REVIEW

OF THE

LINKAGE AND REFERRAL SYSTEM

OF THE MALAWI SOCIAL CASH TRANSFER

PROGRAMME

FINAL REPORT

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EXECUTIVE SUMMARY

This report reviews the pilot phase of Linkage and Referral (L&R) system of the Social Cash Transfer Programme (SCTP) in Malawi, with a view to learning lessons and making recommendations on the way forward.

The problem identified, prior to the design of the L&R system, was that, despite the benefits of SCTP cash transfers, beneficiaries faced gaps in their access to essential services. The anticipated outcome of the L&R pilot was that SCTP beneficiaries would have increased access to appropriate services, thereby enhancing impacts of the SCTP on poverty, hunger, school enrolment, health and child nutrition.

The review concludes that the identified problem is real - SCTP beneficiaries do face constraints on their access to services - but the L&R system as currently designed has largely failed to address it. The fundamental reason for the limited success is that lack of service access is primarily due to supply side challenges, whereas the strategic design of the L&R system focused mainly on the demand side. Most SCTP beneficiary households are accessing the services available to them, as long as those services are local, free and the service providers are active. Supply side challenges are the binding constraint on service access: in some sectors there is a complete lack of services; in others, the problem is that services that are too distant or expensive, or have closed lists of beneficiaries, or that staff lack a service ethos. The strategic design of the L&R system gave insufficient attention to service supply; an implicit (and incorrect) assumption of the model was that supply was adequate.

As for the operational design of the programme - the extent to which the strategic design was effectively translated into operational manuals, training, staffing, communications, service directory and management information systems - this was good overall. Manuals and tools to guide home visits and referrals were comprehensive and largely appropriate to their target group; and extension workers (EWs) who were the frontline implementors of the system received substantial training using a range of methodologies, in line with best practice. The median caseload of EWs (36.5 households) was appropriate to the number of days allocated per round of household visits, as it implied two hours per household. The L&R monitoring and feedback mechanism, the "Quality Survey", was also a positive feature, as it should have enabled beneficiary feedback to inform ongoing improvements to the programme.

On the other hand, there was scope for improvement in some areas of operational design. For example, the design and budgeting meant that the extent of interaction of EWs with beneficiaries in this pilot phase was limited to one single home visit; and that there was no provision for active follow up by the EW with either the beneficiary or service provider. In almost all cases, the challenges of service access were too complex to be so quickly resolved, and, as a result, even in the minority of cases where service supply was adequate, referrals still rarely resulted in successful linkages. Furthermore, the service directory, a key element of programme design, which should have guided referrals to appropriate local providers was of very limited utility as many listed services were not really available. Again, this was partly an operational design issue: the design of the supply capacity assessment questionnaire did not sufficiently tease out whether a service was truly available in the sense of being available on demand to new beneficiaries. Operational design also failed to give sufficient attention to communications to frontline service providers, expecting (wrongly) that awareness-raising of managers at district level about the L&R system would trickle down to frontline staff.

The quality of implementation at district level was similarly variable, with both examples of best practice and weaknesses. In Balaka we found some high-quality household assessment demonstrated by a strong correlation between referral cards and household accounts of their own priorities; and the review of training of EWs carried out by the district office was reportedly useful in correcting misunderstandings and equipping EWs for their roles. In one traditional authority (TA) in Dedza an L&R desk was established at the SCTP paypoint, usefully integrating L&R with other elements of the SCTP. In Mzimba North, there were interesting innovations. The district office accurately identified supply side issues as a key constraint on the success of

the L&R system and innovated to address these: both by holding a meeting with providers to encourage them to develop a more positive service ethos in regard to SCTP beneficiaries; and by working with NGOs to organise group trainings to respond to commonly identified service priorities. On the other hand, weaknesses in implementation across all districts included: hurried household visits in most cases and no household visits at all for some households whose referral cards were simply distributed (sometimes blank) at the paypoint; overlooking of some important child protection issues in the household assessment, such as out of school children and cases of sexual/physical abuse; and major discrepancies between the data on referral status in the MIS, referral cards and household accounts, such that the three sources agreed with each other in only 30 percent of cases.

The over-arching recommendation of the consultants is that the strategic design of the programme be re-thought to ensure that it better responds to the actual service access challenges faced by SCTP beneficiaries, which are largely on the supply side. Access challenges vary by sector and type of service and, as such, a set of linked interventions (rather than a single one-size-fits all design) will be required to address these various challenges. Specific recommendations can be summarised as follows:

1) **Household assessments**: Retain a model of a first home visit similar to the current model to assess needs of all SCTP households.

2) **Basic service provision at paypoints**: Based on common identified needs, make available a range of basic services to all beneficiaries at paypoints. Also consider whether increasing the level of SCTP transfers might be the most effective way to address some service access challenges.

3) **Referrals**: For more personalised support, on the basis of the household assessment, allocate individuals to one of three pathways of support: the *social pathway* for a small number of people with specific social or health vulnerabilities who will benefit most from intensive one-on-one support and referral; the *agricultural pathway* for people prioritising training on agricultural or livestock issues; and the *business pathway* for those with higher productive potential who express a need for business advice.

4) **Policy engagement and advocacy**: Carry out advocacy at national level for improvements in service access for SCTP beneficiaries on issues that require a more systematic policy level engagement and are not amenable to solution through referral. Consider whether a social accountability component would add value in increasing service provider responsiveness to citizens.

5) **Staffing**: Consider alternative staffing models that rely more heavily on skilled social work EWs and on existing community social support committees (CSSCs) and which are adapted to different elements of the revised model (as set out in 3) above).

6) **Supervision**: Given the challenges with the quality of home visiting in some localities, establish more structured supervision arrangements for these frontline workers.

7) **Incentives**: Review the incentive structure. Instead of a one-off payment based on the number of training days and assumed days worked, consider paying monthly allowances on an ongoing basis, subject to satisfactory performance against a set of agreed criteria.

8) **Manuals and forms**: Update manuals in line with L&R redesign and simplify referral forms.

9) **Training**: Strengthen practical elements of training to ensure that frontline workers feel fully equipped for their roles and adapt training to the new staffing arrangements.

10) **Information management**: In the first instance simplify data collection and information management processes. Eventually, the management information system might switch to direct data capture on tablets or phones, in order to reduce data entry errors, but this is not an initial priority.

11) **Service directory**: Simplify this and make a clear distinction between: i) those services available on demand to new clients; and ii) services that are actively targeted, but which might be drawn on to provide group training and/or be made increasingly accessible as the result of advocacy.

ACRONYMS

CBO:	Community-based Organisation
COMSIP:	Community Savings and Investment Promotion Cooperative Union
CSSC:	Community Social Support Committee
DHO	District Health Officer
DP:	Development partner
DSWO:	District Social Welfare Officer
DTT:	District training team
EU:	European Union
EW:	Extension worker
FGD:	Focus group discussion
FISP:	Fertiliser Input Subsidy Programme
HIV:	Human Immunodeficiency Virus
HSA:	Health Surveillance Assistants
HSCT:	Harmonised Social Cash Transfer programme (Zimbabwe)
KfW:	German government aid programme
KII:	Key informant interview
L&R:	Linkage and Referral
MACOHA:	Malawi Council for the Handicapped
M&E	Monitoring and evaluation
MIS:	Management information system
MoGCDSW:	Ministry of Gender, Children, Disability and Social Welfare
NGO:	Non-governmental organisation
OECD DAC:	The Organisation for Economic Co-operation and Development: Development Assistance Committee
SCTP:	Social Cash Transfer Programme
SOLDEV:	Synod of Livingstonia Development Wing
SP:	Service provider
SPRODETTA:	Small Producers Development and Transporters Association
SSI:	Semi-structured interview
SW:	Social welfare
TA:	Traditional Authority
ToC:	Theory of change
UNICEF:	United Nations Children's Fund
VC:	Village Cluster

INTRODUCTION

This draft report is the second output of a consultancy to review the Linkage and Referral (L&R) System of the Malawi Social Cash Transfer Programme (SCTP). The consultants - Tamsin Ayliffe, international consultant, and Peter Mvula, national consultant, and his team - conducted a qualitative assessment of the design and implementation of the system. They documented lessons learned and best practices and provide concrete recommendations on the way forward.

The primary recipients of this work are the Ministry of Gender, Children, Disability and Social Welfare (MoGCDSW) and UNICEF. Other key stakeholders include district councils, development partners (DPs) and NGOs involved in the social protection sector.

The report is structured as follows:

Section 1 – **Background** - explains the context in which the L&R system was designed and piloted, describes the programme and highlights some key lessons from international experience with similar programmes.

Section 2 – **Methodology** - presents the research approach and methods used by the consultants, including methodology for sampling of geographical areas and households, as well as research tools.

Section 3 – **Findings** –presents the key findings from the research. It unpacks findings in line with the Theory of Change (ToC) for the L&R programme, considering whether or not each step in the ToC holds true in practice.

Section 4 – **Lessons learned** –looks in more detail at those steps in the theory of change that did not hold and considers the extent to which this was due to implementation weaknesses, operational design or strategic design of the L&R programme. Based on this analysis, this section highlights examples of good practice from the three districts in piloting of the L&R system, as well as key lessons learned.

Section 5 – **Recommendations** – presents concrete recommendations on the way forward.

1. BACKGROUND

1.1 Genesis of the L&R Programme

The Government of Malawi implements the SCTP, through the MoGCDSW. Beginning as a pilot in 2006, by 2018 the SCTP had achieved national coverage and was reaching over 276,000 beneficiary households. The SCTP provides regular, unconditional cash transfers to households that are both ultra-poor and highly labour-constrained. Promoting access to complementary services was also part of the initial design and it was intended that extension workers (EWs) would carry out information sessions on paydays.

Various evaluation and analytical work has found strong positive impacts of SCTP transfers, but has also documented continued access constraints of SCTP households to other services. For example, the impact evaluation of the pilot SCTP programme in Mchinji in 2008 concluded that, despite strong positive impacts of the cash transfers, more needed to be done to follow through on the commitment to link SCTP beneficiaries to services (Miller et al, 2008).

An assessment carried out in 2012 identified a number of key constraints on SCTP beneficiary households' service access (Robson, 2012). Many of these were supply-side issues: lack of certain services (notably financial services, adult education, vocational training and services for people with disabilities); financial barriers to access (SCTP households unable to afford services); and geographical/transport barriers (services located too far away). However, the report also noted specific access gaps for SCTP households even in

relation to services that were locally available, affordable and relevant to their needs - notably school bursaries, agricultural extension services and birth registration. Key access constraints to these particular services were found to be a mix of discriminatory attitudes of service providers and lack of SCTP beneficiaries' knowledge of their rights.

A more recent impact evaluation, in 2016, again demonstrated substantial positive impacts of the SCTP on consumption, food security, asset accumulation, schooling and the well-being of caregivers (Handa, 2016). It found a multiplier effect of 1.69 for beneficiary households, meaning that (contrary to fears of a dependency effect) households were generating an additional 0.69 Kwacha from every 1 Kwacha they received through the productive investments they made with the cash (Handa, 2016). Furthermore, it found that knowledge of social support services amongst SCTP beneficiary households had increased as a result of the programme: at baseline only one-third of respondents were able to name any available child support or protection service and at endline this had increased to over half (Handa 2016). Nonetheless, the number of children referred to services (mainly health, education and food services), although slightly higher at endline than baseline, remained low, at just 4 percent of all children in beneficiary households (Handa, 2016).

Based on these assessments and other learning, it was decided that more needed to be done to support access of SCTP beneficiaries to complementary services. In 2016, UNICEF, with funding from the Government of the Netherlands, supported the MoGCDSW to design and pilot an L&R system. The decision to opt for a referral system to promote service access for SCTP beneficiaries, rather than other options (such as integrated programming, alignment of the targeting of complementary programmes, or social accountability interventions to improve service responsiveness overall), was driven largely by circumstance: referrals were mentioned in the original SCTP design and the organisation providing technical assistance to the programme, Ayala Consulting, had extensive experience with referral systems in other regions. There was no systematic consideration of the alternatives. The aim of the L&R system was to ensure systematic and standardized linking, monitoring, reporting and referral to existing social services for the most vulnerable SCTP households and their children, thus supporting households to maximize the impact of transfers received.

From 2016, the L&R system was piloted in the two districts of Dedza and Mangochi. UNICEF Malawi engaged a national research institution to undertake a baseline evaluation in these two districts and two comparator districts (Chirwa et al, 2017). This report includes rich information on the living conditions and service access of SCTP households; and Chirwa et al (2017), similarly to Robson (2012), find that the constraints to service access most frequently cited by surveyed SCTP households are distance and cost.

In 2017, six further districts - Nsanje, Mulanje, Balaka, Salima, Chitipa and Mzimba North - were added to the L&R system; and the current assessment reviews the L&R system as a whole, including in pilot and new districts.

1.2 Programme Design

As designed, the SCTP Linkage and Referral System consists of three key processes: i) Supply Capacity Analysis; ii) Refer and Link; and iii) Quality Survey. The Supply Capacity Analysis includes the identification, analysis and confirmation of the capacity and willingness of service providers (SPs) to participate in the provision of services to SCTP beneficiaries; services covered include education, health, agriculture, trade, infrastructure and social services (community). The Refer and Link Process is aimed at guiding beneficiaries to access complementary services of priority to them; extension workers support households to prioritise their needs and then activate referrals to relevant services. Finally, a Quality Survey is conducted with beneficiaries and service providers with the aim of measuring satisfaction and performance.

The design of the L&R system, which was contracted to Ayala Consulting, included the development of detailed manuals, training materials and a Management Information System (MIS) module, to support all

three of these processes. Key actors in the management of the processes are staff of the MoGCDSW and districts, in particular: the L&R Desk Officers at national and district level; Social Support Service Officers (SSSOs) responsible for updating information in the MIS; the District Training Teams (DTTs), composed of staff from various ministries at district level; and Extension Workers (EWs), the frontline workers who support and refer households.

The L&R system in Malawi was designed in such a way that existing EWs already in the field and representing different sectors carried out the frontline work with beneficiary households. This was after they had been trained by the DTTs who themselves were trained by trainers from the MoGCDSW headquarters. Apart from training the EWs, the DTTs also had primary responsibility for compiling the service directory by carrying out the supply capacity assessment, with some participation of EWs. SPs were visited and a detailed questionnaire on their operations administered; after which, if found suitable, they were asked to agree to participate in the L&R system and sign an agreement.

By design, each EW was to deal with one zone, which means that for each SCTP cluster there are three EWs. Once trained, each EW was supposed to visit the households allocated to them, discuss with the beneficiaries their needs, rank the needs and recommend to the beneficiary the SPs that they could visit to have each need addressed. At this point, a referral card was to be issued to the beneficiary. The beneficiary would then take that card to the SP to access the service he/she wanted. The SP would sign the card to show that the service was provided. The EW that referred and linked the individual was later supposed to follow up with the beneficiary to see what had transpired and whatever the result, communicate this to the district so that they could update their MIS.

EWs were government employees from mainly four sectors: Social Welfare, Education, Health and Agriculture. EWs carried out L&R work over and above their normal day to day activities and any other NGO project work in which they were involved. In Dedza and Mzimba districts, most of the EWs that the evaluation team came across were from health (health surveillance assistants) and education (teachers), whilst in Balaka they were largely from the health and agriculture sectors[1].

1.3 Lessons from International Experience

This section briefly summarises some global lessons of key relevance to the design and implementation of the L&R system in Malawi. Firstly, it is important to note that the development of government-led cross-sectoral linkage and referral systems for poor and vulnerable social protection beneficiaries in low-income African countries is at a fairly early stage and that such systems have not yet been extensively evaluated. Whilst there is evidence that complementary services alongside cash transfers can have additional positive impacts (Camacho et al, 2014[2], Hoddinott et al, 2015[3]), detailed evidence regarding what works best in promoting household access to these services is much more limited.

Nonetheless, there is some evidence available on what works from programme reviews/evaluations (largely grey literature) in Ethiopia, Rwanda, Zimbabwe and South Africa, as well from robust published impact

[1] Whilst in Balaka district officers informed us that they had been instructed by UNICEF to exclude teachers so as not to disrupt schooling, this was not the understanding in other districts.

[2] Camacho, Adriana; Cunningham, Wendy; Rigolini, Jamele; Silva, Veronica. 2014. Addressing access and behavioral constraints through social intermediation services : a review of Chile Solidario and Red Unidos. Policy Research working paper; no. WPS 7136. Washington, DC: World Bank Group. http://documents.worldbank.org/curated/en/163481468018056906/Addressing-access-and-behavioral-constraints-through-social-intermediation-services-a-review-of-Chile-Solidario-and-Red-Unidos

[3] Hoddinott, John F.; Berhane, Guush; Gilligan, Daniel O.; Kumar, Neha; and Taffesse, Alemayehu Seyoum (2015). Linking social protection to agriculture: Evidence from Ethiopia. In Policy Focus: The Impact of Cash Transfers on Local Economies. 11(1): 10-11. http://www.ipc-undp.org/pub/eng/PIF31_The_Impact_of_Cash_Transfers_on_Local_Economies.pdf

evaluations carried out in Latin America. In this section, we use these various sources to draw out some generic lessons regarding linkage and referral systems in resource-constrained contexts.

1) The impacts of L&R systems are likely to be muted if substantial supply-side constraints remain unaddressed.

In the design of L&R systems, it is important to consider also the supply of services. Evidence suggests that L&R systems are most effective when combined with attention to the coverage, quality and appropriateness of available services. The positive impacts of a linkage and referral system for social protection beneficiaries in Chile were not replicated in a programme in Colombia, even though Colombia largely copied the Chile programme design (Abramovsky et al, 2015[4]). One key difference between the design of the two programmes that likely contributed to the differential impacts, was that the Chile programme had resources available to fund an expansion of services[5] to cover its beneficiaries, whereas the Colombia one did not (Camacho et al, 2014). Even in Chile, impacts on employment were only observable when there was a corresponding increase in the supply of training and employment programmes (Carneiro et al, 2014, reported in Camacho et al, 2014).

2) Design of the system should respond to the specific needs in a given context, in other words, be "fit-for-purpose".

It might seem obvious that in resource-constrained contexts the focus would be on addressing priority constraints, but this does not seem to always be the case in practice. For example, in their paper, How to Make "Cash-Plus" Work, Roelen et al (2017)[6] raise question marks over the design of the Integrated Nutrition Social Cash Transfer (IN-SCT) pilot programme in Ethiopia and the extent to which it is "fit-for-purpose". This programme offered complementary support alongside cash transfers with the aim of strengthening impacts on child nutrition, health and sanitation. The design focused mainly on behaviour change communication related to hygiene and diet, with only a minor component on water source development. On the other hand, the baseline assessment found already good knowledge, attitude and practices in respect of key aspects of hygiene and child feeding and identified access to clean water as a major constraint, suggesting that the intervention might not have been a realistic response to the most pressing challenges. Another example comes from South Africa, where intense complementary supervision by social workers always goes hand in hand with receipt of the Foster Child Grant (FCG). The problem is that the FCG often faces severe payment delays due to this requirement; and, due to evolution in the caseload of the FCG, it is questionable whether this complementary support is really necessary or value-adding in many cases (Roelen et al, 2016)[7].

3) Integrated service provision for targeted poor and vulnerable households sometimes runs counter to local principles of fairness that entail sharing the benefits on offer around the community.

Experience in several African countries suggests that, in the context of resource constraints and high levels of poverty, local decision-makers prefer to share benefits around the community, in the pursuit of perceived fairness, rather than to concentrate resources on the neediest households. This can create challenges for programmes that attempt to link households already benefitting from cash transfers to additional services and support. For example, in Zimbabwe, whilst the Harmonised Social Cash Transfer (HSCT) programme was intended to provide an integrated set of services (including cash transfers and basic education scholarships amongst others) for ultra-poor, highly labour-constrained households, a rigorous process evaluation found

[4] Abramovsky, Laura, Orazio Attanasio, Kai Barron, Pedro Carneiro, and George Stoye. "Challenges to Promoting Social Inclusion of the Extreme Poor: Evidence from a Large Scale Experiment in Colombia." IFS Working Paper W14/33, November 2014.
[5] The programme promoted linkages to services in health, education, social security, employment and housing (Schulte, undated).
[6] Roelen, K, Devereux, S., Abdulai A., Martorano, B., Palmero, T and Ragno, L., 2017, How to Make 'Cash Plus' Work: Linking Cash Transfers to Services and Sectors, *Innocenti Working Paper 2017-10*, UNICEF, Office of Research, Florence.
[7] Roelen, K., Karki-Chettri, H., Clulow, S., Jones, C, Saksena, P. and Delap, E., 2016, *Researching the Linkages between Social Protection and Children's Care in South Africa*, Family for Every Child/IDS/Children in Distress Network. Accessed here https://www.ids.ac.uk/projects/researching-the-links-between-social-protection-and-childrens-care-2/ on 11/05/2019.

that, amongst those households joining the HSCT, the proportion receiving access to other services, including scholarships, actually fell significantly after joining (AIR, 2014[8]). This was not always due to a simple misunderstanding, but sometimes due to active local rejection of the concept of integrated service provision (AIR 2014). Similarly, in Ethiopia, some cash transfers recipients even described being put under moral pressure to pretend smaller family sizes than they had, in order to reduce their transfer levels and enable more people to benefit from the programme (Ayliffe, 2018b[9]). These local perceptions need to be taken into account in programme design: either accepted and built into design (for example by expanding eligibility to other poor and vulnerable households), or countered (by effective awareness-raising of the merits of concentrating support).

4) The L&R workforce needs to be appropriately skilled

Based on their multi-country review, Roelen et al (2017) highlight how effective psychosocial support to households and case management of referrals to other services requires skilled social workers. On the other hand, they point out that administrative processes do not need to be handled by these same workers and, particularly in contexts where such skills are in short supply, can often be better handled by others; they also flag the important complementary roles that community volunteers can play. In summary, they underline the importance of creative human resource solutions, with an appropriate division of roles and responsibilities that ensure the right skills in the right place.

5) To maximise benefits to beneficiaries, caseloads of extension/social workers need to be manageable

Where caseloads are too high, programme impacts are diluted. Another reason for the lower impacts in Colombia than Chile in the two L&R programmes mentioned above was the much higher caseloads and consequently lighter support provided in Colombia. Both programmes employed full-time qualified social workers, but in Chile they managed an average caseload of 50 households, compared to 130 in Colombia. This meant that, in Chile, households were visited on average ten times per year, whereas, in Colombia, the average number of annual visits was just two. In Rwanda, local caseworkers were supposed to visit households at home, to dialogue, understand their priorities and facilitate their linkage to appropriate services. However, in the context of caseloads of up to 85 households (and around ten hours per week available for this work), they sometimes made very short home visits that involved little more than the repetition of basic messages and appeared to add little value (Ayliffe 2018a[10]). This implies that caseloads, in relation to time available, need to be carefully calculated to ensure sufficient intensity of support to beneficiaries. Furthermore, sometimes, if overstretched, frontline extension workers undertake ad hoc prioritisation of their work in a way that undermines the efficacy of the programme. One-to-one support is time intensive; and, in the context of severe capacity constraints, introducing a new programme of this type may lead to a reduction in other support provided by extension workers. In Ethiopia, with the advent of a programme of one-to-one support of social protection beneficiaries by extension workers, there was actually, between 2010 and 2014, a reduction in the proportion of these same beneficiary households that had any contact with the extension workers. This was because these workers scaled-back their group-based work, under pressure of time (Berhane et al, 2015[11]). (Capacity constraints were actively addressed in the subsequent phase.) In Rwanda, whilst all beneficiaries of the social protection programme were supposed to benefit from caseworker home visits, over-stretched caseworkers unable to reach everyone tended to

[8] AIR (American Institutes for Research), 2014, Process Evaluation of Zimbabwe's Harmonised Social Cash Transfer Programme, UNICEF.

[9] Ayliffe, T., 2018b. *Social Accountability in the Delivery of Social Protection: Ethiopia Case Study,* https://www.developmentpathways.co.uk/publications/social-accountability-in-the-delivery-of-social-protection-ethiopia-case-study/

[10] Ayliffe, T (2018a, unpublished), Case Management in Support of Extremely Poor and Vulnerable Households in Rwanda: an Assessment Report, UNICEF.

[11] Berhane, G., Hirvonen, K. and Hoddinott, J. (2015). The Implementation of the Productive Safety Nets Programme, 2014: Highlands Outcomes Report. Cornell University and International Food Policy Research Institute.

prioritise those perceived to have the greatest potential, rather than the poorest and most vulnerable (Ayliffe, 2018a). This suggest the importance of designing L&R systems in ways that take full account of capacity limitations and avoid any unintended negative effects of overloading frontline workers.

6) The priority focus should be on households most disconnected from services at baseline

In terms of how to prioritise households for support, a rigorous evaluation from Latin America finds that impacts of a linkage and referral system are greatest amongst households most disconnected from services at baseline (Carneiro et al, 2014[12]). This might seem somewhat intuitively obvious, but, as seen above, over-stretched local extension workers do not automatically prioritise the most disconnected households: these households are, after all, likely to be harder to reach and linking them to appropriate services may well be more difficult or take longer. According to Camacho et al (2014) there is a need to give close attention to beneficiary selection in L&R systems. This implies that, in a context where capacities are too limited to effectively support all households in the target group, criteria for prioritising households should be pro-actively specified - and not left to over-stretched local workers.

These findings from the global literature informed the design of the research questions and methodology of the review of the SCTP L&R system.

2. METHODOLOGY

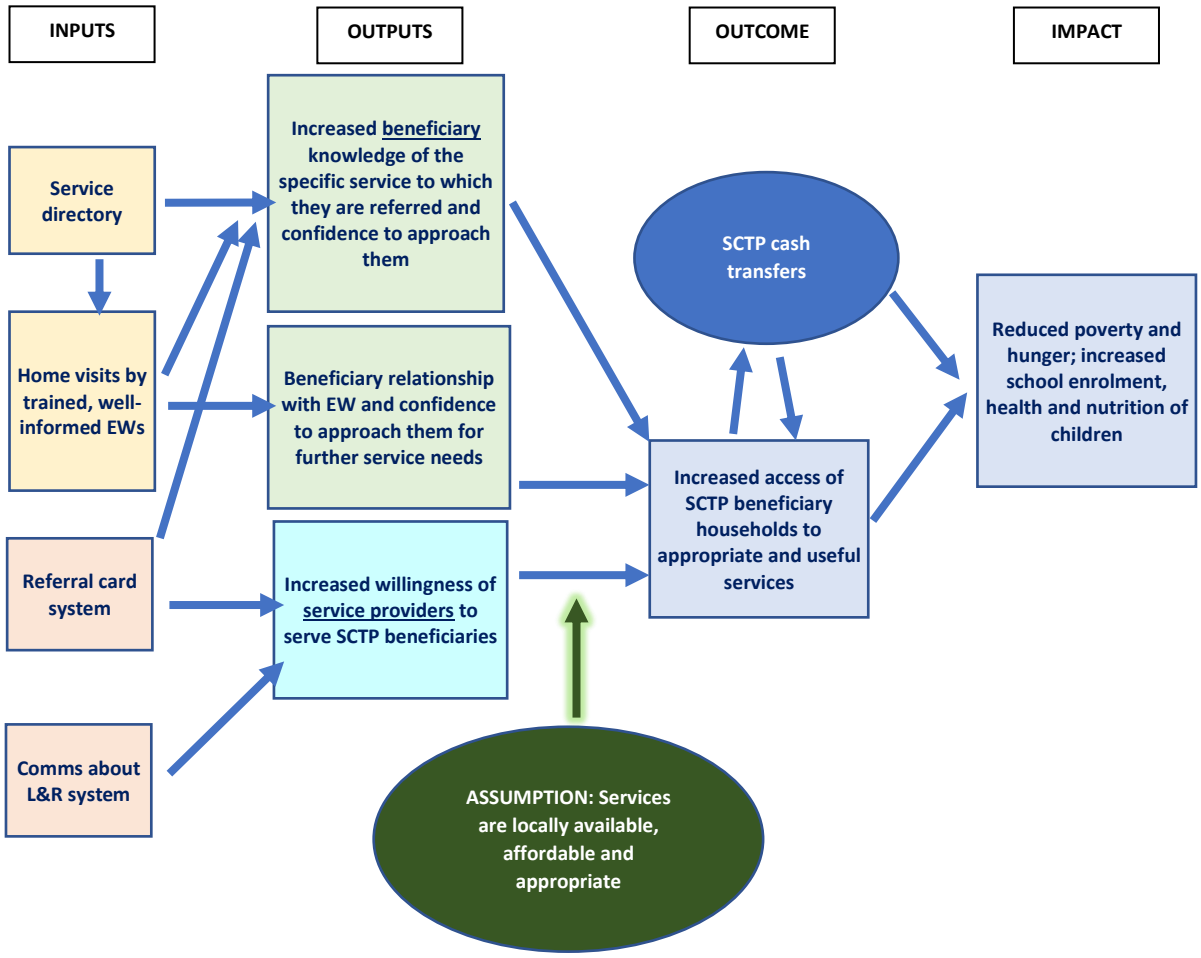
2.1 Theory-Based Approach

The consultants used a theory-based approach in reviewing the programme. This was not an impact evaluation and the consultants did not directly measure impacts of the L&R system on beneficiaries. On the other hand, in order to generate recommendations about the future of the system, it was important that the consultants reach some meaningful conclusions about the likelihood that the system, as currently designed, will lead to the intended impacts. A theory-based approach consists in making explicit the causal chains through which the L&R activities are expected to lead to positive impacts, and then testing each link in the causal chain. The available documents on the L&R system do not provide a detailed ToC, so the consultants constructed one based on their understanding of the L&R system and this was discussed with Government and UNICEF stakeholders during the first mission and amended accordingly. The final agreed version is presented at Figure 1. The key mechanisms through which the L&R programme was expected to bring about its intended impacts were as follows.

Beneficiaries: Beneficiaries will benefit from home visits by extension workers (EWs) to discuss their needs and priorities and identify appropriate services, culminating in a service referral. The utility of these visits will be dependent on EWs' caseloads being manageable (a system design issue) and on EWs' soft skills and knowledge of available services. EW skills and knowledge will be built by training and through the availability of a useful and up-to-date service directory (yellow boxes in Figure 1). The home visits are expected to result in increased beneficiary knowledge about the availability of a specific service appropriate to their priority needs and in their increased confidence in approaching this service provider, armed with a referral card (green boxes).

[12] Carneiro, Pedro, Emanuela Galasso, and Rita Ginja. "Tackling Social Exclusion: Evidence from Chile". Mimeo, The World Bank, 2014. Cited in Camacho et al (2014), op cit.

Figure 1: Theory of Change of the L&R System



Service providers: Communications that highlight to SPs the importance of the L&R system, as well as the referral card system (orange boxes) are expected to result in increased SP willingness to serve and prioritise SCTP beneficiaries (turquoise box).

These outputs will only lead to increased access to appropriate services to the extent that such services exist locally in the six sectors of education, health, agriculture, trade, infrastructure and social services, and are accessible and affordable to SCTP beneficiaries. These assumptions about service supply (green oval) will be critical to the success of the system.

If the outputs are achieved and the assumptions hold, then beneficiaries will increasingly access appropriate and useful services. There is expected to be a two-way interaction between service access and cash transfers: cash transfers will facilitate service access (by covering transport costs, user-fees etc.); and service access will help beneficiaries maximise the returns from cash transfers (by ensuring the health of household members, providing agricultural and business advice, etc.). This should result in enhanced impacts in relation to SCTP objectives: reduced poverty and hunger in SCTP households; and increased school enrolment, nutrition and health of the children in these households.

In addition (and not included the diagram), monitoring and evaluation (M&E) activities, in particular the Quality Survey, are expected to feed back into continual improvement of programme activities.

The overall success of the L&R system will depend on the quality and appropriateness of both its strategic and operational design, as well as on the effectiveness of implementation. As such, the research questions are structured in such a way that they ask whether each step in the theory of change holds true and, if not,

the extent to which this is due to strategic design, operational design or implementation. The key research questions at each of these levels were as follows:

Strategic design: What are the key constraints on service access of SCTP households and how effectively does the design of the L&R system address them?

Operational design: How well was the strategic design translated into the detailed operational design - service directory, operational manuals, training and communications materials, and MIS module?

Implementation: To what extent was the L&R system implemented in line with the operational design? To the extent that there were discrepancies, what was the reason for these: were they simply early implementation weaknesses, or do they flag any underlying issues with design?

The full set of detailed research questions is set out in Annex 1.

2.3 Methodology

The consultants carried out a literature review, followed by consultations with key stakeholders in Lilongwe and fieldwork in three districts: Balaka, Dedza and Mzimba North. Section 3.1 describes the national consultations and section 2.3.2 the methodology used in fieldwork.

2.3.1 Consultations in Lilongwe

At the outset of the first mission, the consultants met with: the UNICEF team; the SCTP Programme Coordinator and L&R Desk Officer in MoGCDSW; DP stakeholders, including KfW, World Bank, Irish Aid and the European Union (EU); NGO stakeholders; and Ayala Consulting. The objectives of these meetings were:

1) To deepen the consultants' understanding of the thinking behind the design of the L&R system and of the causal pathways through which it was expected to achieve its objectives; and to refine and finalise the programme ToC that underpins this review.
2) To receive stakeholders' views on key questions that the review should cover and to use this input to finalise the list of research questions and the field questionnaires.
3) To hear stakeholders' views on key successes of the programme and areas for improvement, and to use these to develop research hypotheses for testing in the field.

The consultants also met with child protection specialists in UNICEF and MoGCDSW to discuss alignment between the L&R and child protection case management systems.

2.3.2 Fieldwork

Selection of Districts, Traditional Authorities and Village Clusters

To review the L&R system in practice, the consultants visited three of the eight districts where it has been implemented: one from each of the three regions of Malawi. These districts were selected by MoGCDSW and UNICEF. The characteristics of the selected districts and the reasons for non-selection of certain others are as set out in Table 1 below.

As can be seen from Table 1, in most districts the percentage of referrals that had, according to the MIS, resulted in a successful linkage was very low indeed. Balaka stands out as more successful with a linkage rate of 32 percent. The consultants took into account in their research the apparent unusual success of Balaka, seeking to understand the reasons for the differential performance.

Table 1: SCTP Linkage and Referral System Assessment District Selection[13]

District (Region: N, C, S)	Total Number of SCTP households	Donor	L&R start date	% linked according to MIS	Selected for L&R Assessment
Mangochi - **S**	19,560	German Govt	2017 – Pilot district	6%	No. Too many studies/pilots- IE, Graduation, Nutrition Top-ups
Dedza - C	**15,635**	**World Bank**	**2017 – Pilot district**	1%	**Yes**
Nsanje - **S**	5,916	EU	2018	16%	No: Graduation
Mulanje - **S**	13,371	EU	2018	1%	No:
Balaka - S	**8,172**	**Irish Aid**	**2018**	32%	**Yes**
Salima - **C**	8,760	German Govt	2018	0%	No: Impact evaluation
Mzimba North - N	**5,520**	**EU**	**2018**	4%	**Yes**
Chitipa - **N**	3,738	German Govt	2018	6%	No: Households re-targeting in progress

In each district, the consultants visited two Traditional Authorities (TAs) and, in each TA, two Village Clusters (VCs). These were purposively selected using the following criteria:

i) **A mix of successful and less successful TAs and VCs in terms of the proportion of referrals that had resulted in successful linkages**. For example, in Balaka, the rate of successful linkages varied across the four TAs between 60 percent and 12 percent and the consultants selected one successful and one relatively less successful TA.

ii) **A mix of remote and well-connected TAs and VCs**. Access to services is likely to be easier in TAs and VCs situated close to key services, markets and roads, so the consultants purposively selected TAs and VCs in order to investigate how the system works in both remote and well-connected locations.

iii) **TAs and VCs that (collectively) have included referrals to a wide range of service sectors**. Whilst most service sectors are included in referrals in most locations, referrals to some service sectors (most notably trade) have taken place in only a minority of VCs. The consultants purposively selected some VCs with referrals to trade services to ensure that this sector was investigated.

In Balaka the TAs selected for field research were: Amidu – very high linkage success rate, close proximity to market and road, including referrals to a wide range of services (the only TA to demonstrate a good success rate with trade referrals, according to the MIS); and Chanthunya - lower linkage success and relatively remote location. The first and third criteria above (success and sectoral mix) were also used for selection of VCs. (We had insufficient information to select on the basis of remoteness). The selected VCs in Balaka district were: Katapira and Hindahinda-Mdenga VCs in Amidu TA; and Nyanyala Kavala and Phalula Tchona VCs in Chanthunya TA.

In Dedza district the selected TAs were Chilikumwendo and Kasumbu; and the VCs were Chidewere and Kathothi in Chilikumwendo TA and Chilasamongo and Madzumbi in Kasumbu TA. In Mzimba North, the selected TAs were Jalavikuwa and Mtwalo; and the VCs were Chandiwira and Thumbi in Jalavikuwa TA and Emusizini and Lunyangwa in Mtwalo TA.

Tables highlighting the performance of each TA and VC against the selection criteria are presented in Annex 2.

[13] Data extracted from the MIS in February 2019.

Research Tools and Sampling of Cases

Methods used were primarily qualitative, complemented by basic quantitative analysis of MIS data (see above). During fieldwork, the consultants carried out:

- Key informant interviews (KIIs) with: staff involved in managing the programme - the L&R Desk Officer and District Social Welfare Officer (DSWO); the DDT; EWs; Community Social Support Committee (CSSC) members; and SPs.
- Focus group discussion (FGDs) with purposively selected groups of beneficiaries and EWs to discuss their experiences of the L&R system; and
- Semi-structured interviews (SSIs) with further purposively selected beneficiaries.

The consultants employed a case study and process tracing approach, whereby particular cases were tracked through the system and, as far as possible, all stakeholders involved were interviewed and asked specific questions about that case. For example, through SSIs, beneficiaries were asked about their experience of the home visit from the EW, how and why a particular service was selected for referral, what happened after they were referred, whether or not they visited the SP and, if not, why not, their experience of the SP (if visited), the extent to which and how the service was useful to them etc. The EW was then asked about their visits to that household and the information they had on the case; and the SP was asked their perspective on service delivery to the beneficiary. Information from different stakeholders was compared and follow-up interviews held as appropriate to investigate any gaps or discrepancies. Information from local stakeholders was also compared to that in the MIS.

It was intended that in each VC, 1 FGD and 4 SSIs would be carried out with beneficiaries, meaning 12 FGD and 48 SSIs in total across the three districts. Beneficiaries for inclusion in FGDs and SSIs were purposively selected to ensure a mix of referrals to different service sectors and referrals of different statuses (open, linked, cancelled, in progress) broadly in proportion to the profile of referrals in that particular VC (according to MIS data). However, at the same time, service sectors with few referrals (such as trade) were over-sampled in order to enable the exploration of such cases; and successful linkages were over-sampled in those VCs were the success rate was very low, in order to understand what had contributed to the unusual successes. The sampling unit was the referral, rather than the household, since the MIS lists each referral separately. However, the SSIs ranged more broadly to cover the household's overall experience with the L&R system.

The sampling entailed a two-stage process of i) purposively selecting the number of households in each category (sector and referral status) to be included in each VC using the criteria set out in the preceding paragraph (see Annex 3 for examples from Balaka district); and then ii) randomly selecting the required number of households from the full list of households in each VC that met these criteria. The purpose of the random selection step was to avoid bias in the selection of particular cases that might have arisen if we had simply asked local actors to select households meeting certain criteria. We selected around twice as many households as we needed, in order to have reserves in case of challenges on the ground in finding the selected households. All the households we eventually interviewed were on the pre-selected list, though, due to logistical constraints on the ground (including heavy rains and mis-communication at local level that resulted in the wrong households turning up in the wrong place or on the wrong day), some interviews had to be cancelled and we ended up relying heavily on our reserves. The actual numbers of interviews and FGDs eventually conducted were as set out in Table 2.

Table 2: Number of Interviews and FGDs Conducted by District

Type of interview	Balaka	Dedza	Mzimba North	Total across three districts
KIIs				
District Social Welfare Officer	1	1	0	**2**
L&R Desk Officer	1	1	1	**3**
Group Int. DTT	1	1	1	**3**
SPs/EWs	9	3	0	**12**
Total KIIs	**12**	**6**	**2**	**20**
FGDs				
FGD with EWs	2	2	2	**6**
FGD with Beneficiaries	2	4	3	**9**
Total FGDs	**4**	**6**	**5**	**15**
SSIs				
SSIs with beneficiaries	**18**	**20**	**18**	**56**
Grand Total	**34**	**32**	**25**	**91**

3. FINDINGS

In this section we use the theory of change (ToC, Figure 1 in Section 2.1) to assess and understand outcomes. We firstly consider the extent to which the intended outcomes were achieved and then track back through the linkages in the ToC to output and input levels in order to unpack the reasons for the observed outcomes.

3.1. Outcome Level

Tables 3, 4 and 5 below summarise the **outcomes** of the 56 referrals we sampled[14]. **Green** colour highlights successful linkages; **red** equals open or cancelled referrals; and **orange** represents cases where service access improved but not due to the referral, or where outcomes are simply unclear.

It can be seen that, according to the MIS, the total number of successful linkages within our sample was 16. It should be noted that, given the low overall percentage of households successfully linked across these districts, our selected households represent a substantial over-sampling of linked households. In other words, we were focusing disproportionately on apparent successes.

Despite this, according to our research, only 4 of the 56 sampled referrals (7 percent) were actually successfully linked. This is based on detailed reports from the households themselves, with triangulation from

[14] NB that we sampled specific referrals, rather than households and the outcomes in the tables are for the specific referrals we sampled. In most cases households had multiple referrals and we consider their experience with these in the qualitative analysis in subsequent sections.

EWs and SPs where appropriate, and defines "successfully linked" as a case where a household has received a service they wanted, that benefited them and that they would not otherwise have received[15].

Of the successful linkages observed, most were in the agricultural sector: one beneficiary received training in compost-making; one received soybean seeds on credit; one received maize seeds and agricultural advice; and one received school uniforms for her children. In the last case it was unclear to the beneficiary whether this positive outcome had been due to the referral or was simply coincidence.

It is useful here to compare these results with those of the Quality Survey carried out as part of the L&R programme to elicit beneficiary perspectives. Whilst the survey was carried out in December 2018, results emerged late and were not available in March/April 2019 when our fieldwork was carried out and analysis conducted. However, results were subsequently shared just before this report was finalised. We noted that the Quality Survey appears to show a higher linkage success rate (40 percent) as compared to 7 percent amongst our surveyed beneficiaries.

Whilst at first sight, this appears a substantial inconsistency, there are several methodological differences that likely explain it. Firstly, the Quality Survey looked at the percentage of beneficiaries that were linked, whereas we looked at the percentage of referrals that were successful. Since most beneficiary households had around three referrals, 40 percent of beneficiaries being linked to at least one service is not the same as 40 percent of referrals being successful (the *referral* success rate according to the Quality survey might actually have been as low as 13 percent[16]). Secondly, as noted above, our definition of "successfully linked" required that the beneficiary would not otherwise have accessed the service, whereas this was not the case for the Quality Survey. In addition to the 7 percent of referrals that were successful according to our definition, we found in a further 13 percent of cases that the beneficiary did access the service mentioned in the referral card, but would have done so anyway, even in the absence of the L&R programme. This was because the service was part of a general distribution or community-wide programme. We did not count these as successful referrals, because they did not represent a value-addition of the programme.

Despite the limited direct benefits of the L&R programme, there were some unexpected outcomes both positive and negative.

Unexpected positive outcomes were mainly observed in Mzimba district, where officials took the initiative to address supply side constraints that they found to be hindering the operation of the L&R system. Noting that during the referral process many SCTP households prioritised farm inputs, local officials: i) collaborated with NGOs to provide group training on compost-making in some VCs; ii) enabled households to access soybean seeds on credit under an ongoing programme in one VC; and iii) in another VC, shared the SCTP target list and L&R data with a project run by the Synod of Livingstonia Development Wing (SOLDEV), which used it to target households for in-kind transfers of seeds and cash top-up transfers in a positive example of harmonised targeting of complementary interventions. In effect, these positive outcomes came about not directly as a result of the L&R system as design, but due to innovations of district officials outside this design.

On the other hand, of particular concern are the reported unexpected negative outcomes for some other beneficiaries across the three districts. Many beneficiaries made an effort to visit the SP to which they were referred, but failed to access the service due to the inability or unwillingness of the SP to provide it. For most this will have entailed costs in terms of travel time and effort, for no benefit. For a minority there were further unintended negative outcomes. Amongst our sampled beneficiaries there were several reported cases of abuse or humiliation by SPs when they attempted to complete their referral.

[15] The reasons for the discrepancies between MIS data and the reality on the ground and the implications of these discrepancies for data management are explored in subsequent sections. In this section, we focus on the actual outcomes for beneficiaries in terms of service access.

[16] If, for example, 40% of beneficiaries had one successful linkage and the other 60% had no successful linkages and the average number of referrals was three per household, the referral success rate would be 13% (40/300).

In Mzimba district one respondent referred for agricultural services to JTI (Japanese Tobacco International who give tobacco input loans) was told that the SP did not know anything about the referral card and was treated rudely,

> *I was shouted at. It was embarrassing. I was rudely described as a thief with new tricks of theft when I presented my referral card. They said that they have their own ways of dealing with their clients and were not aware about the linkages. "We don't accept this. You have devised new ways of theft. Go back home or else we will get you arrested". I was afraid and went back home humiliated*. (Female beneficiary, Lunyangwa VC).

In Dedza, when asked why she had not approached the SP, one beneficiary explained how they had been discouraged due to the treatment of one of her friends,

> *When she took the referral card to the hospital, the service provider rudely told her that 'there is no white person to entertain that referral card'. She came back disappointed without getting the medical services and shared her story, which put off others referred to the same service.* (Female beneficiary, Kadothi VC).

In summary, the intended outcome was not achieved; and, whilst there were unexpected positive outcomes for some beneficiaries in Mzimba district due to innovation at the district level, these were balanced by unintended negative outcomes for others due to negative attitudes of some SPs.

Table 3: Outcomes for Sampled Household in Balaka District

No	Age and sex of beneficiary	Location: TA, VC	Service to which referred	Status according to MIS	Status according to beneficiary's referral card	Status according to the beneficiary's account	Comments
1	80, female	Amidu TA, Katapira VC	Trade	**LINKED**	**Open**	**Data error**	The referral in the MIS was for another individual, but the person is not a member of this household, and was not known to the beneficiary.
2	57, male	Amidu TA, Katapira VC	Agriculture	**LINKED**	**LINKED**	**Visited SP, did not get service**	Wanted chemical fertiliser, but list of eligible hholds could not be altered.
3	6, female	Amidu TA Katipira VC	Education	**LINKED**	**Open**	**Visited SP, did not get service**	Wanted support for school uniforms. Met with headmaster, who just noted their names. Currently no money is available for uniform bursaries and there is not even a waiting list, just the names in a notebook.
4	10, female	Amidu TA, Katapira VC	Health	**LINKED**	**LINKED**	**Issue had been already resolved**	Girl had had malaria, but this had been resolved already at the time of the referral. Nonetheless the girl was referred to the health centre on the insistence of the EW.
5	21, male	Amidu TA, Katapira VC	Health,	**OPEN**	**Open**	**Household head had no recollection of this referral.**	Household head had no recollection of the referral for her 21-year-old son. She did remember being referred to the health centre for herself. Although she was not sick, the EW insisted she go. She was turned away by health staff, due to not being sick.
6	22, male	Amidu TA, Katapira VC	Trade	**CANCELLED**	**No mention of this referral in the card**	**Data error**	The household referral card makes no mention of any referral for the son (22-year-old male) nor of any referral for trade; and apparently he has no card of his own. Household head had no recollection of such a referral either.
7	42, female	Amidu TA, Hinda-hinda VC	Agriculture	**LINKED**	**LINKED**	**Visited SP, did not get service**	Went to visit the lead farmer, but did not get the requested services (training on compost making and information on chicken vaccination). He did not understand from her card what she needed from her. No-one did any follow up.
8	52, male	Amidu TA, Hinda-hinda VC	Agriculture	**LINKED**	**LINKED for service to address "lack of food"**	**Visited SP, did not get service**	Was referred to the SW EW, who was unable to provide any specific service. Just gave him generalised advice to spend his transfer wisely (not tailored to any particular problem with this hhold). NB the children in this hhold are vulnerable – are not attending school, mother is deceased and father has left to live with another wife. But this child protection concern was not picked up during the referral process.
9	48, male	Amidu TA Hinda-hinda VC	Agriculture	**LINKED**	**LINKED**	**Would have received service**	Referral meeting was with the wife, who said she did not participate in agricultural groups etc. But referral for training in manure making was made out for husband. He attended the training, but,

No	Age and sex of beneficiary	Location: TA, VC	Service to which referred	Status according to MIS	Status according to beneficiary's referral card	Status according to the beneficiary's account	Comments
						anyway without referral	given that he is an active member of the agricultural group, he would have participated anyway even without the referral.
10	35, female	Chanthunya TA Phalula VC	Agriculture	**CANCELLED**	**Open**	**Service not accessed despite two visits.**	Beneficiary was referred to the agricultural office for advice on chicken vaccination. Made two visits, but the SP was unavailable. Reported this back to the EW. Still waiting for follow up from either the EW or agriculture officer.
11	68, female	Chanthunya TA, Phalula VC	Agriculture	**IN PROGRESS**	**LINKED**	**Service not accessed**	Did not go to the agriculture office because other beneficiaries went there twice and found the officer unavailable.
12	94, female	Chanthunya TA, Phalula VC	Community	**IN PROGRESS**	**LINKED**	**Service not accessed**	Beneficiary has no recollection of being referred to any CBO for community services and says never went there. Given her severe mobility challenges it seemed highly unlikely that she had managed to walk there, as reported by the EW.
13	68, male	Chanthunya TA, Phalula VC	Agriculture	**LINKED**	**LINKED**	**Visited SP, did not get service**	Although the referral was for him, the household assessment was held at the paypoint with his representative, who is his daughter but not a member of his household. It was also his daughter who went to visit the SP. She reported back to him that the SP provided no assistance.
14	64, male	Chanthunya TA, Nyanyala VC	Agriculture	**OPEN**	**Not seen, possibly never issued**	**Inconclusive**	Interview was held with the elderly household head, not with her son who was the beneficiary of this particular referral, as he was unavailable. No referral card had been issued as far as the respondent knew - apparently the EW had run out of cards and promised to bring it later.
15	68, male	Chanthunya TA, Nyanyala VC	Health	**CANCELLED**	**NOT LINKED**	**Data error - beneficiary was referred only to agriculture**	Referral was only to agriculture, according to the referral card and information from the respondent. Yet in the database it indicates that the household was referred to Mwimba CBO for health services. They did go to the agriculture office but the service was not available.
16	19, female	Chanthunya TA, Nyanyala VC	Mwimba CBO (health)	**CANCELLED**	**NOT LINKED**	**Data error - beneficiary was referred only to agriculture**	Referral was only to agriculture, according to the referral card and information from the respondent. Yet in the database it indicates the households was referred to Mwimba CBO for health services. Went to agriculture office but did not get the service because the officer they talked to said he had no idea about the L&R program and sent them away.
17	32, female	Chanthunya TA, Nyanyala VC	Agriculture AEDC	**CANCELLED**	Missing card	**LINKED**	She went to the agricultural EW by whom she was taught how to make compost manure and she tried to put it into practice, though heavy rains limited crop production.
18	82, male	Chanthunya TA, Nyanyala VC	Agriculture [AEDEC]	**CANCELLED**	Missing card	**Visited SP, did not get service**	Visited the agriculture office where he was told that they were unaware of the L&R system. Followed up with the EW, who told him to simply keep the card. Did not follow up again as unhappy with what happened.

Table 4: Outcomes for Sampled Household in Mzimba District

No	Sex and age of beneficiary	TA, VC	Service to have been linked to	Status according to MIS	Status according to referral card	Status according to beneficiary	Comments
19	16, male	Jaravikuwa TA, Chandiwira VC	Community	OPEN	NOT LINKED	Service not accessed	The service was unavailable in the community.
20	55, female	Jaravikuwa TA, Chandiwira VC	Health	OPEN	LINKED. Health education service	Unclear that this sanitation education was useful to the beneficiary	The card states that the health service accessed was awareness-raising on the importance of having a toilet. The utility of this advice is questionable as the beneficiary had no recollection of it. The beneficiary did receive soybean seeds from the agricultural office, under a different referral – and found this useful.
21	44, female	Jaravikuwa TA, Chandiwira VC	Agriculture	LINKED	NOT LINKED	Linked	Beneficiary received soybean seeds on a credit basis from the agriculture office.
22	37, female	Jaravikuwa TA, Chandiwira VC	Trade	OPEN	OPEN	Service not accessed	The respondent went to the SP, but was turned back as the SP was unaware of the L&R system.
23	43, female	Jaravikuwa TA, Chandiwira VC	Agriculture	LINKED	Not seen	Linked to agriculture service (but not through the SP recorded in the data base)	She received seeds from the agriculture office. Protection issues (beating of child by teacher and sexual abuse of mentally disabled adult daughter) were mentioned in the interview, but not picked up in the L&R system.
24	47, female,	Jaravikuwa TA, Thumbi VC	Community	OPEN	NOT LINKED	Service not available	The beneficiary's priorities were capital to start a small business and help with house construction. Services were not accessed because there are no local providers for such services.
25	65, female,	Jaravikuwa TA, Thumbi VC	Health	LINKED	Health not mentioned	No service accessed.	Health was not mentioned in the referral card. According to the referral card, the beneficiary was linked to some other services, but the beneficiary reported no attempt to seek these, let alone linkages.
26	45, female	Jaravikuwa TA, Thumbi VC	Agriculture	OPEN	LINKED to business capital	Service not accessed	The beneficiary took the card to COMSIP to get business capital. The SP simply signed the card, but no service was received.
27	79, male	Jaravikuwa TA, Thumbi VC	Agriculture	LINKED	NOT LINKED	Not linked.	Went to agricultural office, but was sent away.

No	Sex and age of beneficiary	TA, VC	Service to have been linked to	Status according to MIS	Status according to referral card	Status according to beneficiary	Comments
28	67, female	Jaravikuwa TA, Thumbi VC	Agriculture	**OPEN**	Missing card	**Received training in manure making, but not through this referral**	The respondent did not visit the SP, as her friends came back saying they were not helped. Later many beneficiaries were grouped together to receive training in compost making, which she joined. She also joined a VSL thanks to another of her referrals.
29	75, male,	Mtwalo TA, Emsizini VC	Agriculture	**LINKED**	**LINKED**	**Service accessed**	Given maize seeds and some agricultural advice by the agricultural office. Other referrals were unsuccessful.
30	55, female,	Mtwalo TA, Emsizini VC	Health - bednet	**LINKED**	**LINKED**	**Service accessed, but not because of L&R programme.**	Accessed bed nets, but this was nothing to do with the L&R programme.
31	9, male	Mtwalo TA, Emsizini VC	Education	**LINKED**	Missing card	**Received school uniform but not necessarily due to the referral card.**	Respondent was referred to Mwenje school for school uniform. She did not go to see anyone, but she received uniforms. She does not know why she received these or whether it had anything to do with the L&R system.
32	51, female	Mtwalo TA, Emsizini VC	Health	**LINKED**	Missing card	**Unclear, as beneficiary herself was unavailable for interview.**	Received bednets during general distribution. Unclear whether received any other health service through referral, because another member of the household, rather than the beneficiary herself, was interviewed.
33	41, female	Mtwalo TA Lunyangwa VC	Agriculture	**OPEN**	**NOT LINKED**	**Service not accessed**	Made unsuccessful attempts to access several services, including agriculture. The list for receipt of fertiliser was closed and it was too late in the season for training in compost making to be useful. She was shouted at and called a thief by one service provider.
34	36, female	Mtwalo TA Lunyangwa VC	Trade	**OPEN**	**Trade not mentioned in card**	**Service not accessed**	Health service already accessed – L&R system made no difference. The beneficiary is already going regularly to the health centre to get her insulin. Health is her priority – not trade.
35	23, male	Mtwalo TA Lunyangwa VC	Education	**OPEN**	**LINKED**	**Service not accessed.**	The beneficially was referred to education for assistance with school uniforms. She did not receive the service, but the headteacher signed the card.
36	80, male, 8	Mtwalo TA Lunyangwa VC	Health	**OPEN**	**NOT LINKED**	**Received bednets, but through general distribution, not L&R.**	The beneficiary and various members of his family were referred to health, agriculture, infrastructure and trade. His referral to health (for a bednet) shows as still open in the card.

Table 5: Outcomes for Sampled Household in Dedza District

No	Age and sex of beneficiary	TA, VC	Service to which referred	Status according to MIS	Status according to referral card	Status according to beneficiary	Comments
37	42, female	Kasumbu TA Chilasamongo VC	Education	OPEN	Missing card	Open	The respondent remembered being visited by an EW and the issue of school uniforms being raised. But she did not remember being told to go anywhere specific to get assistance and there was no follow up, despite the EW being the headteacher of the primary school that her children attend.
38	43, female	Kasumbu TA Chilasamongo VC	Agriculture	OPEN	No mention of agriculture in referral card – only health	Service not accessed	She never went to any service provider as she had no idea what to do with the card.
39	40, male	Kasumbu TA Chilasamongo VC	Health	OPEN	Missing card	Service not accessed	He was not told what to do with the referral card given by the EW.
40	46, male	Kasumbu TA Chilasamongo VC	Health	OPEN	Missing card	Visited SP, did not get service	Visited the health service to try to access chlorine for water purification as per referral, but was told to await mass distribution exercise.
41	45, male	Kasumbu TA Chilasamongo VC	Community	OPEN	Missing card	Open	The beneficiary was told he needed to take a witness with him when visiting the SP, but could find no willing person, so did not go.
42	7, female	Kasumbu TA Madzumbi VC	Education	OPEN	Open	Did not access service	Did not go to the school for the referral for school uniform. It was unclear to us why, because the respondent was not directly involved in discussions with the EW and the referral was a long time ago - in 2016.
43	45, female	Kasumbu TA Madzumbi VC	Agriculture	OPEN	Open	Did not access service	She did not visit the SP, because it is very distant.
44	31, male	Kasumbu TA Madzumbi VC	Trade	OPEN	Open	Service not accessed	He has never accessed any service nor met any service provider.
45	46, male	Kasumbu TA Madzumbi VC	Trade	OPEN	Open	Service not accessed	Beneficiary did not go to the SP (FINCA), because he did not want to access credit whilst on the SCTP.
46	8, female	Kasumbu TA Madzumbi VC	Health	OPEN	Open	Service not accessed	Beneficiary (mother of child) does not know the use of the referral card and thinks it is one of the cards required for SCTP payments.

No	Age and sex of beneficiary	TA, VC	Service to which referred	Status according to MIS	Status according to referral card	Status according to beneficiary	Comments
47	63, female	Chilikumwendo TA, Chidewere VC	Agriculture	**LINKED**	**Open**	**Did not go to the service provider**	The beneficiary is yet to access any of the services from either phase, as she was simply told to keep the card safe and that it will be required at a later date.
48	31, female	Chilikumwendo TA, Chidewere VC	Agriculture	**LINKED**	**Card completely blank**	**Service not accessed**	A blank referral cared was given to the beneficiary, who was advised to simply keep the card safe for future use. She is still waiting to be advised as to when and how to use it.
49	49, female	Chilikumwendo TA, Chidewere VC	Education	**LINKED**	**Card completely blank**	**Did not go to the service provider**	Having heard from others who went to a health centre to seek a referral that the card was being thrown away by the SP, she did not dare approach her proposed SP.
50	42, female	Chilikumwendo TA, Chidewere VC	Health	**LINKED**	**Card completely blank**	**Service not accessed**	Was issued a blank referral card. Just keeping it safe for future use.
51	38, male	Chilikumwendo TA, Chidewere VC	Health	**LINKED**	**Has never received a card**	**Service not accessed**	Beneficiary was not told where to go to access services and was never given a referral card.
52	45, female	Chilikumwendo TA, Kakhoti VC	Education	**OPEN**	**Open**	**Service not accessed**	There is no service provider who provides school uniforms to the needy in the community. Instead, she just used her SCTP earnings to buy school uniforms.
53	37, female	Chilikumwendo TA, Kakhoti VC	Agriculture and livestock	**OPEN**	**Card completely blank**	**Service not accessed**	EW gathered the beneficiaries at the school ground where he distributed blank referral cards. He did not explain their use.
54	88, male	Chilikumwendo TA, Kakhoti VC	Trade	**OPEN**	**Card completely blank**	**Service not accessed**	Beneficiary was given a blank card at the paypoint and was not explained its purpose.
55	55, male	Chilikumwendo TA, Kakhoti VC	Community	**OPEN**	**Open**	**Service not accessed**	The respondent wanted HIV counselling, but he was just told to keep the card safe and that it would be required at some future point.
56	66, female	Chilikumwendo TA, Kakhoti VC	Infrastructure	Not seen	**Open**	**Service not accessed**	Was told by the EW to keep the card safe awaiting communication from the EW once SPs were identified. No follow up since.

3.2 Assumptions

In this and subsequent sub-sections we unpack the reasons for the limited positive outcomes of the L&R system, with a view to making recommendations on how the programme can be strengthened.

As can be seen in Figure 1 in Section 2.1 above, the critical assumption underpinning the ToC of the L&R system is that service supply is appropriate, adequate, accessible and affordable across the six sectors of education, health, agriculture, trade, infrastructure and social services.

A key reason for the limited success of the programme is that this assumption did not hold. There are serious supply side constraints across all sectors as follows.

Education

Most of the education-related referrals in our sample were for assistance with school uniforms. Uniforms are a priority for parents because without them their children risk being sent home from school. However, in almost all cases these referrals met supply-side constraints. The constraints were of various kinds: sometimes there was simply no SP offering such assistance in the locality; in other cases, the timing of the L&R system did not fit with the timetable for provision of uniforms, such assistance having been provided shortly before the referral process and no further round being envisaged. The following scenario was typical,

> *I also went to the head teacher at the primary school to access school uniform and unfortunately he told me that they don't offer such a service. He told me to try at the Ekwendeni Resource Centre, but when I went there the response was also disappointing as well. I was told to go back home and keep waiting*. (Female beneficiary Mzimba district, Lunyangwa).

Even when support is offered, selection of children is generally carried out by school committees, such as mothers' groups, using their own criteria that have nothing to do with the SCTP and are not subject to influence by the L&R system. As such, a referral for uniform usually simply led to the beneficiary finding that they were not on the pre-determined list for distribution.

A key challenge facing SCTP beneficiaries is the high cost of secondary education, especially when the school is located at some distance. SCTP transfers were reported to be insufficient in such cases to maintain children in school and we met several cases of children who had dropped out. In theory the L&R system could help in such cases by linking households to bursary schemes, but we found no examples of this.

> *… [school fee] was K8,000 but now raised to K12,000 per term...My child who has dropped out of secondary school needed school fees, money for food and learning materials and also money to pay rent as she was a self-boarder. She was fending for herself at school which is far from here* (male beneficiary, Balaka district, Hinda-hinda VC).

Health

Most beneficiaries are aware of the health services available in their areas, including the community services offered by Health Surveillance Assistants (HSAs) and, as long as the services are sufficiently close and affordable, report that they are already accessing them,

> *When a child is sick I would go and see the HSA to look for help* (female beneficiary, Dedza district, Chilasamongo VC).

> *Mainly they [HSAs] teach people about sanitation, making sure that people have toilets, bathrooms, drying lines for clothes, a kitchen, make sure that they clean their homes and surrounding things like those. They also make sure that we have handwashing facilities outside the toilets to encourage people to wash hands after visiting the toilet.* (Female beneficiary, Mzimba district, Lunyangwa VC.)

> *I have been visited around twice, and they came with a health talk. They were teaching me about sanitation, the importance of having a toilet, rubbish pit, clean house and encouraging us to cover our food. They regularly visit me because this one was born premature, so when she is down with malaria it gets scary.* (Female beneficiary, Mzimba district, Chandiwira VC).

We encountered only one beneficiary who reported that, thanks to the L&R system, she was now accessing health services more than previously,

> *At first, I wouldn't go to the hospital and sometimes I would just buy over the counter pain killers or just lie around till I got better without doing anything about it. Now with the chat that I had with the EW I decided that I should be going to the health facility every time* (female beneficiary, Balaka district, Phalula VC).

The main constraints on service access are distance, cost and lack of medicines in facilities. In some localities (for example Phalula VC in Balaka), the only local services are fee paying and cost is a key barrier to access. In others, the services are theoretically available and free, but medicines are lacking,

> *the girl was not given any medicine because they said that there were no medicines* (female beneficiary, Balaka district, Katapira VC).

Agriculture

There are two types of agricultural services available in the surveyed villages: subsidised agricultural inputs and training/advisory services. The Fertiliser Input Subsidy Program (FISP) is the key national input programme, providing coupons to selected households to access fertiliser.

The FISP has been extensively studied. Kilic et al (2013)[17] find that, "the Farm Input Subsidy Program is not poverty targeted" (p4), and that the relatively well-off and locally well-connected - rather than the poor or the very wealthiest - have a higher likelihood of programme participation. Given this, it is unsurprising that most of our surveyed household reported not being on the list for coupon distribution in the current year. There were a few reports of households on the SCTP being actively excluded from receipt of fertiliser coupons, though this was not the case in all localities,

> *Yes, for example, FISP and last year my name was on the list. People reacted and it was replaced by someone else who is not on SCTP* (female beneficiary, Mzimba district, Chandiwira VC).

The practice of sharing of coupons between those on the list and other households varies between geographical areas – in some this is the common practice, in others little or no sharing takes place. Where sharing takes place, our respondents were much more likely to report having some access to fertilizer. However, Kilic et al (2013) report that, in general, even when sharing takes place, the relatively well-off still receive a greater number of input coupons than the poor.

[17] Kilic, T., Whitney, P. and Winters, P., 2013, Decentralized Beneficiary Targeting in Large-Scale Development Programs, Insights from the Malawi Farm Input Subsidy Program, World Bank Development Research Group, Policy Research Working Paper no. 6713, accessed at http://documents.worldbank.org/curated/en/819561468055790131/pdf/WPS6713.pdf on 10/05/2019.

Critically, for the L&R system, the FISP lists are established independently of the SCTP or L&R and are fixed – they are not subject to amendment by agricultural EWs. This meant that no referral to this programme was ever successful: households were simply told that they were not on the list and sent away. In some areas there is additional support available for agricultural inputs from NGOs. But, again, lists are generally established independently and are fixed. The only exception to this that we found was the Synod of Livingstonia project in Mzimba district, which harmonised its targeting with the SCTP in one VC, as discussed in sub-section 3.1.1 above.

As for agricultural extension, many of our surveyed households already have access to whatever training and advisory services are available in the locality, training in compost-making being the most widely reported available service,

> *We were trained on how we can make compost manure by mixing some of the compost together with a little bit of fertiliser* (female beneficiary, Dedza district, Chilasamongo VC).

> *They usually call us every now and then… they train people on how we can make compost manure by mixing a little bit of fertiliser and other things. When the manure is ready, we usually use it when we are planting the maize* (male beneficiary, Mzimba district, Lunyangwa VC).

Where access to these services is lacking this often seems to be because there is no EW nearby or the nearest one is not very active. Given this, the L&R system often failed to add value. In some cases, the referral was for services that the beneficiary would have received anyway through the normal community training plan; and in other cases, there was no local EW willing and available to provide support.

Trade

Trade services were severely lacking in all VCs surveyed. In Balaka, beneficiaries (without disabilities) requesting business advice or capital were mistakenly referred to the Malawi Council for the Handicapped (MACOHA), a disability organisation, there being no other trade-related SPs.

In Chandiwira VC in Mzimba, beneficiaries were referred to SPRODETTA, an NGO which promotes small scale business. However, this SP turned beneficiaries away,

> *I also went to SPRODETTA for training in business but they said they need to consult their bosses first because they knew nothing about this programme* (female beneficiary, Mzimba district, Chandiwira VC).

There were no available trade-related SPs in Dedza and all referrals to trade remained open.

Infrastructure

The supply constraints in the infrastructure sector are also severe across the three districts. Apart from a few community-based organisations (CBOs) providing very small-scale support to house renovation, there were no available SPs in this sector. The supply of services from CBOs was inadequate to meet demand and most referrals remain open. The following quote highlights the small scale of operations of most CBOs,

> *Sometimes, say, seven people would come asking for help regarding house renovations and that meant that we were a bit overstretched* (Dedza district, Chimwemwe CBO).

Social Services (Community)

The supply response to referrals for social services has also been inadequate and we found no successfully linked referrals in this sector. One beneficiary in Kathothi in Dedza was referred for HIV counselling in 2016, because he is HIV positive and felt he needed psychosocial support. He was told that he would be contacted once an SP was identified and he has been waiting ever since. A male beneficiary in Hinda-hinda VC, Balaka district was referred to the social welfare (SW) EW for advice, but received just generalised instructions to spend his SCTP transfer wisely, not tailored to his particular circumstances. In fact, in this case (as mentioned above) there were apparent child protection issues – the father had left the children in the care of relatives to move in with a new wife and the children were out of school - but these issues were not addressed.

Cross-cutting

Apart from the sectoral governmental services highlighted above, a cross-cutting challenge with NGO services is that they tend to have their own catchment areas and targeting criteria, dependent on funding source. As a district official in Mzimba put it,

> *We have gone into their offices but still most NGOs get funds for a specific project they want to implement in a specific catchment area. They have their own characteristics and at the end of the day they want their outputs to convince the donor.*

Summary

In conclusion then, wherever appropriate, affordable services are available locally most SCTP beneficiaries are already accessing them. Service access gaps due to the failure of beneficiaries to demand services are rare. Instead, gaps are generally due to supply side constraints, which are extensive and, depending on sector and locality, include: a complete lack of services; services that are too distant or expensive; services with closed lists of beneficiaries; or, frontline staff who are unresponsive to clients' needs. As summarised by a District official in Mzimba, "We didn't succeed very much because of the resistance we faced from the service providers".

3.3 Output Level

In section 3.1.2 above we saw how the key assumption underpinning the design of the L&R design – sufficient supply of services across the six sectors – did not hold. This means that, even if intended L&R outputs had been achieved, they would probably not have resulted in achievement of intended outcomes.

In this section we go on to consider the extent to which L&R programme outputs were, in fact, achieved. As per Figure 1 in Section 2.1, the key intended outputs were: i) increased beneficiary knowledge of the specific service to which they are referred and confidence to approach them; ii) beneficiary relationship with EW and confidence to approach them for further service needs; and iii) increased willingness of service providers to serve SCTP beneficiaries.

We find the status of the outputs to be as in Table 6 below:

Table 6: Output Status

Output	Status	
Increased beneficiary knowledge of the specific service to which they are referred and confidence to approach them	Largely	achieved
Beneficiary relationship with EW and confidence to approach them for further service needs	Not achieved	
Increased willingness of service providers to serve SCTP beneficiaries.	Not achieved	

The colour coding in Table 6 follows that in Tables 3, 4 and 5 above: red for not achieved, green for achieved, orange for indeterminate. In addition, a colour combination (green/orange) is used to represent an outcome falling between orange and green.

Increased beneficiary knowledge of the specific service to which they are referred and confidence to approach them

There were a few examples where the L&R system increased beneficiary knowledge of services. Two cases of increased awareness of available services are of particular interest. According to a key informant in Dedza district office, in Dedza, some pregnant women who are SCTP beneficiaries did not know that when they go for antenatal care they can receive a free mosquito net. Due to the L&R system they learned this and now demand the net. In one VC in Dedza, children from SCTP beneficiary households risked dropping out of school because of lack of uniform and were unaware that a benefactor was willing to provide school uniforms to children in the community; thanks to the L&R system they were able to approach the person for assistance.

However, in the main, as noted above, beneficiaries were already aware of services available in their community. The effect of the referral system was less on knowledge of services and more on confidence to approach SPs. As a result of the referrals in their cards, some beneficiaries took action to approach the SP to which they were referred and this seems to be partly because having the card increased their confidence to approach the SP. The extent to which this happened varied between districts: in Balaka and Mzimba districts approximately half our sampled households approached the SP to which they were referred; whereas in Dedza only a single household did so, due to weaknesses in the household assessment process (see section 3.4 below).

On the other hand, not all the referrals in Balaka and Mzimba were even potentially useful to the beneficiaries. In particular, there were cases of beneficiaries being referred to health providers when they were not sick, and of being referred for ongoing health issues for which they were already under treatment or had been recently seen,

> *I was not sick, but the extension worker insisted that I should still go to the health facility despite telling her that I was not sick at the time and that's why I went to the health facility because she insisted that I would be attended to* (female beneficiary, Balaka district, Katapira VC).
>
> *He said that when I get the referral card I should go to the hospital. But I already go to the Mzuzu Central Hospital regularly to access insulin injections to stabilize my sugar levels* (female beneficiary, Mzimba district, Lunyangwa VC).
>
> *There were some beneficiaries who were found to be sickly in the communities. Without checking in their health passbook when they had their last HIV test, they [EWs] were sending*

them to the clinic to have their blood tested for HIV when actually the person had taken the test maybe just a week earlier… going by the HTC protocols we were not supposed to test the person again, so we had to send them back (HSA, Balaka district).

Furthermore, not only did many SPs send referred beneficiaries away without explanation, but some SPs reacted negatively to the referral card and treated beneficiaries rudely. Reports back from their friends about these incidents led to some beneficiaries lacking the confidence to approach SPs. Some examples are quoted in section 3.1.1 above. A further example comes from Dedza district where a beneficiary heard from a friend that on approaching a health facility with her card she was rudely sent back. She felt that "this card brings mischief and shame" and did not have the courage to pursue her own referral to a school (female beneficiary Kathothi VC).

District level respondents collaborated such stories of rude reception by some service providers,

The people that are supposed to receive a Mosquito net are only those that are under five years of age, or a pregnant woman, so for cases where a man stays alone and suffers from frequent malaria and was referred to a health centre to seek for a mosquito net, a health personnel was asking the man whether he was pregnant, which was rude (DTT member, Dedza district).

We conclude that this output was largely achieved (particularly in Mzimba and Balaka districts), but with some gaps. Whilst most beneficiaries already have good awareness of locally available services, there were a few cases where the L&R system increased this. There were many cases where the card increased beneficiary confidence to make an initial approach to an SP, but some cases where it actually undermined this confidence due to reports back from friends of rude and dismissive treatment by SPs.

Beneficiary relationship with EW and confidence to approach them for further service needs

This output was not achieved. There was no evidence of any beneficiary building a relationship with the EW who visited them and going on to approach them for further service needs. Nor did increased knowledge of SPs in the locality lead to any beneficiary taking action to approach SPs for new needs beyond those listed in their referral card. Any benefits of the system were limited to the specific listed referrals.

Furthermore, even in relation to the initial referrals, whilst there is evidence that, thanks to the referral card, many beneficiaries made initial approaches to an SP, their confidence to take follow up action with either the EW or SP when things went wrong was extremely low. Many beneficiaries simply waited, sometimes for years, hoping for some follow up action,

He said that once they identify the service provider, they will come to us and we have been waiting ever since [since 2016] (male beneficiary, Dedza district, Kadothi VC).

Our names were called out and then they gave us the cards saying they will be needed in the future. So everyone received this card. We were told to take very good care of them because they will be required in the future. I just kept it, waiting for the right time (female beneficiary, Dedza district, Chidewere VC).

*I have not bothered to go to [CBO] because I felt very discouraged when I heard that my friends who were also referred to the same service provider were never assisted when they went there. They were told that the iron sheets are out of stock and they should wait until stock is restored. They are still waiting and for me going there would just be a waste of time (f*emale beneficiary, Mzimba district, Emisizini VC).

I just gave up that nothing will ever work out (male beneficiary, Balaka district, Hinda-hinda VC).

Community Social Support Committees (CSSCs) already play roles in the implementation of the SCTP, but have been engaged to only a very extent in the SCTP, due to concerns that they lacked the educational level and literacy skills required to complete the referral forms. Some of the CSSC members met during the course of fieldwork clearly had stronger existing relationships with SCTP beneficiaries than the EWs; and some district officials indicated that there may be merit in re-examining the role of CSSCs in the L&R system,

> *There are people out there who are committee members and who are more active and more intelligent than the EWs themselves. You are right, we have certain centres where the committee members asked to be included in some of the trainings because some of the EWs spend their time drinking and do nothing on the ground.* (District official, Mzimba).

On the other hand, another official pointed out the challenges of working with volunteers who are not receiving allowances,

> *You know it's not always the same between those that get paid and those that are just volunteering their services. Those volunteers, when they have something to do, they prioritise that first. When we have something for which there are no allowances those are on the payroll you can push them and say it's part of your job, while the volunteers you cannot and we can only work with them comfortably when there is an allowance for the job. (District official, Dedza).*

Increased willingness of SPs to serve SCTP beneficiaries

This output was not achieved. The L&R system does not appear to have had any positive effect on the willingness of SPs to serve SCTP beneficiaries. Indeed, the introduction of a specific intervention around referral appears to have decreased willingness in some ways. Rather than promoting the idea that serving SCTP beneficiaries is a core part of the day-to-day work of frontline service staff, the L&R system appears to have been perceived as a special project. Many frontline staff are EWs and a minority of these EWs were selected to carry out home visits to assess referral needs of SCTP households and paid allowances for this and the associated training. As such, those frontline staff not directly implicated in the system as EWs and not in receipt of the allowances sometimes felt resentment and were resistant to playing their part as SPs,

> *The other problem that was there amongst us health workers or extension workers, there are some who did not undergo the linkage and referral training. So it was happening that a service provider is one of those who did not attend the training, so you know there are some jealous tendencies among those of us working in the Government…you could refer a person to them and they could say they didn't know anything about the linkage and referral system.* (HSA, Balaka district).

> *Others could send back the beneficiaries and said no we don't know this program. Who are you people? Go back!* (District official, Mzimba district).

> *…the service providers should also have a clear knowledge about what is happening because some of the service providers would not give the service assuming that those that were referring the beneficiaries to them had pocketed money which was meant for them, which was not right. So it is important that they all have knowledge and that would help our beneficiaries to receive the right attention* (FGD with EWs Dedza district, Kasumbu TA).

Whilst the referral forms did capture information on unmet needs there was no defined channel to use this information, for example to advocate for improved service supply.

Several district officials questioned the L&R model of relying on individual referrals to elicit a supply response. Given that many priorities were shared across households, they suggested that more use could be made of paydays as an opportunity to bring service providers to the beneficiaries in a kind of "one-stop shop" model,

> *We thought this linkages and referrals program was supposed to be like a one-stop centre, whereby when you are going for payment it means we have hospital personnel, agriculture personnel, perhaps police personnel on board. Beneficiaries can be receiving their payments while on the other hand others are being weighed on the scale, blood pressure measured, sugar and so on and so forth. The HSAs would be offering primary health care. So it's a lot of services in one basket.* (District official, Mzimba district.)

3.4 Input Level

Having established the status of the three intended outputs, the current sub-section further explores the reasons for these, by looking at programme inputs. As per the ToC in Figure 1, the key inputs to the L&R system were: i) the service directory; ii) home visits by trained and well informed EWs; iii) the referral card system; and iv) communications to SPs about the L&R system. Information on inputs is summarised in this report, being presented in more detail in the accompanying district level report[18].

We find the status of inputs to be as follows:

Output	Status
Service directory	**Not achieved**
Home visits by trained, well informed EWs	**Partially achieved**
Referral card system	**Partially achieved**
Communications about the L&R system	**Not achieved**

The demand side interventions – home visits and referral card system – worked relatively well. However, those activities concerning the supply side – the development of a service directory and communications to SPs about the L&R system – were not effective.

Service directory

Service directories were developed in all three of the surveyed districts, in line with programme design. They listed services available in the locality, each of which was given a code that figured in the directory and was used on the referral forms. District officials reported finding the directory useful for purposes beyond the L&R system, such as when asked for information on NGOs by other government departments. However, the service directory was of very limited utility to EWs in actually referring SCTP beneficiaries and for this reason we conclude that the input was not delivered. The reasons for this were several.

Firstly, there were serious quality challenges with the directory: in all districts, there are substantial discrepancies between the services listed in the directory and the reality on the ground. For example:

[18] Mvula, P. and Ayliffe, T, May 2019, A Qualitative Review of the Linkage and Referral System of the Malawi Social Cash Transfer Programme: Draft District Level Report.

- In TA Amidu in Balaka, the code for one key government service provider, the Agriculture Office was missing entirely, leading beneficiaries' referral cards to refer instead to an NGO that had left the area.
- In TA Chilikumwendo in Dedza district, the service directory contained some CBOs that were non-existent and others that had no staff stationed in the area.
- In Mzimba district, there was a mix up between Chandiwira and Thumbi village clusters where service providers listed in Thumbi cluster were found to be in Chandiwira cluster.

In some cases, such issues were simply due to compilation errors, but there was also a more systematic challenge of SPs providing false information. As explained by a district official in Dedza district,

> *The fact is that they did understand, but it's just the syndrome that when you try to involve them in something, they just assume that there is money involved. That is why they could not be truthful, thinking that maybe in the end they will get some kind of funding, but we were clear on this from the beginning.*

An earlier recommendation arising from the first pilot in 2016 was that EWs (rather than the DTT) should lead the development of the service directory, as they have better knowledge of service availability on the ground, but this recommendation was not implemented[19].

Another more fundamental problem is that the service directory questionnaire and service agreements did not focus sufficiently on the extent to which services were available to new beneficiaries on an "on-demand" basis; that is to say whether the SP could and would accept referrals. With the exception of health services (and to some extent agricultural extensions), most NGOs and government programmes in rural Malawi are actively targeted and have an already fixed list of beneficiaries. This is different to the "on-demand" model of service provision prevalent in some other contexts where clients can approach a provider and request a service, which (based on an assessment of their eligibility where appropriate) will then be provided. Whilst the service supply questionnaire asked SPs general questions about their capacity to take on new clients, it did not explicitly ask whether services were available on an "on-demand" basis.[20]

As a result, of these constraints, the service directory rarely added value to the work of EWs. Working in the local area, EWs were generally aware of locally available services. When the service directory listed services of which they were unaware, these often proved not to actually be available for one or other of the reasons set out above.

Home visits by trained, well informed EWs

This is one of the central pillars of the L&R system as designed. Beneficiaries are supposed to benefit from home visits from EWs to discuss their needs and priorities and identify appropriate services, culminating in a service referral. The utility of these visits is dependent on: EWs' caseloads being manageable (a system design issue); EWs' skills, developed through training; and appropriate manuals and guidelines. Overall, we found this input to have been partially delivered. In this section we look in turn at: how visits were actually conducted; the extent and quality of training; and the utility of manuals and forms.

Home visits

The effectiveness of home visits varied substantially between and within districts. In Balaka and Mzimba, home visits were made to most beneficiaries for initial assessment, with a few isolated cases

[19] Ayala Consulting, 2016, Referral and Linkages, Presentation 20/11/2016.
[20] Ayala Consulting, 2016, Manual A: L&R Service Providers Supply Capacity Analysis, Annex E.

of assessment at the paypoint or carried out by someone other than the EW. In Dedza there were two waves of implementation – a first pilot in 2016 and a scale-up pilot in 2018. Home visits were generally made in the first wave, but not in the second when assessment was most often done at the paypoint. Overall, of 41 beneficiaries who indicated the exact location of assessment, 25 were visited at home and 16 assessed at pay points. The weaker performance in Dedza regarding home visits may have been related to higher caseloads. The four EWs we interviewed in Dedza had caseloads of between 64 and 128 households, as compared to a median[21] of 36.5 households across the districts.

In Balaka and Mzimba districts, there was a wide variety of referrals and, in some cases, an impressive coherence between beneficiary statements of their priorities during SSIs and the list of referrals in their cards. This suggested that EWs had done a good job in eliciting specific beneficiary priorities, a pre-requisite for useful referrals. This was much less the case in Dedza, where beneficiaries struggled to recall what their priorities had been and often seemed unaware of the referrals listed in their card.

The beneficiary household assessment guidelines in the Refer and Link manual suggest that EWs are supposed to develop a deeper relationship with households, "During the assessment the EWs understand the household dynamics, e.g. the interaction between members, any observable effects of maltreatment, behaviour of the members and their physical conditions in order to identify needs. The best way to conduct the assessments is through building a relationship of trust with the household and the use of dialogue techniques."[22]

However, even in Balaka, home visits were brief (20-30 mins) and according to the beneficiaries, felt rushed. Whilst the questionnaire / checklist provided to EWs is a very useful entry point for discussion, it appeared that instead of being used in this way it was often instead a tick-box exercise,

> *He was rushing to go elsewhere so he did not stay for long* (female beneficiary, Balaka district, Katapira VC).
>
> *He had many places to visit and he was very busy* (female beneficiary, Balaka district, Chalula VC).
>
> *He didn't take much time. You have actually taken longer than he did. It was so brief and he left* (female beneficiary, Mzimba district, Thumbi VC).

Whilst we cannot directly measure the effect of rushed visits on the quality of work, it seems unlikely that trust could be built or that sensitive issues would emerge in such conditions. It is after all, as commented by a district official in Dedza, "not easy to visit somebody and identify the needs just like that". There is a risk that beneficiaries simply articulated obvious, but not necessarily top priority, needs. Indeed, a district official in Mzimba observed that many of the problems emerging from this exercise were the same for all households,

> *When we visited and assessed these people all they said was that their major problems were fertilizer, food shortage and seeds. In the real sense these are not the only needs that a person may have. These are the short-term needs because we forced them to tell us their problems.*

We found, perhaps as a result of the rushed visits and "tick-box" approach, several examples of child protection issues that had not been flagged or followed up with the L&R system. For example, in Hinda-hinda VC in Balaka a father had left his children in the care of relatives to move in with a new wife, who refused to care for the children of another woman, and the children were out of school. These issues were not mentioned in the referral. In Phalula VC, Balaka district there was a household

[21] The median is the middle caseload, calculated by ordering the EWs' reported caseloads from lowest to highest. The mean caseload is slightly higher than the median – 42 households – due to a few outliers (very high caseloads) in Dedza district.

[22] Ayala Consulting, 2016, Social cash transfer program: linkages and referrals. Manual B: Refer and Link Process.

in which a 17-year-old child with a hearing disability had an 8-month old baby. In another household in Chandiwira VC, one child had been physically abused by a teacher and a mentally disabled adult had been sexually abused multiple times and given birth to two children, the first apparently when still a child herself.

In all three districts, EWs were given 10 days in which to make the home visits and our findings show the median caseload to be 36.5 households. In line with the finding from the global literature that it is important to carefully calculate caseloads in relation to available time (see section 1.3 above), we carried out this calculation. If we assume a 7-hour working day, the 10 days means a total of 70 hours, so an average of nearly two hours per household, including travel and associated paperwork. This appears adequate for one substantial visit, so lack of sufficient time allocated to this task in programme design is not an obvious reason for the rushed visits made by most EWs[23]. For most EWs, the problem may have had more to do with their other work priorities and the incentive structure they faced for work on the L&R. This is discussed in more detail in section 4.2.2 below.

Furthermore, although the time allocation appeared sufficient for one visit, it would have been insufficient to enable most EWs to carry out any follow up visit; and they reported receiving only one day's payment in total for follow up of all households. It is thus perhaps not surprising that in only a small minority of cases did households report receiving any follow up visit after the initial one. In most cases, follow up consisted of a quick check of referral cards at the paypoint or other meeting point; and in one third of our sampled cases for which this information was available there was no follow up at all.

Training

Adequate training is clearly critical to the quality of the home visits carried out by EWs. In line with programme design, training happened through a cascade system: firstly, national trainers were trained, including Ministry staff; they went on to train DTTs in each district; who, in turn, trained the EWs.

The DTTs generally felt that the training they received was sufficient to equip them for their roles. As for EW training, there were some notable strengths of this: substantial upfront training was offered in all districts - six days (three days each for the supply capacity analysis and the referral system); appropriate methodologies were used, including role plays and a practical element whereby training participants visited SCTP households for practice; refresher trainings were offered in districts with multiple waves; and there were follow ups by the district office to check EWs' understanding and correct any misperceptions.

On the other hand, many EWs expressed concern that the time allocated to training was too short and that they did not feel fully prepared to carry out the work at the end of it.

> *We were not fully ready and that is why at the end of data collection some of us were sent back to redo some of the households, which means that those who were ready at the end of the training were few but a good number of people were not.* (EW, Mzimba district.)

> *You know we had a lot of forms that we needed to understand, but due to time limitations we were not well equipped and it was not until we got into the field that we understood some of the forms. At first, we made a lot of errors.* (EW, Balaka district.)

Whether or not three full days of focused, high quality training would have been sufficient is unclear, as most participants do not actually seem to have received this. Training often started later in the day

[23] A caveat to this, though, is that those with unusually high caseloads (such as the EWs we met in Dezda) would have faced serious time constraints.)

than planned (due to late arrival of participants and/or of the company contracted to manage per diem payments); and the training was not residential, so participants were often called to their offices to attend regular work during the training, or would leave early in order to arrive home on time. Furthermore, in one district the manuals arrived only part way through the training course, which is likely to have undermined the effectiveness of the early part of the training.

A further problem for EWs in one district (Balaka) was that what the DTT told them during training did not accord well with either the manuals or with what the district social welfare team subsequently told them during the follow up process; which raises the question as to whether the DTT was really as prepared as they thought they were to deliver the training.

The greatest cited challenge post-training was in completing the forms (rather than interacting with households). Examination of the forms to be completed by EWs revealed that they were required to complete several forms requesting similar information in different formats. As such, the problem of insufficient training to complete the forms could perhaps be alternatively characterised as one of overly complex forms.

Manuals and other tools

Manuals and other operational tools were critical to ensuring that EWs were well-informed about how to conduct home visits. They were found to be comprehensive and stakeholders expressed themselves happy with the content. The interview guide to support EWs in their needs assessment with households, which included basic text and pictures, seemed particularly useful in enabling EWs to complete a comprehensive household assessment.

On the other hand, some respondents suggested that the tools needed to be better adapted to the educational background of users. The DTT in Mzimba recommended that they should be written in simpler English and some EWs would have preferred them to have been produced in Chichewa,

> *We also noted that the forms, they were in English but we were supposed to ask the questions in Chichewa language, knowing that this is a local person. You can see here we can mix the languages, Chichewa and English but you do not do that with a local person. You could take some time to interpret the question into Chichewa language. That was a big challenge.* (EW, Dedza district).

Referral card system

The referral card system was a structured way of promoting service access. It was intended to: record the household's service priorities; remind the household of the specific provider to visit; communicate to the SP the purpose of the referral; enable the EW to track whether or not the service had been provided or not; and serve as the source for entry of tracking data into the MIS. We found that it partially fulfilled these objectives.

We found examples of the system working as intended, particularly in Balaka district. However, challenges were multiple.

In some localities in Dedza and Mzimba cards were not issued at the time of assessment, but later, and sometimes the cards issued were simply blank; some EWs made errors in entering information, such that the sector of referral, SP or required service were unclear; even when information was well entered, in the context of limited follow up with EWs (see above) beneficiaries without literacy skills were sometimes unaware of what had been written in their card; the information in the card was often insufficient to communicate to the SP what was expected of them and few were proactive in following up for clarification.

As a result of these challenges and other limitations in the system noted in previous sections, the information entered in the referral cards often diverged from both the beneficiary's account of the status of the referral and from the data in the MIS. Of the 46 cards of sampled households examined, in only 14 cases (30 percent) did the information on them tally with both the MIS and the beneficiary's account.

Furthermore, in a context of SPs' limited understanding of the L&R system and resentment concerning their perceived exclusion from it, the referral cards even created problems for some beneficiaries. By associating them with the resented L&R system, the presentation of a referral card resulted in some beneficiaries being insulted by SPs (see sections 3.1.1 and 3.1.3 above).

Communications about the L&R system

Communication to frontline SPs was very weak. Numerous beneficiaries were told by the SPs they visited that they were unaware of the L&R programme and this probably contributed to the poor treatment of beneficiaries by these SPs. From the interviews with EWs and district level staff it was established that sensitization of SPs, especially those in government sectors was done only at the district level and failed to filter down to the people with whom beneficiaries had direct contact,

> *I mentioned earlier on that we started with sensitisation meetings before we even trained the DTT, but for me I would say it was not very well done. We called the heads of government departments, the SPs that were based here at boma and we thought they would go to the grassroots but they didn't go. For example, the District Health Officer (DHO) was available during the meetings but he is not the one working on the ground providing the service. The ones involved are the nurses, clinical officers and HSAs out there who at the end of the day didn't know anything about this programme* (district official, Dedza).

> *Initially, the design of the programme says the heads of the institutions should be sensitized so that later these heads should pass the message to their juniors. We managed to get these heads of institutions and there were a number of them, a lot of them both government and NGOs. We had a good chat at Chatonda Lodge. They promised to pass on the message but we found that if you go to a certain health centre in Mpherembe they say they don't know. But we say the DHO came and she assured us that she will pass on the information to her juniors but they insist that they know nothing. That means that we have to start all over again with this clinical officer at a health centre. We started explaining the very same things to him which we already discussed with the DHO. Similarly, with the District Agriculture Development Officer and the District Education Manager. This has been a big challenge because we have managed to sensitize the heads at district level but the work takes place in the field outside the city where such information is not passed to the juniors. This has been our challenge* (district official, Mzimba).

Despite the existence of communications materials in the documents reviewed by the consultants, almost none of our respondents had seen any of these during the 2018 L&R pilot.

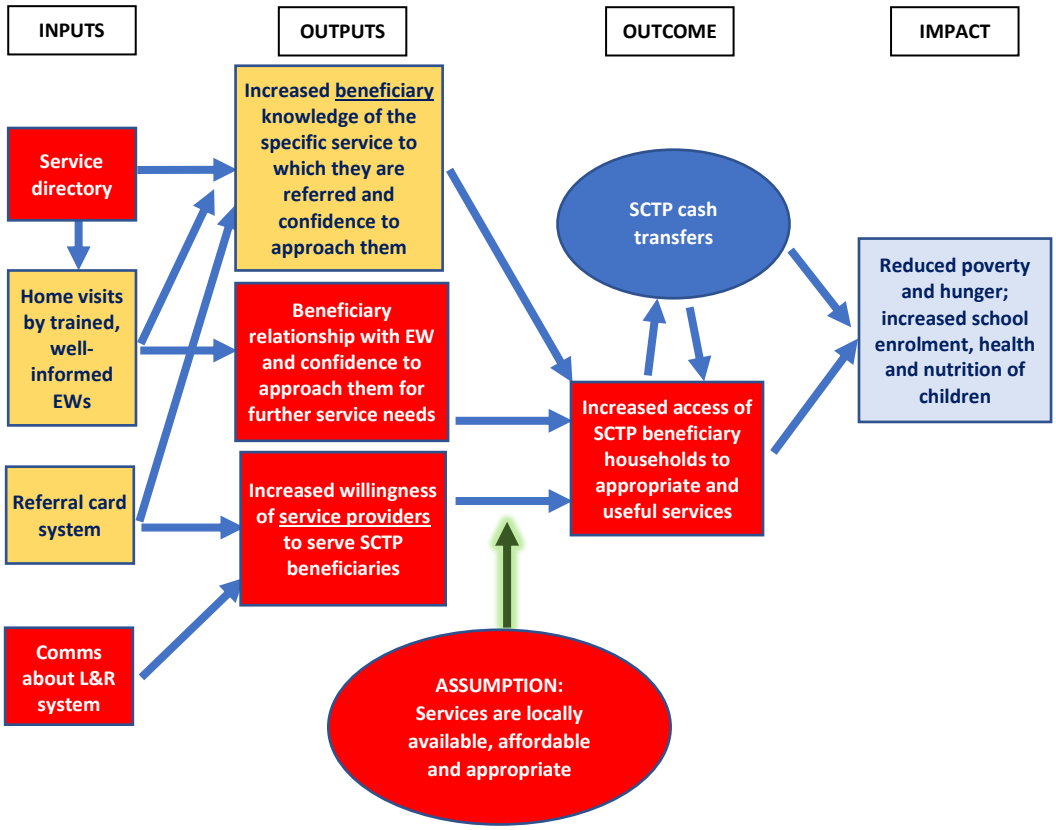
> *From the beginning, we have never received any leaflets to distribute to others to read about the programme. They only gave materials for us to use when conducting our duties. There was nothing for beneficiaries or other stakeholders* (FGD with EWs, Dedza district).

> *Let me say that we had brochures during the first phase [2016], but we did not have any brochures in the second phase. During the first phase after chatting with the service provider we could provide them with the brochures so that they should continue reading about the system* (discussion with DTT, Dedza district).

3.5 Summary

In Figure 2 below the ToC is reproduced with inputs, outputs and outcome coloured red or orange or to signify the extent of achievement (red not achieved, orange partially achieved).

Figure 2: Theory of Change – Extent of Achievement



As documented in previous sections, there have been challenges across all inputs. However, the inputs that focused on the demand side - home visits and the referral card system – saw some modest success, as compared to the supply side interventions - communications to service providers and the service directory - which were largely unsuccessful.

At the output level, as a result of inadequate attention to the supply side, SP willingness to serve SCTP beneficiaries has not increased. Furthermore, whilst home visits by EWs have sometimes resulted in beneficiaries making one-off approaches to specific SPs to which they have been referred, the limited intensity of support and lack of follow-up has meant that no ongoing relationship with the EW has yet been built.

Not only has achievement of outputs been limited, but the underlying assumption about service availability necessary to translate these outputs into the intended outcome has not held. As a result, there has been little improvement in the intended outcome of improved service access of SCTP beneficiary households.

4. LESSONS LEARNED

Having, in the previous section, detailed the extent to which intended inputs, outputs and outcomes have been achieved, the current section looks at the extent to which gaps are due to either implementation, operational design or strategic design. In so doing it highlights both examples of best practice and key lessons. The first three sections look in turn at implementation, operational design and strategic design. The final section summarises key lessons learned.

4.1 Implementation

Whilst the programme was implemented largely in line with its design, the quality of implementation varied across the three surveyed districts. Some weaknesses in implementation contributed to the gaps in achievement of outputs and outcomes, though we also observed some examples of best practice.

4.1.1 Best Practice

Needs assessment. In both Balaka and Mzimba North districts, many households concurred that the list of referrals listed on their card accurately represented their priorities. As noted earlier, it is not easy to identify household priorities in one short visit, and this suggests that the training, interview guide and existing skills of EWs combined to enable the EW to carry out accurate needs assessment in some cases. There are some caveats to this, however: the rushed nature of many visits means that more complex or sensitive issues are unlikely to have emerged; not all needs assessments were accurate even in Balaka and Mzimba - the quality varied between EWs; and needs assessment was generally much weaker in Dedza district. Nonetheless, there were pockets of good practice and needs assessment emerges as a relatively strong element of the programme.

Integration with other SCTP processes. In one TA in Dedza district, a special desk for L&R was set up at the paypoint to enable EWs to engage with L&R beneficiaries[24], a positive example of integration of SCTP processes, (though this was not the case elsewhere),

> *[at the paypoint] we have a separate desk for conducting our business with our facilitators…they also provide opportunities for us to meet the beneficiaries which we could not meet. You meet them and provide feedback* (FGD with EWs, Dedza district, Chilikumwendo TA).

Mzimba district innovations. In Mzimba, district officials accurately identified supply side problems as a key constraint to the effective implementation of the L&R system,

> *We haven't made a good fight. It is like we are fighting. We are at war with service providers. We need to make them understand and accept the reality that these people need to be assisted as they are poor (District official, Mzimba).*

They innovated in very interesting ways to overcome these challenges. In particular, they organised an additional meeting to persuade SPs to be more responsive to the needs of beneficiaries,

> *When we saw that the resistance was a little bit high, we organized what we call a district review meeting. The intended purpose was to invite the DTTs to see how we have fared on the programme of referrals and linkages. But for us we twisted it. Instead of inviting the DTTs, we*

[24] Although this is not a complete solution and should not replace home visits, as some of the most vulnerable beneficiaries do not visit paypoints, sending alternates instead.

invited the service providers so that we should hear from them why there is this resistance which makes them fail to assist the beneficiaries. So we invited the service providers to the district review meeting. Most of them came and we selected most of those who fail to understand. Not everybody but those who we got, we gave the message that they are too tough and don't want to help despite having the capacity to help our people. We invited them during the review. After that they opened up their minds. (District official, Mzimba).

They also worked with local NGOs to organise some group training sessions in response to common priorities emerging through the household needs assessment,

But we were fortunate enough in that in a few village clusters, after noting that their problems had to do with farm inputs, some few NGOs helped us by training these few beneficiaries on how to make organic manure which is an alternative to the inorganic fertilizers (District official, Mzimba).

In addition to this, in one VC in Mzimba district an NGO (SOLDEV) approached the EW who was working on L&R in that zone asking him to carry out an assessment to identify potential beneficiaries of their new programme (cash top-ups and seeds). The EW used the L&R referral forms to identify two groups of households: the seven most vulnerable households - to benefit from the top ups; and seven households that had prioritised agricultural inputs - to receive the seeds. He presented the list to the NGO, who accepted the proposals. This was a positive example of harmonised targeting, albeit on a very small scale and somewhat accidental.

Mzimba district innovations suggest that some district officials are very well attuned to the challenges on the ground and have valuable insights to share. These might usefully inform the design of the next phase, for example through a participatory design workshop.

4.1.2 Gaps

Demand side

Even though the demand-side activities were generally implemented more effectively than the supply side ones, there were, nonetheless, a number of weaknesses.

Monitoring of EWs and beneficiary feedback: Arrangements for monitoring the quality of work of the EWs appear to have relied heavily on examination of forms, rather than on any feedback from beneficiaries about the quality of their interactions. Responses to the question as to how district officials were monitoring EWs elicited the following responses,

The trips we were making, we were checking the data that they have so far collected, how they have filled the forms, as well as to check if they understood what they were supposed to be doing and if they demonstrated that they knew what they were doing. But if they demonstrated that they were not on track we would explain to them again what was required of them and we would give them new forms if the errors were too many that they could not be corrected (district official, Mzimba district).

Basically, we were checking the history, page 1 and 2, and all other forms that were supposed to be with them, basically just to see how they are filling them - that's all (DTT member, Mzimba district)

Extension Workers hand you the reports form and at that time we check it to ensure that it has been correctly filled or if there are some problems with the form (DTT member, Dedza district).

The number of EWs per district was too high to enable the District Desk Officer to provide meaningful oversight of their work (180 EWs in Mzimba district, for example) and there was no structured system of supervision by DTTs beyond the occasional review of forms described above.

Rushed home visits: As noted above, the rushed nature of most home visits meant that relationships between EWs and beneficiaries were not built and that more sensitive or complex issues, such as those related to abuse, did not emerge. Not all visits were rushed: a small minority of beneficiaries reported that EWs took their time over the discussion. However, with no effective oversight or feedback mechanism, the quality of home visits depended on the individual motivation of EWs.

Payment problems: In Dedza district it was reported that many EWs were paid very late and some not at all and that this was (unsurprisingly) a key factor undermining the motivation of EWs to fulfil their intended roles.

> *There are some extension workers who even collected data from households, who were involved at every step who up to now have not been paid* (DTT member, Dedza district).

Integration with other SCTP processes: The extent to which the L&R system was integrated with other SCTP processes was generally limited: to a large extent L&R seems to have been perceived as a standalone exercise. District officials explained that the tight timeline for completion of L&R and other SCTP activities made integration difficult. Rather than integrating, they tended to sequence efforts between L&R and other SCTP activities,

> *At first we wanted people to know about this [L&R] programme, so we did it on its own as we were waiting for the transfers* (district official, Dedza district)

> *When the SCT programmes were coming in we could stop the linkages and the referrals…we could alternate* (District official, Mzimba district)

> *…it was a tight programme…To me I felt like completing my task and forging ahead with my normal duties* (EW, Balaka district)

That said, there were some positive examples of integration. As noted above, in one TA in Dedza district, a special desk for L&R was set up at the paypoint to enable EWs to engage with L&R beneficiaries; and the District Training Team in Balaka said that,

> *We used the time for the community visits to explain some of the L&R concepts when doing the SCTP activities* (DTT member, Balaka district).

However, this does not appear to have been a widespread practice. Beneficiary focus group participants in Jalavikuwa TA, Mzimba district stated that pay days were never used as an opportunity for follow up on referrals there; and many beneficiaries attested that there were no communications about L&R on SCTP pay days and that they, therefore, remained unaware of the purpose of the card,

> *We were just thinking that those papers are part of the SCTP programme, that they are just one of those papers that they give us* (FGD participant, Dedza district, Chilikumwendo TA).

Furthermore, whilst L&R desks at paypoints would be a positive feature of the programme if providing an *additional* opportunity for engagement, in some localities they appear to have been used as an *alternative* to home visits. As noted above, of 41 surveyed beneficiaries indicating the exact location of the assessment discussion 16 (39 percent) indicated that engagement on the L&R happened only at pay points; and this was particularly the case in Dedza district. In such cases, it is difficult to interpret the integration of L&R and payment processes positively. The paypoint does not offer much opportunity for confidential, in-depth discussion and only one member of the household is likely to be present. Furthermore, given that many of the most vulnerable beneficiaries send representatives

to collect their payments, carrying out all engagement on L&R at the paypoint effectively excludes them.

Supply side

Service directory errors: As noted in section 3.4 above, the service directory contained many errors that led at best to inconsistencies in records and at worst to beneficiaries being referred to inappropriate services.

Data inconsistencies: In all three districts there were found to be numerous divergences in the status of the referral between MIS data, information on the referral card and the reality according to the beneficiary. As noted above, amongst our sampled households in only **30 percent** of cases did these three sources of information actually concur. One cause of these widespread documentation errors might be the poor understanding of SPs of the L&R system, leading to some SPs to sign the referral card when no service had been delivered and others to refuse to sign it when a service had been delivered. Furthermore, the rushed nature of follow-up by EWs with beneficiaries is likely to have contributed to subsequent mis-recording of referral statuses in the MIS.

As a result of the numerous errors, the information in the MIS cannot be seen as a reliable source of information on the actual status of referrals. Whilst one response to this might be to invest even more in data collection, it is questionable whether this would be the best use of scarce resources. An alternative approach would be to focus increased attention firstly on the quality of interactions with beneficiaries, whilst simplifying form-filling as far as possible. Investment in improved data collection and management might perhaps come later – once face-to-face beneficiary interactions are working well and the L&R system has proved its worth.

4.2 Operational Design

A key conclusion of this review is that weaknesses in the results of the L&R system were not due simply to poor implementation at district level. Whilst implementation was variable, it was not uniformly poor. Despite some pockets of effective implementation in Balaka and Mzimba districts, results were still disappointing there. In this section we explore whether this was due to operational design, that is to say whether there were weaknesses in the way that the programme concept was translated into manuals, training programmes, staffing structures etc.

4.2.1 Best Practice

Overall, we assess operational design of the L&R system as good. The strategic design was translated into an appropriate and comprehensive set of manuals and training materials to guide implementation. There were a few areas of best practice that stand out:

Interview guide: The interview guide used by EWs for home visits is particularly impressive: the simple language and pictures made it user-friendly and at the same time it was sufficiently comprehensive to guide a wide-ranging discussion of household circumstances and priorities. It is in part thanks to this guide that, even in short, one-off visits, EWs have in some cases elicited accurate accounts of specific priorities of beneficiary households.

Training methodology: The training of EWs made good use of a range of methodologies, including role play and practical sessions in communities, to ensure that EWs knew what was expected of them in the field.

4.2.2 Gaps

On the other hand, we identified some areas for improvement in operational design. These include the following:

Demand side

One-off nature of the intervention. In the majority of cases, beneficiaries faced a problem with actioning their referral - for example, the SP was unavailable or unwilling to provide the service, or the beneficiary failed to understand the referral or faced a distance or cost constraint. The fact that the operational design of the pilot allowed for no further visit by the EW to follow up on the referral meant that such constraints were never identified or addressed. This problem appears to be primarily one of operational design rather than local implementation, in that, according to all district-level respondents, the budget allocated for follow up was for only one day's work per EW. A one-off home visit was never likely to have had much impact, because few service access challenges of SCTP beneficiary households are so simple to resolve that one visit will suffice.

The one-off nature of the intervention is also likely to have contributed to an unhelpful perception of the L&R as a project in which one was either included or not, rather than an enhancement of normal business; and thereby to resentment towards it by EWs not included. As pointed out by district officials in both Balaka and Mzimba districts, referring vulnerable people to other services is supposed to be part of the core business of social welfare and had already been happening to some extent informally before the L&R programme.

Staffing structure. The use of EWs from multiple sectors as frontline implementors might have been expected to be more efficient than paying dedicated staff, more effective than relying on volunteers and allowed more cross-fertilisation between sectors than relying on SW EWs alone. Indeed, whilst some EWs complained of insufficient time, others explained how they had managed to integrate L&R work with their existing duties,

> *On top of that it's not so different from daily routine because as extension worker we don't just do one thing, so it was easy to include L&R in our daily routine. We could plan that I am going this way and I am going to do A, B, C but on top of that we could also do L&R work. We harmonise the programmes* (EW Mzimba).

However, contrary to expectations, in practice this does not seem to have enabled a higher quality of work within the available time: as we saw above, most home visits were rushed and documentation was of poor quality.

One possible explanation for the rushed nature of home visits has to do with the motivation of EWs and the incentive structure they faced. The L&R pilot appeared as a one-off short-term project and EWs were paid a fixed amount to complete the task. There was no system for systematically monitoring the quality of their interactions with beneficiaries, and satisfactory performance in this regard was not taken into account in their remuneration. As cross-sectoral EWs (with multiple opportunities for additional paid work from various projects) there was no particular reason to expect them to be intrinsically interested in the quality of linkages of SCTP beneficiaries. Plus, the incentive structure they faced and the perception of the L&R as a one-off project was not conducive to them feeling ownership of the initiative as part of their ongoing work responsibilities, nor motivated to complete the work to a high standard.

Furthermore, the use of EWs from across different sectors may have contributed to the fact that some evident child protection concerns were missed and that there was no link with the child protection

case management system (see above for examples), as they did not necessarily bring any prior knowledge of child protection to the role.

Information management: The widespread data inconsistencies noted in section 4.1.2 above may also be partly attributable to operational design. Referral cards were completed in part by the EW and in part by the SP, who signed to attest that the service was delivered. This information was then communicated from the EW to district officials by means of the referrals report form, and then passed to the data entry clerk to input to the MIS . The system thus created numerous opportunities for data entry errors. An informatised system enabling direct data entry into iPads or smartphones by EWs may have reduced the level of error.

Supply side

Service directory: Similarly, the weaknesses in the service directory cannot all be blamed on implementation errors in data collection but are also partly attributed to operational design. In the design process there was a lack of clear thinking through of what it really means for a service to be "available" to SCTP beneficiaries. For example, the directory included some services that required payment, which was flagged as problematic by some respondents. More fundamentally, there was no differentiation between "on-demand" and actively targeted services and, as a result, people were often referred to services that already had closed lists of beneficiaries based on their own targeting criteria. The supply capacity analysis could have made better use of EWs' local knowledge of services that are or are not truly available to new clients on demand. Indeed, a recommendation of Ayala Consulting after the first pilot in 2016[25] was to change the methodology of the supply capacity assessment to start at local level, but this recommendation does not appear to have been implemented.

There is an even more fundamental question mark over whether such a service directory would be useful to the frontline workers in an L&R system, even if its contents were accurate. In most cases services actually available on demand are limited to those delivered by HSAs, local health centres, schools and agricultural extension workers. Local EWs (and most beneficiaries) are already aware of these services. Most other services and support are actively targeted and have fixed and closed lists. Thus, even if they were accurately listed it is unclear what the added value of including them in a service directory would have been.

Communications: Operational design did not allow for proper awareness raising of frontline SPs. As seen above, the assumption that the information would trickle down from district level staff to the grassroots did not hold. Whilst communications materials were produced at national level and some district level interlocutors were aware of them, they were not widely distributed to frontline providers where they were most needed. As a result, many of the SPs approached by beneficiaries were unaware of the L&R system. Whilst the lack of communication does not excuse some of the reported rude and dismissive reactions reported by beneficiaries it does appear to have exacerbated an existing problem of poor service ethos.

4.3 Strategic Design

4.3.1 Best Practice

Regarding the strategic design of the L&R system, on the positive side, we conclude that the identified problem is real: SCTP beneficiaries do face constraints in accessing services (including health services, agricultural inputs, training and advice, education for their children, business development services

[25] Ayala Consulting, 2016, Referral and Linkages, Presentation 20/11/2016

and social services). As such the strategic decision to develop an initiative to address service access was appropriate.

4.3.2 Gaps

On the other hand, it is clear from the preceding sections that results of the pilot were disappointing. Furthermore, from the sub-sections above we see that this was not primarily due to either weak implementation or operational design. Whilst there is undoubtedly scope for improvement in implementation, there are also notable examples of good practice in Mzimba and Balaka districts. As for operational design, this was good overall – manuals, training materials and other tools were comprehensive and appropriate.

The problem appears to be more fundamental: the strategic design of the initiative needed to be grounded in an accurate diagnosis of the specific service access constraints facing the target group. As noted in section 1.3, key lessons from international experience include that the design of a system needs to respond to the context-specific service access constraints, and that the impacts of L&R systems are likely to be muted if substantial supply-side constraints remain unaddressed. In rural Malawi supply side constraints do remain unaddressed, and so the system failed.

As commented by one district officials in Mzimba, if you develop a demand-driven system that starts by asking beneficiaries what their problems are then the service has to be there to respond,

> *It was supposed to be the beneficiary telling us I have this problem; how can I access the service? So the service has to be there* (district official, Mzimba district).

A one-off referral as piloted under the L&R system would only have worked had the primary problem been that SCTP beneficiaries were unaware of locally available services. However, as seen in section 3.2 above, this was not the main problem. Where services are locally available, appropriate and free, most SCTP beneficiaries are already accessing them. Gaps in access are primarily due to supply-side constraints, which are extensive and, depending on sector and locality, include: a complete lack of services; services that are too distant or expensive; services with closed lists of beneficiaries; and frontline staff who are sometimes unresponsive to clients' needs.

Given the challenges with the L&R system, there were calls from some beneficiaries to simply top-up the SCTP cash transfers, instead of investing in a system to link them to services,

> *I would suggest that we should be given money to access the services we got linked to. These free things are turning us into frustrated people when we fail to access the services we need. If we have money, we can access the services anywhere. We can use that money as business capital. Let them top up the money we get* (female FGD participant, Mzimba district, Lunyangwa VC.)

On the other hand, district officials tended to feel that there were important issues that could not be resolved through cash transfers alone and that there was merit in pursuing a re-vamped version of the L&R system, in order to promote beneficiary access to complementary services,

> *About the issue of L&R resources being added to the SCTP, it will still not help. If we say every beneficiary should be receiving K20,000, it will still not be enough. Linkages and referrals has its own priorities and social cash transfers has also its own priorities… Perhaps the question should be "do we roll out into other districts or we should first correct the mistakes that we have made and try again before we move on?" That should be the question, because rolling out means we need more funds. But if we say let's concentrate on the same districts that have had the pilot and correct the mistakes we have seen and try again, so that by the time we go*

into other remaining districts we are sure that what we are doing is 100% perfect. (District official, Mzimba district.)

4.4 Summary of Lessons Learned

Based on the preceding sections, the lessons learned can be summarised as follows:

Cross-Cutting

1) SCTP beneficiaries face real problems of service access – the problem is real. But the design of any intervention to address the service access challenges of SCTP households needs to be firmly grounded in an understanding of what the specific challenges are, on both the supply and demand sides.
2) The primary service access challenges in rural Malawi are on the supply side and include: a complete lack of services in some sectors (especially trade and infrastructure); distant or costly services in others (health services and secondary schooling in some areas); fixed lists of beneficiaries and no services available on demand (most services, except health and agricultural training/advice); and unresponsive service providers (variable across sectors).
3) Given the nature of service access constraints, an L&R system is only ever likely to be part of the solution. Attention also needs to be given to the supply side.

Supply-side

4) A service directory is only useful to an L&R system insofar as it includes services that are available "on-demand" to clients referred to it. Since these services are few in rural Malawi and generally already well-known, the potential utility of a service directory for this purpose is limited.
5) SCTP beneficiaries are often confronted by a poor service ethos. Any attempt to improve service access needs to address not only the structural problem of the physical accessibility of services and their cost, but also the attitude of some service providers to their clients. Sending beneficiaries to inappropriate or unresponsive SPs can create disillusionment and discourage future attempts to approach SPs, thus doing more harm than good.
6) Different solutions are required for different service access challenges across sectors. The L&R system is not appropriate to address most of them, but another 'one-size-fits-all 'approach is unlikely to be effective either. A set of interventions adapted to specific challenges is required.
7) Some needs (especially social needs) are very specific to individual households and require intensive one-to-one support.
8) Other priorities are widely shared (such as agricultural training and business development advice) and might more efficiently be provided through small group training than by sending beneficiaries one-by-one to SPs asking for the same training.
9) Some of the service access challenges (for example targeting of agricultural subsidies, and secondary school bursaries) are systemic and cannot be effectively addressed through individual referrals. On such issues, national level policy engagement/advocacy would be a more appropriate response than L&R.
10) As for other cost-related challenges faced by beneficiaries (such as the cost of school uniforms and of transport to health facilities), there is a need to consider the trade-off between i) promoting access of SCTP beneficiaries to services that cover these (often CBOs), which are not available at scale in most areas and ii) ensuring that SCTP transfers are adequate to cover them. Increasing

transfer levels and ensuring timely payments might arguably be a better solution than L&R for some such services.

Demand-side

11) To the extent that there are demand-side service access constraints these tend to be more complex than a simple lack of beneficiary awareness of the existence of a service, and thus require more intensive and ongoing support. Services are often difficult to access and SCTP beneficiaries exhibit weak agency in terms of following up when service providers fail to deliver. Support should include multiple home visits and follow-ups with both beneficiaries and SPs.

12) If home visits are to provide effective support to SCTP beneficiaries, those carrying them out require a high-level of motivation, as well as social work skills. This needs to be taken into account in both the selection of frontline workers and the development of incentive structures for their remuneration.

13) Intensive one-to-one support is time consuming. Regular home visits from highly skilled staff need not be the primary mechanism for service linkage for all SCTP households. Group training/ awareness-raising has an important role to play; regular home visits could be targeted on the most vulnerable.

5. RECOMMENDATIONS

Based on the findings of this review, as well as lessons from international experience, it is recommended that the L&R be fundamentally re-designed to better respond to the nature of the service access challenges faced by SCTP households, which are largely on the supply side.

The consultancy work undertaken was a review of the existing programme, rather than a design mission for a new programme, and as such the recommendations in this section are only indicative of a future design. Given the substantial changes proposed, it is recommended that further detailed design work be undertaken and that a revised set of interventions then be (re)piloted in limited geographical areas. That said, key recommendations are as outlined below. Section 5.1 looks at strategic elements of design and section 5.2 focuses on operational ones.

What is presented here is a comprehensive system, incorporating all the elements that would be required to improve SCTP service access across the six sectors in the L&R pilot. Given the complexity and costs involved in doing this effectively, in practice, some sequencing and prioritisation will be required. Strategic choices will need to be made about which sectoral linkages to prioritise.

5.1 Strategic Design

Household Needs Assessment

1) Retain a model of home visits similar to the current model to assess needs of all SCTP households.

Other assessments of supply side capacities and/or market potential will also be required, depending on the specific sectoral priorities. These assessments will underpin all the other elements.

General Initiatives for all SCTP Households

A number of initiatives can be envisaged to promote general improvements in service access for all SCTP households: basic service provision; policy engagement and advocacy; and review of core cash transfer design.

Basic Service Provision

2) Based on identified needs, provide a range of basic services at paypoints.

EWs from different sectors often attend anyway for payments, so, in rotation, they might carry out short information sessions, including an overview of the services on offer, information on upcoming training sessions in the locality etc. Health personnel might even offer basic health checks and advice at the paypoint and CBO/NGO staff might also be invited to give presentations. This would be in line with original SCTP design, but does not appear to have been fully implemented to date. In line with lessons from international experience, the design of these sessions should focus on information and advice that the majority of households currently lack. Thus, design should be grounded in the household needs assessment in the locality and care should be taken not to simply duplicate sessions that are already taking place at community level.

Policy engagement and advocacy

3) Using information collected from households on unmet needs and feedback on systemic service access issues, carry out advocacy at national level for improvements in service access for SCTP beneficiaries.

Based on issues that have emerged through this review, possible topics for national level policy engagement with other sectors to improve SCTP beneficiary service access might include: i) improved poverty targeting of fertiliser subsidies; ii) avoidance of discrimination against SCTP beneficiaries in targeting of other programmes; iii) alignment of targeting of NGO complementary poverty-targeted assistance with SCTP targeting, as appropriate; iv) prioritisation of areas with no free health services for new health provision.

Given the need to strengthen service responsiveness and citizen agency, there may also be value in social accountability interventions that: increase citizen knowledge of their service entitlements and empower them to articulate their concerns when these are not fulfilled; and include mechanisms to promote provider responsiveness to these concerns and hold providers to account when services are inadequate. See Ayliffe et al (2018) for a comprehensive review of social accountability in social protection[26].

Design of cash transfers

4) Review the adequacy of cash transfer levels for households of different sizes and structures.

Where the key constraint on service access is cost (for example, school uniforms, secondary school fees and boarding costs, or transport to health facilities), ensuring that transfer levels are adequate may sometimes be a more straightforward way of resolving the issue than linking a household to a complementary source of support.

Targeted Referrals

Referrals also have a role to play. However, in order to ensure that a referral model is affordable and adds the most value, it is proposed that only some SCTP households would receive personalised support through home visits.

[26] Ayliffe, T., Aslam, G. Schjødt, R., 2018. Social Accountability in the Delivery of Social Protection: Final Research Report and also Guidance for Practitioners. Development Pathways, UK. http://www.developmentpathways.co.uk/resources/wp-content/uploads/2018/02/Social-Accountability-Final-2018.pdf

On the basis of the household assessment, it is recommended to allocate individuals to one of three pathways of support, depending on expressed priorities and circumstances[27].

i) ***Social pathway***.

- This would be for people with specific vulnerabilities who are not already accessing appropriate services. Specific target groups might include households with children out of primary school; or with other child protection issues; or people with disabilities, mental health or chronic health issues not yet being addressed; or adolescents with need for sexual and reproductive health advice, etc.
- In line with lessons from international experience, this pathway would focus intensive support on a subset of SCTP households most disconnected from services at baseline.
- Support under this stream would involve regular home visits, referrals to appropriate health, education and social services and active follow up with both beneficiaries and service providers. As such it would be the part of the system most similar to the current L&R programme, but narrower in scope.
- It would essentially be a social work function and would be staffed by skilled SW EWs, with support from CSSC members.
- Attention should be given to how best to join up this stream of work with the evolving child protection case management system, given its overlapping (but not identical) remit.

ii) ***Agricultural training pathway***.

- This would be for people who highlighted training or advice on agricultural or livestock issues to be a priority and who are not already active members of farmers groups.
- Support under this stream would involve organising group training sessions that would be delivered by EWs or NGOs. Specific topics would depend on specific priorities of SCTP beneficiaries and different training might be delivered to different sub-groups. As well as training on agricultural and livestock issues, people might be offered practical support to establish village savings and loans associations where this was a priority for them.
- It is not suggested that this pathway would involve training EWs or NGOs on new agricultural topics (that would be beyond the remit of the SP sector). Rather it would involve making use of the existing skills of EWs and NGO staff.
- A small responsive fund would likely be required to pay allowances to SPs who deliver training sessions. Depending on the geographical availability of services, it might involve bringing in trainers from outside the VC, but these would normally be within the TA to minimise costs.
- An officer (most likely an agricultural EW) would be required to organise the training and CSSC members could be the link with SCTP beneficiaries.

iii) ***Business development pathway***

- This would be for people with higher productive potential, without substantial unmet needs for social support or agricultural training who expressed a need for business advice.
- It would include such things as financial literacy training and coaching in the development and implementation of business plans.

[27] If allocations are for individuals a household might sometimes be referred to multiple pathways, but the budgetary implications of this would need to be considered.

- Given that business training services are less available than agricultural services this might require bringing in SPs from outside the TA to deliver training sessions. Again, this would require small-scale resourcing to cover transport and trainer costs.

5.2 Operational Design

To underpin the implementation of the referral model, there is also a need to give attention to operational issues including staffing, supervision, incentives, manuals, training and information management.

Staffing

6) Given the challenges met with employing cross-sectoral EWs for home visiting, consider alternative staffing models that rely more heavily on SW EWs and CSSCs.

Whilst recruitment and training of more social workers would be required, the model could be rendered affordable by means of creative solutions that take account of the variable skills, available time and motivation of different potential workers (in line with lessons from the SCTP L&R pilot and from international experience). Arrangements might vary across different elements of the model, for example:

- SW EWs could lead the social pathway and ideally also the household needs assessment, which would require the recruitment of some additional EWs, in order to ensure caseloads remain manageable. In line with lessons from international experience, establish caseloads based on a realistic assessment of the number of hours required per household per month for visits and follow up.
- HSAs might be allocated to support those households under the social pathway whose main problems are health-related.
- It would make sense for an agricultural EW to manage the agricultural pathway.
- Policy engagement and advocacy should be led by SW staff at national and district level
- Across all elements, CSSC members might play a more active support role than they did under the pilot. This additional work, in order to retain motivation, should be associated with payment of additional incentives.

Supervision

7) Given the challenges with the quality of home visiting in some localities, establish more structured supervision arrangements for frontline workers.

There might be one dedicated supervisor per TA, who would receive specific supervisory training. Their role would include meeting regularly with frontline workers to monitor and support their work, and also making visits to a sample of households to receive their feedback on the support received.

Incentives

8) Review the incentive structure. Instead of a one-off payment based on number of training days and assumed days worked, consider paying monthly allowances on an ongoing basis, subject to satisfactory performance against a set of agreed criteria.

Manuals and forms

9) Redesign manuals, forms and training materials in line with changes in strategic design, but build on existing materials, as these have many strengths.

Households allocated to pathways (ii) and (iii) would not need complex referral forms – there would simply need to be records of lists of people allocated to group training. The forms to be completed for households on the social pathway (i) could be based on the current forms, but simplified. This would reduce the need for frontline workers to record the same information in multiple formats and should ensure that, even if less information is captured it is, at least, accurate. It would also enable frontline workers to devote more attention to interactions with households and SPs.

Training

10) Strengthen training to ensure that frontline workers feel fully equipped for their roles, in particular the practical elements.

Differentiate the training content for different workers (for example, supervisors, social workers, officers responsible for organising agricultural/business training, CSSC members etc.). Review the number of training days (but do not necessarily increase). Despite widespread calls by district stakeholders for an increased number of training days, it is possible that with simplification of the supply-side assessment and of referral forms, the overall number of days of upfront training (six) might suffice.

Information management

11) In the first instance, simplify data collection and management processes.

Eventually, the management information system might switch to direct data capture on tablets or smartphones, in order to reduce data entry errors. However, in a context of limited resources, it is recommended that the primary focus in the next phase be on strengthening the practical elements of the system – face-to-face interactions with beneficiaries and SPs. Once these are working more effectively, comprehensive information management will be a higher priority.

Service directory

12) Given the limited utility of the current service directory, substantially revamp this in the next phase.

Further consultation with frontline EWs will be necessary to design a format that adds real value. For example, a simple list of services truly available in the locality with up-to-date contact details might be useful; or, instead, a series of meetings where EWs present on their services. Or possibly EWs already have such good local knowledge that neither of these would add value. In any case, whatever format is chosen, it is recommended that a clear distinction be made in future between: i) those services available on demand to new clients (which in most localities are limited to government health services and agricultural advice), with names and contact details of key personnel; and ii) services that are actively targeted and not necessarily available to new clients, but which might be drawn on to provide group training and/or where active recommendation and lobbying by EWs might enable high priority households to access specialised services.

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ANNEX 1: RESEARCH QUESTIONS

<u>Strategic design</u>: What are the key constraints on service access of SCTP households and how effectively does the design of the L&R system address them?

Detailed questions (structured in line with OECD DAC evaluation criteria)

Relevance

What was the process of decision-making around the strategic design and what factors influenced the choice of design? What alternatives to address the identified problems were considered and was the chosen design the most relevant solution?

How well adapted is the strategic design of the L&R system to the context in which it operates? How well does it align with relevant national policies, local and national stakeholders' priorities, the overall design of the SCTP and other related national referral mechanisms, such as that in place for child protection?

Effectiveness

Does the L&R system design include an appropriate balance between addressing supply and demand side constraints on service access? Is supply side capacity sufficient to provide appropriate services in the six sectors of education, health, agriculture, trade, infrastructure and social services?

To the extent that the L&R system itself does not address all key supply side constraints, to what extent does it complement other interventions addressing these?

Are the three key elements of the L&R system - supply capacity assessment, refer and link process, quality assessment – appropriately conceived to achieve the intended objectives?

Outputs and Outcomes

What has happened as a result of the L&R system? Is there evidence of increased beneficiary awareness of services and/or confidence to approach SPs? Are SPs more willing to serve SCTP beneficiaries?

How many beneficiaries have been linked to services, as a result of the L&R system? What added value do they report from these services?

What have been the key constraints on increased service access? Does the L&R system work better for some types of service than others, and/or for some categories of beneficiaries than others? Which ones? Why?

Efficiency

Is the value added by each of the three L&R elements commensurate with the required investment of time and resources?

What is the approximate cost of the system per beneficiary linked? Are there likely to be any other, more efficient ways to achieve equivalent outcomes?

Sustainability

To what extent is the L&R system financially sustainable, given current SCTP financial and human resource capacities? How much additional investment would be required to scale it up and would this be the best use of scarce resources?

To what extent is the L&R system institutionally sustainable – does it respond to Gov political and institutional policy priorities? To what extent is there Gov ownership of the system and is it likely to

be a priority for Gov financing? What capacities exist at national, district and community level that could be used to ensure effectiveness and continuity of the system.

To what extent had the L&R system, with its focus on integrated support to SCTP households, gained local acceptance and become aligned with the social support system as a whole at decentralised levels?

<u>Operational Design</u>: How well were the intended objectives and scope of the L&R system translated into the detailed operational design – service directory, operational manuals, training and communications materials, and the MIS module?

How appropriate and effective is the detailed design of each of the three components of the Linkage and Referral System i.e. Supply Capacity Analysis; Refer and Link; and Quality Survey.

How relevant and useful is the service directory to its intended users?

How effective, relevant and user friendly are the operational manuals, communication materials and other documents for each component of the system?

How appropriate and adequate were capacity building activities in terms of building a cadre of appropriately skilled EWs? How comprehensive and appropriate for each target group (national trainers, DTTs and EWs) were the training materials and the nature of the training sessions?

How appropriate were the staffing levels to the workloads? Did they ensure manageable caseloads for effective support?

How well-designed and user-friendly is the Linkage and Referral MIS module and how useful are the reports generated? How well does the Linkage and Referral System's MIS module fit into the overall SCTP MIS?

How well does the Linkage and Referral System link to and complement other components of the SCTP such as case management, cash payments, monitoring and issues of coordination?

<u>Implementation: overall question</u> - To what extent was the L&R system implemented in line with the operational design as set out in the manuals?

What discrepancies, if any, were there between design and implementation? If there were discrepancies, what was the reason for these? To what extent were they simply early implementation weaknesses, capable of remediation? Or do they flag any underlying problems of design?

How adequate were training and capacity building activities in terms of duration, methodology and capacity of trainers?

How is the service directory used in practice?

How did the home visits work in practice in terms of frequency, duration and nature of interaction? Was there any ad hoc prioritisation within the target group? (by location, age, household structure, service preferences, etc.)

How effectively were EWs monitored and supported?

How were monitoring reports and survey results used in practice? If use was sub-optimal, why was this?

How well timed was the implementation of the linkage and referral activities in relation to targeting, payments and case management activities of the SCTP?

How are beneficiaries experiencing the L&R system? How are service providers experiencing it? How are government officials experiencing it?

ANNEX 2: TA AND VC SAMPLING

Table 7: Referrals in Balaka District by TA and Status

TA	Total	Cancelled	In progress	Linked	Open	Comments
Amidu	**1,697**	**25%**	**2%**	**62%**	**11%**	**High performing, not remote, good sectoral mix**
Chanthunya	**1,275**	**43%**	**15%**	**20%**	**22%**	**Low performing, relatively remote**
Nsamala	**2,338**	49%	5%	**12%**	34%	Low performing, not remote
Sawali	**1,053**	27%	2%	**42%**	30%	Moderately high performing

Table 8: Referrals in Balaka District by TA and Service Sector

TA	Agri	Comm	Edu	Health	Trade	Infra	Unknown	Total
Amidu	40%	22%	14%	18%	6%	0%	0%	100%
Chanthunya	60%	8%	12%	20%	0	0%	0%	100%
Nsamala	46%	13%	6%	25%	4%	0%	6%	100%
Sawali	52%	18%	17%	13%	0	0%	0%	100%

Table 9: Referrals in Amidu TA by VC and Status

	Cancelled	In progress	Linked	Open	Selected, reserve or not selected - and reasons
Amidu	18%	16%	**48%**	18%	Not selected: low number of beneficiaries
Chagunda-Mbera	43%	5%	**47%**	4%	Not selected: atypical focus of referrals on health services
Chibwana-Chatama	27%	0%	**67%**	6%	Not selected: referral success rate neither especially high nor low
Hindahina-Mdenga	**26%**	**1%**	**49%**	**23%**	**Selected: relatively low success rate; challenges with trade linkages will be interesting to explore**
Katapira	**4%**	**1%**	**81%**	**15%**	**Selected: high success rate; successful trade linkages interesting to explore**
Mwalabu	6%	1%	**90%**	3%	Reserve: high success rate
Ngasale	43%	0%	**48%**	9%	Reserve: relatively low success rate

Table 10: Referrals in Chanthunya TA by VC and Status

VC	Cancelled	In progress	Linked	Open	Selected, reserve or not selected – and reasons
Chimpakati	32%	30%	**22%**	17%	Not selected: linkage rate neither high nor low
Chizungu Kuthambo	23%	43%	**9%**	25%	Reserve: low linkage rate, but few beneficiaries
Govati Tsite	59%	3%	**24%**	14%	Not selected: linkage rate neither high nor low
Kankawo	54%	4%	**25%**	17%	Not selected: linkage rate neither high nor low
Mfulanjovu	47%	0%	**1%**	51%	Not selected: low linkage rate, but few beneficiaries and high proportion of open referrals, possibly not much to review
Nyanyala Kavala	**66%**	**20%**	**2%**	**12%**	**Selected: low linkage rate, high number of cancelled referrals**
Phalula Tchona	**35%**	**29%**	**27%**	**8%**	**Selected: relatively high linkage rate, good sectoral mix**
Siliya Maitoni	8%	0%	**39%**	53%	Reserve: relatively high linkage rate

Table 11: Referrals in Dedza by Traditional Authority and status

TA	Cancelled	In Progress	Incomplete	Linked	Open	Total
Chauma	9	0	0	0	91	100
Chilikumwendo	**0**	**0**	**2**	**15**	**83**	**100**
Kachere	3	0	1	1	94	100
Kachindamoto	3	0	2	2	94	100
Kamenya Gwaza	0	0	3	0	97	100
Kaphuka	1	0	1	0	97	100
Kasumbu	**0**	**0**	**2**	**0**	**98**	**100**
Tambala	3	0	1	2	95	100

Table 11: Referrals in Dedza by Traditional Authority and service sector

TA	Agriculture	Community	Education	Heath	Infrastructure	Trade
Chauma	36	0	27	33	0	3
Chilikumwendo	**27**	**6**	**26**	**35**	**3**	**2**
Kachere	15	6	20	59	0	1
Kachindamoto	19	7	23	48	3	1
Kamenya Gwaza	26	8	20	45	0	1
Kaphuka	33	1	20	42	2	2
Kasumbu	**27**	**0**	**20**	**50**	**10**	**2**
Tambala	27	6	31	32	1	3

Table 12: Referrals in TA Chilikumwendo by VC by Status

VC	Incomplete	Linked	Open	Total
Bua	0	0	0	100
Chidewere		**86**	**14**	**100**
Kapilira	1	0	99	100
Katewe	1	36	63	100
Kathothi	**1**	**0**	**99**	**100**
Kavuluvulu	2	13	84	100
Kathambala	17	0	83	100
Luwani	5	0	95	100
Magomero	1	0	99	100
Masinja	1	0	99	100
Mphanyama	1	0	99	100

Table 13: Referrals in TA Kasumbu by VC by Status

VC	Cancelled	Incomplete	Linked	Open	Total
Chikuse	0	1	0	99	100
Chiwamba	3	4	0	93	100
Kanyama	0	0	0	0	0
Kanyenda	0	0	0	0	0
Kapesi	0	1	0	99	100
Kasumbu					100
Kasumbu Chilasamongo	**0**	**1**		**99**	**100**
Kasumbu Magunditsa	0	0	0	0	0
Madzumbi	**0**	**4**	**0**	**96**	**100**
Mkoma	0	2	0	98	100
Mkomeko	0	0	0	0	0
Mwenje	0	0	0	0	0
Mzoola	0	7	0	93	100
Ngondo	0	4	0	94	100
Ngwere Kalinde	0	0	0	0	0
Ngwere Mphalare	0	3	0	97	100
Nkumpira Kanyanda	0	0	0	0	0
Tembwe	0	0	0	0	0

Table 14: Referrals in MzimbaNorth by Traditional Authority and status

TA	In Progress	Incomplete	Linked	Open	Total
Jalavikuwa	**1**	**0**	**45**	**54**	**100**
Kampingo Siwande	0	0	0	100	100
Mtwalo	**0**	**0**	**3**	**96**	**100**

Table 15: Referrals in Mzimba North by Traditional Authority and service sector

TA	Agriculture	Community	Education	Heath	Infrastructure	Trade
Jalavikuwa	**48**	**11**	**11**	**23**	**4**	**3**
Kampingo Siwande	17	1	19	64	0	0
Mtwalo	**33**	**5**	**18**	**41**	**2**	**2**

Table 16: Referrals in TA Jalavikuwa by VC by Status

VC	In Progress	Incomplete	Linked	Open	Total
Chandiwira	**0**	**0**	**34**	**66**	**100**
Kacheche	0	0	72	28	100
Luzi	0	0	52	48	100
Matomola Magaga	0	0	38	63	100
Thumbi	**4**		**49**	**47**	**100**
Wankhama	0	0	0	0	0

Table 17: Referrals in TA Mtwalo by VC by Status

VC	In Progress	Linked	Open	Total
Boma Makwakwa	0	0	100	100
Bwabwa	0	0	100	100
Chauluma	0	0	100	100
Chibisa Kaunda	0	0	100	100
Chilinda	0	2	98	100
Chingawawa nkhonjera	0	0	100	100
Chotha tembo	0	0	100	100
Edakweni	0	6	94	100
Ekwaiweni	1	0	99	100
Elangeni	0	0	100	100
Embombeni	0	0	100	100
Emusizini	**3**	**8**	**89**	**100**
Engutwini	0	0	100	100
Ezondweni	0	46	54	100
Jacob mdili	0	0	100	100
Jumbo 2	0	0	100	100
Kabanda	0	0	100	100
Kafukule	0	0	100	100
Kamkhoti	0	0	100	100
Kamkwamba nyombose	0	0	100	100
Kanthete	0	0	100	100
Kapota mbunge	0	0	100	100
Kasuma	0	0	100	100
Katokoli	0	0	100	100
Kaweche	0	0	100	100
Kazuni	0	2	98	100
Lunyangwa	**0**	**0**	**100**	**100**
Luvyere	0	12	88	100
Madise	0	0	100	100
Mombwe	5	0	95	100
Mphawa	0	0	100	100
Shadreck Makwakwa	0	0	100	100

ANNEX 3: HOUSEHOLD SAMPLING

Amimidu TA

Katapira VC:

4 hholds successfully linked to agricultural services

4 households successfully linked to community services

3 households successfully linked to trade services

2 households successfully linked to education services

2 households successfully linked to health services

2 households whose linkage to health services is still open

2 households whose linkage to trade services is still open

2 households whose linkage to community services is still open

Hindahina-Mdenga

6 households successfully linked to agricultural services

2 households successfully linked to community services

2 households successfully linked to health services

3 households whose linkage to trade services was cancelled

2 households whose linkage to community services was cancelled

2 households whose linkage to education services was cancelled

2 households whose linkage to health services was cancelled

2 households whose linkage to health services is still open

Chanthunya TA

Phalula Tchona

4 households whose referral to agricultural services is cancelled

3 households whose referral to agricultural services is “in progress”

3 households successfully linked to agricultural services

3 households whose referral to education services is cancelled

2 households successfully linked to health services

2 households whose referral to health services is cancelled

2 households whose referral to community services is “in progress”

2 households successfully linked to community services

Nyanyala Kavala

5 households’ whose referral to agricultural services was cancelled

5 households whose referral to health services was cancelled

3 households whose referral to agricultural services is “in progress”

3 households whose referral to agricultural services is open

2 households whose referral to education services is “in progress”

2 households whose referral to community services is cancelled

ANNEX 4: LIST OF PEOPLE MET

Sophie Shawa – UNICEF

Amanda Sefu – UNICEF

Brian Kaswii - UNICEF

Laurent Kansinjiro - MoGCDSW

Chifundo Nachikuwa - MoGCDSW

Innocent Phiri - MoGCDSW

Kennedy Nyirenda – Concern Worldwide

Emily Vonck – Concern Worldwide

Patience Masi --- KFW

Phina Rebello – Irish Aid

Chipo Msowoya – World Bank

Carlotta Rego - EU

Bessie Msusa – EP&D

Christopher Ndawona - DSWO Balaka

Steven Sililika - L&R Desk Officer Balaka

Hellen Mafuleka Simwaka - DSWO Dedza

Given Mkisi - L&R Desk Officer Dedza

Ishmael Kaunda - L&R Desk Officer Mzimba North

Davie Sambani - DTT Balaka

Eliza Kawonga - DTT Balaka

Alfred Ritche - DTT Balaka

William Mtambalika DTT Dedza

Abigail Kasawala DTT Dedza

Clara Chithabwa DTT Dedza

John Vitsitsi - DTT Mzimba North

Dafa Mphande - DTT Mzimba North

Darlene Chilongo - DTT Mzimba North

Chimwemwe Ngwira - DTT Mzimba North

Allan Khangadza - DTT Mzimba North

Mwami Mwarwanda - DTT Mzimba NorthSungani Guwa - DTT Mzimba North