for further planning. - There is an attempt to gather information on all activities conducted prior to the year-end review meeting. - An evaluation report including quantified results for all activities conducted is prepared	- The Committee looks at the annual plan quarterly to check its progress and for further planning. - Information on all activities conducted are gathered and summarized at the year-end review meeting. - A comprehensive evaluation report is prepared and shared with the public.

Capacity sub-components and indicator	1st Stage	2nd Stage	3rd Stage	4th Stage	Final Stage
		and in planning throughout the year.	- Some annual review results and recommendations are considered in creating new annual plan and in planning throughout the year.	and shared with the Committee. - Most annual review results and recommendations are considered in creating new annual plan and in planning throughout the year.	- A system is in place to ensure all annual review results and recommendations are considered in creating new annual plan and in planning throughout the year.
2) VDC/VHC Use of Health Information in Planning Does the VDC/VHC ensure data quality control in health data collection and consider health information in planning?	- Committee does not receive or consider health information during planning. - No system is in place to ensure that community level health data is collected and submitted).	- Community or district health information is available but rarely considered in planning. - Reminders/ advice are sometimes given to HSAs regarding quality control but no steps are taken to check quality.	- Some health information is considered during planning. - There is some effort to ensure timely reporting and quality of some health data (e.g. HSA reports) but it is not done on a regular basis.	- Community and district health information is regularly considered during planning of activities. - Some steps are regularly taken to ensure that high-quality community health information (HSA records, village registration).	- Community and district health information is always considered during planning and baselines information is included in annual plan. - A quality control system is in place and steps have been taken to ensure that key community health events (births, deaths) are investigated and recorded.

7.7 Interview Guides and Tools

The following tools were used as interview *guides.* Rarely was the interview conducted exactly as written in the guide for the following reasons:

- The guides are very broad: if an interviewee raised new topics of interest, the line of questioning would be adapted,
- Time constraints: particularly in group discussions, when working through a translator, or if it became clear that participant's knowledge of/involvement in the topic was not as expected, the number of topics and questions would have to be scaled down or refocussed,
- Group dynamics and expectations: some groups are naturally more open and vocal than others, and gender or other group dynamics and participants' expectations are examples of factors that inform what the best style and line of interview works to gather reliable, informative data,
- Triangulating data: where possible, additional questions would be included to confirm or supplement answers given by other interviewees (i.e. triangulation between community members' and VDC members' answers from the same community, or men and women from the same VDC).

At the beginning of interviews, an introduction of the consultant and consultancy was given, to explain the reason for the line of questioning. For smaller groups or individual interviewees, the 'ToR summary' handout (see Annex 7.11) was shared.

At the end of all interviews, respondents were given the opportunity to add comments and/or ask questions, which often provided the grounds for new discussion and very useful information.

7.7.1 SSI: Concern Staff

1. Please tell me about your role and projects you work on?
2. Can you describe HICAP's role in the wider project?
3. What do you see as the strengths and weaknesses of the HICAP tool?
4. How reflective is the scoring system of actual capacity:
    a. Is averaging scores for each of the 5 areas reasonable?
    b. Is the 1-5 scale easy to use?
    c. Are there any incentives to manipulate scores?
5. Is the HICAP measuring the right areas to reflect capacity needs? If not, what could be added/taken away?
6. What feedback (if any) have you had from communities/VDCs on the HICAP?
7. Can you give me a practical example of how the HICAP has contributed to improved community planning and management of health initiatives?
    a. Improved VDC leadership capacity in health
    b. Better linkages with the community
    c. Changes resulting from HICAP
8. Do you think the HICAP is a useful tool for supporting women and the most vulnerable in communities? If so, why/ why not?

9. How do election cycles impact on VDCs' capacity?
    a. Does the HICAP have any impact on that? E.g. through encouraging better VDC management – handovers, description and understanding of roles and responsibilities?
    b. Could the HICAP better support such a transition? If so, how?
10. When capacity needs are identified through HICAP self-assessments, how does Concern address those?
11. Do you see potential to hand the HICAP over to VDCs, under the Ministry of Local Government?
    a. If not, why not?
    b. If so, how do you see that working? (policy framework, manpower, resources, motivation, political considerations)
12. What financial or logistical support does concern give/ is needed for implementation of HICAP?
13. Are any other NGOs/FBOs etc working with VDCs and VHCs in related areas?
14. How could the implementation of the HICAP be improved (if at all)?

7.7.2 SSI: Local Government and Extension Workers

1. Please can you explain to me your role and your work with VDCs/VHCs?
2. Please tell about your experience in using the HICAP and how it fits into your role?
3. In your opinion, what are the strengths and weaknesses of the HICAP?
4. Do you think the HICAP tackles the most important capacity needs in your area?
    a. Are there any unmet needs or unnecessary parts of the HICAP?
5. Do you think the HICAP scores are reflective of VDC capacity? (Show table of scores to remind interviewee about the scores for VDCs in their areas)
6. How does the HICAP compare to any other capacity building initiatives you've observed or been involved with?
    a. Government
    b. NGO/FBO
    c. Other
7. How (if at all) have you seen the capacity of VDCs change since they've begun using the HICAP?
    a. How?
    b. Why?
8. Can you give me a practical example of how the HICAP has contributed to improved community planning and management of health initiatives? (Prompts:)
    a. Improved VDC leadership capacity in health
    b. Better linkages with the community
    c. Changes resulting from HICAP
9. Do you think the HICAP has contributed to an improvement in community health indicators? (Examples? What other work/stakeholders have contributed to these?)
10. What feedback (if any) have you had from communities/VDCs on the HICAP?

11. Are there any changes that you would make to the HICAP?
    (Prompts:)
    a. Scoring system
    b. Categories
    c. Time scale
    d. Implementation (level and type of training/support)
12. Do you think it would be feasible for the local government to take over the HICAP process
    a. Why/ why not?
    b. Which institution would take responsibility – MoLG, DHO, other?
    c. Are 6 monthly capacity assessments manageable?
    d. Ability to respond to capacity needs?
    e. Motivation and resources?

7.7.3 SSI: VDC/ VHC members

1. What is your role in the VDC?
2. Can you please outline the broader VDC membership? (prompt for gender of key positions)
3. What are the health priorities in your community?
4. What projects are you implementing and what are your main challenges in these?
5. How long have you been using the HICAP?
6. How useful have you found to:
    a. Building VDC members' capacity
    b. Improve your management of community health needs?
    (Prompt for examples and other factors/ stakeholders contributing to these changes)
7. What are its main strengths and weaknesses in your opinion?
8. Does it address all the areas in which you would like to build VDC capacity?
    a. Which areas are unnecessary?
    b. What other areas would you like to add?
9. Do you find it easy to use the scoring system?
    a. And do you think the agreed scores are reflective of your VDCs capacity? (use an example of definition of their latest score to test understanding)
10. Can you give me an example of changes in the VDCs capacity to manage planning and implementation of community health initiatives since using the HICAP?
11. How do you develop your plans and identify priority actions?
12. How do you finance your activities?
13. If you have a concern/problem/challenge, who do you address it to?
    a. Can you give me an example of when you've done this and what the outcome was?
    (use this question to assess understanding of and interaction with decentralised structures)

14. Do you see any impact in terms of empowerment of women and vulnerable members of the VDC and of the community? (prompt on different demographics and consulting them to identify community health needs and to meet them)
15. Do election cycles impact on VDC capacity? How?
16. If you were to change anything about the HICAP implementation, what would it be and why?
17. Would you like to see the HICAP process continue under the Ministry of Local Government (i.e. without Concern's support) and do you think this is feasible?

7.7.4 SSI: Community members

1. What are your main health concerns in this community?
2. Have you seen changes in the services in this are in the last 3/5 years? (number of years to match how long HICAP has been used)
    a. If so what/how?
    b. If not, why do you think nothing is changing?
3. Do you know the role of the VDC?
    a. Do you think they fulfil this role?
    b. Have you seen any changes in the way they work in the last 3/5 years?
4. When you have a problem with health services, can you raise it in your community e.g. with the chief, VDC, health extension workers?
    a. If not, why not?
    b. If so, who do you talk to?
5. Have you ever taken an issue to the VDC?
    a. If not, why not?
    b. If so, can you tell me about your experience?
6. **Women only:** As a woman, do you find it easy to have your voice heard in the VDC/wider community? Has it always been this way?

7.7.5 FGD Guide: VDCs and VHCs

Introduction
My name is Liz O'Neill. I live in Lilongwe. I am here as Concern Worldwide has asked me to review the HICAP process to see how well it is helping VDCs fulfil their roles; to see how well it helps in strengthening health capacity and coordination at the community level.

<u>This is NOT an evaluation of any of the people involved in HICAP, of the VDCs, or of any other parts of the health system.</u>

<u>There are no right or wrong answers – I'm just interested in your opinions. All information given will be kept confidential.</u>

Is everybody happy to continue or are there any questions before I start?

1. To start with, please could you all introduce yourselves and tell me your position within the VDC? (use this to determine gender distribution of roles)

2. Thank you. And how many of you are newly elected? (check when elections were)

3. Congratulations to all of you on being elected. What are the main health needs in your community?

4. Now can you tell about the work you do to improve health in your community? (Encourage people to call out responses. Interrupt if there are no female respondents and prompt if it seems question isn't understood. Write/draw answers on A4 paper and place them on the floor/table/stick to wall)

5. Participatory ranking: give everybody a sweet and ask them to keep the wrapper. Ask them to then 'vote' on which of the roles they've mentioned is easiest by placing their sweet wrapper on the correct piece of paper. Remind them of what each paper says in case of illiterate members.

6. Summarise results to group and repeat the exercise but this time voting on the most difficult.

7. Summarise the results. Then ask why they find those things easy and hard. Leave time for discussion.

For VDCs using the HICAP, continue from Q7. For VDCs who don't use the HICAP, continue from Q13.

8. How has this changed since using the HICAP? Has it made any things easier? Which things?

9. What is your score at the moment? (to test understanding and accuracy of scoring system)
    a. What does this mean?
    b. What do you need to do in order to improve your score?

10. Do you think you're more able to respond to your community health needs since using the HICAP? (Can vote with sweets on tick and cross signs if it worked well the first time)
    a. How has the HICAP helped you to respond to them?

11. Is there anything about the HICAP that you would like to change? (Prompt:)
    a. Is it easy to use?
    b. Is the scoring easy to do?

c. Are there any unnecessary areas? Or any extra you would like to include?
d. Is there anything you could change to make it more helpful to you?

12. Are you able to do the HICAP by yourselves? Or do you need support? (Prompt:) Capacity building, supervision, resources. End here for VDCs using HICAP. Skip to closing Comment.

13. Do you currently receiving any training or support to help you respond to community health needs? From whom and what kind of support?
14. Are there any areas in which you think training could help you? Which areas and why?
15. What other support would you like? (if any)

Closing comment
Those are all of my questions so thank you for your time and sharing your knowledge. Are there any questions/comments for me before we end?

7.7.6 FGD Guide: Community members (women and mixed)

Introduction
My name is Liz O'Neill. I live in Lilongwe. I am here as Concern Worldwide has asked me to review the HICAP process to see how well it is helping VDCs fulfil their roles; to see how well it helps in strengthening health capacity and coordination at the community level.

This is NOT an evaluation of any of the people involved in HICAP, of the VDCs, or of any other parts of the health system.

There are no right or wrong answers – I'm just interested in your opinions. All information given will be kept confidential.

Is everybody happy to continue or are there any questions before I start?

1. To start with, please could you all introduce yourselves and tell me if you have a role within your community in the area of health (e.g. volunteer positions to support extension workers)

2. What are the main health needs in your community?

3. What is the role of your VDC in health specifically? (what you think it should do, not what it actually does) ? (Encourage people to call out responses. Interrupt if there are no female respondents. Write/draw answers on A4 paper and place them on the floor/table/stick to wall)

4. Participatory ranking: give everybody a sweet and ask them to keep the wrapper. Ask them to then 'vote' on which of those roles the VDC does best. Remind them of what each paper says in case of illiterate members.

5. Summarise results to group and repeat the exercise but this time voting on what the VDC does least of/doesn't do well.

6. Is this the same as 3/5 years ago? (time frame matches use of HICAP by VDC, if they've used HICAP) How/why do they think it has it changed?

7. If you have a health problem in your community (not an illness, but for example, if you need more services or more education) who do you go to? (Prompt: Chief, VDC, MP, VHC, health clinic, extension workers – can also do this as vote if it went well last time)
   7. Do you think the voices of women are listened to as much as men's? Why? Examples?

   8. Did you all vote in the VDC elections (show of hands)?

   9. And are you happy with the results of the election? Is your VDC performing well? What do you do if you're not happy with their performance? (leave time for discussion)

Those are all of my questions so thank you for your time and sharing your knowledge. Are there any questions/comments for me before we end?

7.7.7 SSI: Chiefs and Village Headmen/women

1. Please can you describe your role, particularly in terms of improving community health?
2. Do you work with/advise VDCs/VHCs? How do you do this?
3. How do you view the role of the VDC/VHC?
   a. What do they do to promote community health?
   b. How do they fit into government structures?
4. What do you see as the strengths/ weaknesses of the VDC?
5. Do you think the capacity of the VDC has improved since using the HICAP? If so, how?
6. Can you give me an example of something they've done to improve community health?
7. Are the health needs of all members of your community addressed (women, disabled, elderly etc)
8. What support do you think they need to improve their work?