Mid-term Evaluation of Moyo wa Bana Capacity Building Initiative

(ZMB036 – ZM330)

May/June 2011

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July 2011

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Acknowledgements

The consultants would like to thank the many individuals who contributed to this evaluation, including representatives of the Government of Zambia Ministry of Health, Care Zambia, and CIDA. Particular thanks to Mr Michael Schroll, MELU Director and Mr Francis Mangani, Moyo wa Bana Programme Manager and his team.

Acronyms

AIDS	Acquired Immune-Deficiency Syndrome
ARI	Acute respiratory illness
ART/ARV	Antiretroviral therapy/Anti Retro-Viral
CHP	Child Health Promoter
CHW	Community Health Worker
CHU	Child Health Unit
CIDA	Canadian International Development Agency
C-HMIS	Community health management information system
C-IMCI	Community Integrated Management of Childhood Illness
DHMT	District Health Management Team
DHO	District Health Office
FPP	Focal Point Person
GMP	Growth monitoring point
GRZ	Government of the Republic of Zambia
HF	Health Facility
HIV	Human Immune-deficiency Virus
HMIS	Health management information system
IMCI	Integrated Management of Childhood Illness
ITN	Insect treated nets
MDG	Millennium Development Goals
MoH	Ministry of Health
NHC	Neighbourhood Health Committee
PHO	Provincial Health Office
PIP	Project Implementation Plan
PMTCT	Prevention of mother to child transmission
PSC	Project Steering Committee
RBM	Results based management
ToT	Training of trainers
U5	Under-five years of age
U5MR	Under-five mortality rate
VCT	Voluntary counselling and testing
WHO	World Health Organisation
ZDHS	Zambia Demographic and Health Survey

Executive Summary

The Care Zambia Moyo wa Bana (MwB) Capacity Building Initiative (CBI) Programme is a four year programme that commenced in early 2007 focusing on providing support for the Integrated Management of Childhood Illness (IMCI). The programme works within a strategic capacity building framework emphasising an iterative and consultative interaction with the Government of Zambia's Ministry of Health, specifically the Child Health Unit (CHU), Provincial Health Office (PHO) and District Health Office (DHO) health managers to plan and support health workers and communities to deliver gender-sensitive, holistic health system and community IMCI services. The MwB CBI programme was funded by CIDA with CAN$ 10.3 million for the initial four-year period 2007-2011 and approximately CAN$2 million for a two-year extension to mid 2013. The programme builds on previous CIDA/CARE collaborations in child health (2001-07). The programme currently operates in eleven selected districts of three of the nine provinces in Zambia, Northern, Central and Luapula. From 2007 to June 2010 Care Zambia seconded staff to the MoH at the District, Provincial and central CHU level. As part of the 'Exit and Sustainability Plan', for what was thought to be the final year (2010-2011), District level Care Zambia staff were withdrawn and the two year extension (2011-2013) has a remaining core team of three secondments at the Provincial level and programme team members in Lusaka.

The external mid-term evaluation was conducted in May/June 2011 by Ms Sally Monkman, Team Leader, Dr Thabale Jack Ngulube and Mr Peter Chabwela via the review of key documents, meetings with key stakeholders and visits to Northern and Central province MwB programme sites. The main purpose of the evaluation, as set out in the Terms of Reference, was to: 'systematically and independently assess programme implementation as well as factors that enabled and constrained the achievement of results to date. Value added from this evaluation is expected to be achieved through documenting lessons learned that can be immediately utilized to inform the programme extension phase'.

The mid-term evaluation was focused on assessing progress towards the three programme outcomes:

- Improved institutional performance of the Child Health Unit of the MoH and the Directorates of selected provincial and district health offices to manage all aspects (planning, budgeting, resource mobilization, monitoring) of the implementation of gender sensitive health system IMCI programmes that mainstream HIV/AIDS
- Improved institutional performance of the Child Health Unit of the MoH and the Directorates of selected provincial and district health offices, to plan and deliver sustainable, gender sensitive IMCI capacity development and supervision to primary health care workers.
- Enhanced institutional performance of selected district Directorates and clinics to plan and support gender-sensitive community based IMCI activities and programmes that promote child health for under 5 girls/boys.

The evaluation team found strong evidence that there has been good progress towards achieving these three outcomes, particularly at the PHO, DHO and community levels and there is solid evidence of capacity building at all levels. Care Zambia has developed and supported strong relationships within the MoH and managed the process of embedding staff well at both the Provincial and District levels, although difficulties have been encountered at the national CHU level. The programme period has seen encouraging saturation levels for training in IMCI although these have suffered as a result of redeployment of health workers as part of the MoH

restructuring. Superb results are evident in Community IMCI (C-IMCI), with strong performance at the District, health facility and community levels in terms of training and supporting community volunteers in the provision of C-IMCI.

Concerns remain regarding issues of sustainability, including training, technical support and supervision at all levels and the retention of community volunteers, particularly amidst on-going resource constraints and restructuring within the MoH. However, the restructuring process should also be viewed as an opportunity, in that the restructuring of DHOs has now defined the required skills and competences for office bearers, in urban and rural areas, with incentives for those who choose to work in rural areas. These actions may have the effect of ensuring an even distribution of the required capacity for undertaking innovation; compared to the uneven distribution of leadership capacity that disadvantaged rural and remote districts under the previous structure of staff deployment.

There has been a lack of documented evidence regarding progress to date. Programme reports only consider the previous six-monthly reporting period rather than cumulatively across the programme period to date and so it is difficult to ascertain exact results in relation to an agreed baseline. It is increasingly important that evidence relating both to results and what has been learned is packaged and disseminated in such a way as to encourage scale up and assist with influencing national policy.

The MwB programme has demonstrated that a high intensity low resource IMCI approach is possible however there are still questions around whether a roll-out of this approach by the Zambian health system can be sustained in the current resource environment. Scale up is essential as the programme covers only 11 out of the 72 districts in Zambia, with 3 of the 11 districts being recently included as part of the extension phase. The MwB approach can provide a viable and sustainable contribution to the Zambian health sector but evidence of the positive outcomes of the programme must be used directly in the remaining two years to influence national policy, linking to broader issues at the central policy and funding level.

Recommendations

Care Zambia

- Care Zambia should concentrate on developing closer linkages with MoH structures at the national level, including the Directorate of Public Health, the Directorate of Technical Support Services and the Directorate of Planning and Policy. This will be essential in terms of sharing lessons learned and evidence gained from the MwB CBI programme for advocating for the wider adoption of the IMCI approach in Zambia. This can be developed both in collaboration with CHU or directly by Care Zambia as appropriate given capacity issues at CHU. As part of this Care Zambia should explore the potential of participation in a wider variety of national level MoH meetings and working groups, for example meetings of the Sector Advisory Group meetings, Joint Annual Reviews and the HR Technical Working Group.
- Allied to this is the need for Care Zambia to carefully and systematically plan how to support a more proactive approach to monitoring during the final two years of the programme. It is recommended that a monitoring strategy is designed for the final two years, focusing on documenting and disseminating lessons and evidence, both quantitative and qualitative, with activities culminating in the final evaluation of the programme at the end of the two years and the dissemination and promotion of final evaluation findings. It is also important that the logframe for the MwB programme is reviewed and updated as appropriate and that

programme progress reports provide cumulative progress to date against the agreed outcomes and agreed baseline information.

- Care Zambia is implementing a number of programmes within the health sector and it is important to identify and support more formal ways for Programme Managers to share experience and consider linkages. Programmes are often working with the same stakeholders, particularly at the community level for example the PRISM agents and MwB child health promoters, but there is currently only limited interaction between Programme Managers. A more integrated approach would be beneficial in terms of planning for future sustainability, particularly at the community level.

Central Level

- Continued ways of supporting capacity building within CHU based on the recommendations of the CHU Institutional Assessment should be explored. It is important that agreement is reached between CHU and Care Zambia regarding on-going MwB programme support for the institutional strengthening of CHU as soon as possible. It may be that this support can be provided by the programme team at the Care Zambia Lusaka office or that an additional person is required. Any recruitment should be undertaken jointly between Care Zambia and CHU and careful consideration should be given to the length of contract available and remuneration so as to attract high calibre applicants.
- CHU and Care Zambia should document the critical interventions that can form part of the sub-package of IMCI interventions of value for effective intervention in high intensity, low resourced settings, at the management, health facility and community levels. This sub-package could then be tested in the three new districts and the additional amount of funding needed (per capita) to fully implement the sub-packages should be costed. When this is completed CHU should then be supported to develop policy guidelines for the nationwide scaling up of the sub-package and to push for their adoption.
- CHU capacity development for training will need to focus on systemic sustainability. Given the restructuring within the MoH and redeployment of many IMCI trained staff from MwB programme areas the need is not just for training itself but also the supervision and monitoring of training, ensuring for example that all training schools incorporate IMCI and that their curricula is regularly reviewed and updated as appropriate. That is not to say that training is not important. The remaining two years will need a continued focus on the monitoring of saturation levels of IMCI trained health workers at all levels of the health system and the provision of IMCI training to fill gaps, identified by the CHU training database.
- Ensuring continued practice for supportive supervision and monitoring visits by CHU to the Provincial and District levels remains essential and should be prioritised. Evidence is showing that these visits are critical in terms of motivating all levels of health workers to continue the prioritisation of IMCI and for CHU to make sure that IMCI is integrated through all levels: community, health facility, District, Provincial and national.
- The strengthening of CHUs capacity in terms of communications both with partners and with the lower levels of the health system should continue, maximizing IT support and back up as appropriate.

Provincial

- Ensuring continued practice for supportive supervision and monitoring visits by PHOs to the District and community levels remains essential and should be prioritised. It is accepted that IMCI is integrated into a wider focus for such visits given the current resource environment. However the MwB programme should ensure that PHOs are still undertaking regular visits where IMCI support is considered a priority. Care Zambia seconded staff at the Provincial

level should continue to provide support and help to institutionalise IMCI supportive supervision at all levels.

- Effective use and support of the Provincial IMCI training teams is also required during the final two years. There should be close liaison with both CHU and DHOs regarding training needs and the planning process. Both initial and refresher training in IMCI and C-IMCI should be considered. Care Zambia seconded staff should continue to support PHOs in developing approaches to external donors for financial support for IMCI training. In addition. non MwB districts should be encouraged to financially support their health workers in IMCI training provided through the MwB programme.

- One new district in each of the three programme provinces has been added for the final two years. However total national coverage will remain limited. Therefore it is important for Care Zambia and CHU to find ways of working with PHOs to spread impact and broaden the rolling out of the MwB IMCI programme approach.

- Provinces report directly to the DTSS with data for the HMIS. It is therefore important Care Zambia seconded staff trace the movement of information and impact and how best the MwB programme can inform national policy, including the potential incorporation of community data within the HMIS.

District

- Excellent progress has been made at the District level in terms of institutionalising the IMCI approach and this has been sustained following the departure of the Care Zambia seconded staff during 2010. However MoH redeployment has meant that many positions in the DHO have changed recently and some of the DHMT with IMCI training have been moved. It is therefore important for the PHOs and Care Zambia Provincial secondments to make sure that on-going support is provided as appropriate to the DHOs to ensure the continued prioritisation of IMCI and C-IMCI.
- Supportive supervision visits to health facilities and communities by the district teams remains vital (see above).

Health Facility

- Health facilities should continue to have at least one trained C-IMCI member of staff in order to support IMCI initiatives at the community level.
- Access to basic IMCI equipment, materials and drugs should be monitored by the MwB programme and addressed where possible.

Community

- Maintaining the motivation of community volunteers is essential. The MwB programme should continue to investigate and support ways of retaining volunteers and addressing issues of sustainability into the future, taking into account Government of Zambia progress with this issue. At a basic level this will include the need to make sure that all communities have basic equipment such as weighing scales and thermometers. Volunteers will also need access to stationery, particularly U5 cards. Finally the provision of bicycles to those volunteers without would make a tremendous difference in terms of motivation and coverage.

- Where possible training for additional CHPs should be supported to ensure adequate coverage. An ideal scenario is 4 CHPs per zone, although this is probably an unrealistic level given the resources available for the remaining two years of the MwB programme.
- Care Zambia should consider supporting the mapping of volunteers in all its programme/project areas to provide a database of community volunteers. This would help to ascertain the number of volunteers working with more than one programme/project and could form the basis for discussions regarding enhanced integration and longer-term sustainability issues. This could also inform national policy development.
- Communities, health facilities and districts should be supported to consider the more effective use of the community 10%-14% available in budget allocations at the health facility level. This could play an important role in future sustainability. Examples of how the allocation could be used include successful income generating initiatives which provide income for volunteers and motivation for their continued role in health care provision.

Additional Areas:

- Advocacy: MwB partners will need to consider and agree what is meant by and needed in terms of advocating for IMCI and its appropriate resourcing. External consultancy support may be helpful to take this forward and assist in the development of an advocacy strategy for the remaining two years of the programme.
- Gender: The MwB programme can continue to build awareness and knowledge in terms of gender mainstreaming, given that this is a donor priority. However it should be acknowledged that this will be a slow process and incremental gains will be largely dependent upon the progress made by the MoH in operationalising the National Gender Policy.

1. Introduction

The findings and recommendations contained in this report are based on the mid-term review of the Moyo wa Bana Capacity Building Initiative Programme, funded by CIDA and implemented by Care Zambia from 2007 to 2011.

The review was conducted by a team of three consultants:

- Ms Sally Monkman (UK Independent Consultant) Team Leader and Institutional and Organisational Development Specialist
- Dr Thabale Jack Ngulube (Zambian Independent Consultant) Heath Systems Specialist
- Mr Peter Chabwela (Care Zambia Programme Support Manager, Monitoring Evaluation and Learning)

The mid-term evaluation was undertaken during May and June 2011. The Team Leader designed the Evaluation Framework and Evaluation Workplan, based on the agreed Terms of Reference, in consultation with evaluation team members and Care Zambia. Field work in Zambia was undertaken by the evaluation team from 25 May to 10 June 2011. The evaluation report has been prepared by the Team Leader, with input from team members and comments from Care Zambia, the Ministry of Health Zambia and CIDA.

Purpose of the review

The purpose of the mid-term evaluation was: 'to systematically and independently assess programme implementation as well as factors that enabled and constrained the achievement of results to date. Value added from this evaluation is expected to be achieved through documenting lessons learned that can be immediately utilized to inform the programme extension phase'.

Terms of Reference are attached at Annex 1.

2. Evaluation Methodology

The specific objectives of the mid-term evaluation were:

- To assess progress towards the achievement of programme results (including unintended results) – specifically the three programme outcomes in comparison to the baseline and initial targets;
- To assess the sustainability of these achievements and suggest – if necessary - how to improve sustainability;
- To document and assess the mechanism of programme implementation to date, and provide suggestions for improvement;
- To identify lessons learned and provide evidence-based recommendations to guide the extension phase.

Terms of Reference are attached at Annex 1.
In order to respond to these specific objectives an Evaluation Framework and Evaluation Workplan were designed by the Team Leader and discussed and agreed with evaluation team members and Care Zambia. The Evaluation Framework is attached at Annex 2. The Evaluation Workplan outlined evaluation questions, methodology, stakeholders to be consulted, a draft schedule of visits/meetings/focus group discussions and the format for the evaluation report and is attached at Annex 3.

Consultation with Stakeholders

Discussions with stakeholders included the following (with the number of key informants consulted in brackets):

- National level
  - Government of Zambia: Child Health Unit and the Ministry of Health HQ (3)
  - Multilateral: UNICEF, WHO (2)
  - Bilateral: CIDA (1)
  - CIDA – External MwB Programme Monitor (1)
  - NGOs: ZISSP (1)
  - Care Zambia (6)

- Provincial
  - Maternal and Child Health Coordinator (1)
  - Clinical Care Specialist (1)
  - CARE Programme Management Coordinator (2)

- District
  - District medical officer (2)
  - Planning officer (2)
  - District Nutritionists (2)
  - Clinical Care Officer (1)
  - MCH Coordinator (3)
  - Information Officer (2)
  - Former CARE District Coordinator (1)

- Health Facility
  - IMCI Focal Point Persons (6)

- Community based Focus Group Discussions
  - Community agents (6)
    - Child Health Promoters
    - Neighbourhood Health Committee Members
    - Child Health Workers
  - Mothers with children age under 5 (4)

Details of stakeholders consulted are attached at Annex 4 and a Visit Schedule is attached at Annex 5. A list of documents reviewed is attached at Annex 6.

Limitations

The following limitations applied to the evaluation:

- On-going restructuring within the Ministry of Health has led to a very fluid situation as personnel are currently being redeployed. This was evident at all levels during the evaluation period and did mean, particularly at Provincial Level, that the evaluation team was not always able to meet with key health management team members. It also meant that some of those interviewed were relatively new to their posts and so did not have an institutional memory of the MwB CBI programme.
- Programme reports focus on progress during the last six-monthly reporting period. There is little documented evidence in terms of cumulative achievements to date and it is therefore difficult to obtain a clear picture as to overall progress on an on-going basis or progress against an original baseline.
- Timing in the field was limited, although this is always a difficulty with evaluations. The evaluation team visited Northern Province (2 districts) and Central Province (1 district). Overall what was seen was sufficient to provide detailed insights to the overall MwB CBI programme.

3. Project Profile/Background Information

The latest United Nations under-five mortality estimates released in September 2010 by UNICEF show the total number of under-five deaths decreased globally from 1990 to 2009 from 12.4 million per year to 8.1 million. The global under-five mortality rate has dropped by a third over that period, from 89 deaths per 1,000 live births to 60 in 2009. However some 22,000 children under five still die each day, with some 70 per cent of these deaths occurring in the first year of the child's life. The highest rates of child mortality continue to be found in sub-Saharan Africa, where 1 in 8 children die before their fifth birthday – nearly 20 times the average for developed regions (1 in 167). Southern Asia has the second highest rates, with about 1 in 14 children dying before age five. While the speed at which under-five mortality rates are declining improved for 2000 to 2009 compared to the previous decade, the under five deaths are still not decreasing fast enough –especially in sub-Saharan Africa, Southern Asia and Oceania – to achieve Millennium Development Goal 4: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate.

The Zambian Demographic and Health Survey 2007 showed the infant mortality rate to be 70 deaths per 1,000 live births, with the under-five mortality rate at 119 per 1,000 live births for the five years preceding the survey. The neo-natal mortality rate is 34 per 1,000 births. Almost two-thirds of childhood deaths occurred during infancy, with more than one-quarter taking place during the first month of life. The survey further shows that child mortality is consistently lower in urban areas than in rural areas. Infant mortality is highest in Luapula, Western and Northern provinces, while the under-five mortality rate is highest in Northern and Luapula provinces**.** According to UNICEF, most child deaths (and 70% in developing countries) result from one of the following five causes or a combination thereof: acute respiratory infections; diarrhoea; measles; malaria and malnutrition. WHO statistics for 2010 show that Zambia is ranked 13th in the world for under-five mortality, at 141 per 1000 live births (Source: World Health Statistics, 2011 WHO).

The Integrated Management of Childhood Illness (IMCI) is an integrated approach to child health that focuses on the well-being of the whole child. IMCI aims to reduce death, illness and disability, and to promote improved growth and development among children under five years of age. IMCI includes both preventive and curative elements that are implemented by families and communities as well as by health facilities.

The strategy includes three main components:

- Improving overall health systems
- Improving case management skills of health-care staff
- Improving family and community health practices.

In health facilities, the IMCI strategy promotes the accurate identification of childhood illnesses in outpatient settings, ensures appropriate combined treatment of all major illnesses, strengthens the counselling of caretakers, and speeds up the referral of severely ill children. In the home setting, it promotes appropriate care seeking behaviours, improved nutrition and preventative care, and the correct implementation of prescribed care.

CARE Zambia, supported by CIDA and in partnership with the Zambian MoH, has adopted the WHO/UNICEF-developed IMCI strategy that aims to contribute to the reduction of morbidity and mortality of children under five years of age. The *Moyo wa Bana Capacity Building Initiative*

programme is being implemented by Care Zambia (2007-2013) and is investing in the long-term sustainability of IMCI and capacity of the Zambian MoH to deliver the IMCI strategy to health centres and communities.

This programme builds on Phase I of Moyo wa Bana which ended on March 31st 2007. The first phase focused on delivering services along with MoH caregivers at health centres in Kasama town and Ndola. The project reduced diarrhoea, pneumonia and malaria case fatalities among children under 5, but did not explicitly seek to build MOH capacity to plan, budget, manage and deliver IMCI services in the operational framework. This is not to say that the project did not build these capacities among some MOH staff. Project activities included: capacity building for health care workers in the delivery of IMCI; strengthening of the relationship between health centres and their catchment areas through support for NHCs and CHPs; provision of equipment and supplies to health centres for the delivery of IMCI; training in drug use and logistics; supplementation of Vitamin A stocks for children and some provision of essential drugs; and support for creation of community-based plans for HIV/AIDS, including expanded voluntary testing and counselling as well as treatment options, with a focus on assisting mothers or fathers who are or suspect they are HIV positive.

Findings from previous MwB projects have all directly influenced the current programme. The previous project findings are consistent with MOH documents and identified challenges highlighted in a recent CHU institutional assessment report:

- While child health indicators have shown nascent improvement, achievement of Millennium Development Goal # 4, to reduce child mortality by two thirds, is distant.
- The crisis in health human resources is a major challenge. Ongoing restructuring of MOH has seen IMCI staff moved out of the project districts and provinces and replaced with individuals with no IMCI training.
- Zambia has adopted IMCI and put in place an enabling policy framework for child health but progress in taking child health and IMCI services to children is slower. Overall monitoring, feedback systems and evidence based decision making are relatively weak.
- For the most part there is broad consensus on the challenges involved with child health service delivery and steps to overcome them but capacity to deliver all of the required measures needs to strengthen further.
- A significant gap identified in the midterm review of the NHSP 2006-2010 is the weakness of supportive supervision throughout the delivery chain.
- Capacity development is needed at all levels. The quality of IMCI services, in particular case management of pneumonia, is poor and has not kept pace with overall improvements in the other key areas such as HIV, TB and malaria;
- Meaningful gender and HIV mainstreaming capacity also needs to be built.

(Source: MwB Semi-Annual Report October 2010 – March 2011

The MoH has struggled to provide adequate support and services to Luapula and Northern provinces and their respective districts. A recent review found that Zambia's rural districts rank the highest in terms of the under five mortality rate (U5MR). Districts in Luapula and the Northern Provinces, in addition to the Western and Eastern province, have the highest U5MR and the highest infant mortality rate. These districts face shortages and inequitable distribution of health workers, and inadequate and poor conditions of infrastructure. These districts also manifest high poverty levels.

With a view to these challenges and building on the successes of the earlier project, the current phase of the MwB programme was selected by the MoH and Care Zambia to operate in two of the four highest U5MR provinces; Luapula and Northern Province plus the third province, Central. It was hoped that project achievements in IMCI case management and case fatalities from the first phase of the MwB project, could be replicated in these rural provinces.

The new *MwB Capacity Building Initiative* is a four year programme that commenced in early 2007 and has been extended for additional two years until mid 2013. It is funded by CIDA with CAN$ 10.3 million for the four-year period 2007-2011 and is building on the previous CIDA/CARE collaboration in child health (2001-07). The budget for the two-year extension amounts to around CAN$ 2 million. MwB CBI is modelled on the Tanzania Essential Health Interventions Project (TEHIP), a CIDA and IDRC funded health systems strengthening initiative. The Care Zambia MwB CBI programme works within a strategic capacity building framework that emphasises an iterative and consultative interaction with CHU, PHO and DHO health managers to plan and support health workers and communities to deliver gender-sensitive, holistic health system and community IMCI services

The programme currently operates in eleven selected districts of three of the nine provinces in Zambia:

- Central Province
  - Kapiri Mposhi
  - Serenje
  - *Mumbwa (as part of the two year extension)*
- Luapula Province
  - Mansa
  - Milenge
  - Samfya
  - *Kawambwa (as part of the two year extension)*
- Northern Province
  - Kasama
  - Mungwi
  - Mporokoso
  - *Mpika (as part of the two year extension)*

From 2007 to June 2010 Care Zambia seconded staff to the MoH at the District, Provincial and CHU level. Details of the original proposed structure of the MwB CBI programme can be seen at Annex 7 and the relationship between key partners at Annex 8. As part of the 'Exit and Sustainability Plan', for what was thought to be the final year (2010-2011), District level Care Zambia staff were withdrawn and the two year extension (2011-2013) has a remaining core team of three secondments at the Provincial level and programme team members in Lusaka.

The goal of the programme is to: 'Support the enhancements in the health and well-being of Zambian boys, girls, men and women through the development of sustainable, equitable and holistic child health services'. The expected impact is: 'Improvements in child survival among 200,000 female/male children under 5 in project areas'. The three outcomes of the programme to be achieved are:

- Improved institutional performance of the Child Health Unit of the MoH and the Directorates of selected provincial and district health offices to manage all aspects (planning, budgeting,

resource mobilization, monitoring) of the implementation of gender sensitive health system IMCI programmes that mainstream HIV/AIDS

- Improved institutional performance of the Child Health Unit of the MoH and the Directorates of selected provincial and district health offices, to plan and deliver sustainable, gender sensitive IMCI capacity development and supervision to primary health care workers.
- Enhanced institutional performance of selected district Directorates and clinics to plan and support gender-sensitive community based IMCI activities and programmes that promote child health for under 5 girls/boys.

The MwB CBI programme has taken place against a background of restructuring in the MoH following the abolition of the Central Board of Health in 2006. Following this event all public sector health workers reverted to the civil service and a new structure was created within the civil service with new job descriptions. All health workers have had to apply for the newly available posts and were subsequently deployed, often to new areas of the country. This restructuring process is coming to an end in 2011, with some staff still finalising new postings.

4. Evaluation Findings

- To assess progress towards the achievement of programme results (including unintended results) – specifically the three programme outcomes in comparison to the baseline and initial targets;
- To assess the sustainability of these achievements and suggest – if necessary - how to improve sustainability;
- To document and assess the mechanism of programme implementation to date, and provide suggestions for improvement;

4.1 Achievement of Programme Results

The following section provides a summary of key findings related to results achievement – specifically the three programme outcomes. It should be noted that the updated version of the logframe was agreed with Care Zambia as the basis for this review, not the original logframe agreed at the start of the project. The original outcomes remained unchanged whilst the outputs were jointly revised between Care Zambia and CIDA. The updated outline logframe is attached at Annex 9. This summary considers the outcomes and key supporting outputs and notes strengths, areas of difficulty and possible areas to inform the remaining two years of the programme.

Outcome 1: Improved institutional performance of the Child Health Unit of the MoH & the Directorates of selected provincial & district health offices to manage all aspects (planning, budgeting, resource mobilization, monitoring) of the implementation of gender sensitive health system IMCI programmes that mainstream HIV/AIDS

The MwB programme aimed to support the improved institutional performance of CHU. The main areas of intended change were identified as follows:

- Increased ability of CHU to coordinate and lead the child health and IMCI agenda with partners
- Increased evidence based planning and decision making for child health at CHU, PHO and DHO
- Increased ability of CHU to advocate for appropriate policy environment and increased support to child health/IMCI
- Increased capacity for CHU to mainstream HIV/AIDS and gender into child health/IMCI
- Improved skills of IMCI trained health workers to assess and treat children U5 according to updated IMCI case management protocols

Increased ability of CHU to coordinate and lead the child health and IMCI agenda with Partners
CHU has the following mandate:

- Setting national direction regarding child health in Zambia
- Support for PHOs to provide oversight of Districts
- Development of guidelines/documents/strategies/manuals
- Provide guidance on new trends in child health

There is strong evidence that CHU has strengthened its ability to coordinate and lead the child health and IMCI agenda with its existing partners, supported by Care Zambia and the MwB

programme. This is admirable given the generally agreed consensus that CHU is an under-resourced and under-staffed unit. CHU has successfully convened quarterly meetings of the Inter-Agency Coordinating Committee (ICC) and twice monthly meetings of the Child Health Technical Working Group. These consultative meetings between CHU and child health stakeholders have been instrumental in enabling CHU to provide details on activities being implemented by the unit, progress achieved and activities still pending or required. Partners have been able to contribute to discussions around child health and IMCI and relationships have been strengthened. A conference room has been refurbished for CHU with MwB funding and although this may appear of minor significance, it has proved instrumental in improving CHUs capacity and confidence in hosting meetings, including national level trainings and workshops. CHU collaboration with and coordination of partners has also been strengthened through MwB's on-going support and funding for an internet connection and IT support. In addition CHU has been able to mobilise funding for child health initiatives from a number of organisations.

Child Health Week is a key event in the child health calendar in Zambia and is coordinated by CHU. It is a semi-annual health intervention targeting children under five years of age. Beginning in 2000 as a vitamin A intervention and national immunisation days, it has grown to a broad range of interventions that include: vaccination, growth monitoring, treatment of children using guidelines for the integrated management of childhood illnesses, re-treatment of bed nets, screening of children for malnutrition, and provision of family planning services. The MoH uses the bi-annual Child Health Weeks to supplement routine health services and ensure that mothers and children who have missed out before will get a second opportunity. Child Health Weeks enable the delivery of a package of high-impact, low-cost child survival interventions. As an interim measure and during a period of reduced financial resources, Child Health Week was funded primarily by external donors including DFID, USAID and CIDA through UNICEF, and it is widely acknowledged that CHU has proved increasingly successful in coordinating, planning and implementing this initiative.

An Institutional Assessment of CHU, supported by the MwB programme, was undertaken during 2010 and has highlighted key recommendations for the continued strengthening of CHU. There has been some delay in finalising and releasing the report and it is anticipated that this should now happen during June/July 2011. The report was not seen by the evaluation team. It is unfortunate that the institutional assessment was not undertaken earlier in the MwB programme lifecycle in order to provide a framework for the institutional strengthening of the unit, outlining support and activities required over the term of the programme. It is difficult to say to what degree positive structural change has actually taken place within CHU following MwB inputs. Given that there is now an additional two years of the programme it is essential that recommendations arising from the assessment are discussed between programme partners and urgent agreement reached in terms of how to take these forward.

Increased evidence based planning and decision making for child health at CHU, PHO and DHO

The increasing use of data to inform planning and the prioritisation of child health were evident to the evaluation team at all levels. Planning decisions are based on the reviews of child health indicators from the HMIS and other reports and are resulting in improved evidence based planning. The MwB programme has been instrumental in supporting the introduction of community level gender disaggregated data, focusing on child health of the under 5's and collected by the CHPs within their communities. This is not currently part of the national HMIS although the programme is lobbying for its inclusion following a possible review in late 2011. The community level data is assisting health centres and DHOs plan and target interventions in

relation to child health/IMCI. However community level data appears not to be utilised fully at the Provincial and national level, given its non inclusion in the HMIS. There is also the added complication that CHU reports to the Directorate of Public Health whereas the PHOs report to the Directorate of Technical and Support Services (DTSS) and PHO data (HMIS data) goes directly to the Directorate of Planning and Policy (M&E unit). However despite this CHU are able to access HMIS data and do use this for planning purposes.

CHU successfully conducted a national IMCI facility survey at the beginning of the MwB programme and has been able to build on this in terms of identifying training needs for IMCI. MwB supported CHU in the recruitment of a Data Manager who introduced a computerised training inventory, vastly improving the ability of CHU to see IMCI skills coverage nationally and on-going requirements. Unfortunately the Data Manager left his position during 2010 to work for an NGO and CHU is currently looking to recruit a replacement. As an interim measure, an officer from the MoH's M&E unit is currently assisting CHU.

During the course of the Programme CHU has supported the development of integrated child health action plans that include technical and management support by CHU to PHO and DHO levels. Supportive supervision visits have been undertaken at PHO and DHO level to ensure continued capacity development and mentoring on strategic leadership and support for IMCI. This includes semi-annual performance assessment with the PHOs, enabling the PHOs to then provide the same for the DHOs and ultimately the DHMTs supporting the health centres to ensure planned child health IMCI activities are implemented as scheduled. Due to CHU support PHOs are now able to provide IMCI technical supervision to DHOs through performance assessment and technical support visits. However it should be noted that financial resource constraints within the MoH have, at all levels, impacted on the ability to fund regular supportive supervision visits focusing on child health and IMCI. A pragmatic approach is therefore being taken and visits are being integrated with other aspects of healthcare thus maintaining a focus, albeit not an exclusive focus, on child health and IMCI.

During 2010 CHU successfully facilitated results based management training for 30 key MoH managers, including participants from MwB programme PHOs and DHOs. This proved extremely useful and positive feedback was received from participants regarding its value in decision making and planning for effective child health and IMCI interventions. The PHOs and the DHOs tend to follow performance levels achieved and make decisions on promotion or incentives as a way to reward high achievers. Due to lack of resources, rewards may include: being nominated to attend a fully sponsored workshop and time off work to refresh ideas. Health managers consulted by the evaluation team expressed their appreciation of NGO programmes that were less prescriptive in terms of the selection of workshop attendees and appreciated donors that left the selection of attendees to the health teams. It is now planned that the RBM training component will be strengthened and rolled out to more health managers.

Increased ability of CHU to advocate for appropriate policy environment and increased support to child health/IMCI

CHU has participated in the preparation and development of the 2011-2015 National Health Strategic Plan which is currently being finalised. It was also involved in the development of the National Community Health Worker Strategy and IMCI has been included as part of the one-year training curriculum. In 2010/2011 staff from CHU participated in a three-day training course in advocacy and lobbying with support from MwB. It was anticipated that this would assist CHU to develop an advocacy strategy to guide its efforts. This has not yet been developed. It should be noted that CHU recognises the difficultly in terms of its capacity to

develop and implement an advocacy strategy. Whilst Care Zambia and CIDA are pressing for the further development of advocacy initiatives by CHU, CHU is concerned regarding its absorptive capacity. It is acknowledged that Care Zambia may have to take the lead in some advocacy initiatives, working with and supporting CHU if possible but also working directly when required. It is also important for all partners to agree on what is understood by the term 'advocacy' as it would appear that CHU is already involved in initiatives which can be seen as advocating for an appropriate policy environment and increased support to child health/IMCI. It is anticipated that the findings and recommendations of the CHU Institutional Assessment will be helpful in this regard.

CHU has traditionally served as an agent for advocacy with partners (the ICC consists of various stakeholders) on behalf of MoH. CHU now needs to also serve as an advocacy agent for the MwB programme, with a view to incorporating positive lessons into operational/ implementation guidelines on child health and IMCI in particular. In this regard, CHU is best placed to undertake this role. Any lack of capacity to do this can be supported by Care Zambia under the MwB programme. It should also be noted that since C-IMCI activities at community level also involves activities falling under the health promotion unit and the nutrition unit at the MoH headquarters, the CHU may need to secure the support of these two units within the Directorate of Public Health and Research to work alongside it. There are procedures that can be followed and the Care Zambia MwB programme can support these steps once the minimum package of IMCI interventions in the Zambian context has been worked out. The Directorate of Technical Support & Supervision (DTSS) can be involved with a view to incorporating policy guidelines into implementation guidelines so the minimum package can be supervised and supported. This would include assigning roles and responsibilities as well as inclusion in the evaluation criteria for merit awards.

Increased capacity for CHU to mainstream HIV/AIDS and gender into child health/IMCI

- Mainstreaming HIV/AIDS

The evaluation team found evidence that good progress is being made in terms of mainstreaming HIV/AIDS in child health and IMCI interventions at all levels and future prognosis appears good. The National HIV/AIDS Policy was available at all PHOs and DHOs visited and information was available relating to the HIV/AIDS Workplace Policy. In the last quarter of 2010, as part of supportive supervision visits to PHOs and DHOs, CHU undertook assessments on the implementation of paediatric HIV/AIDS. The availability of MoH Workplace Policy in the sites was also monitored.

Following a review of the institutional arrangements for the coordination of paediatric HIV at the national level, the Child Health Specialist of the CHU has been assigned as the paediatric HIV focal point person by the MoH. This will hopefully lead to an additional way of information sharing between CHU and child health stakeholders. The standard meeting schedule for the fortnightly TWG meetings held at CHU has been revised to include paediatric HIV.

MwB programme initiatives include:

- CHU facilitated the updating of IMCI materials to include the management of paediatric HIV/AIDS assessment, classification and dry blood spot testing and treatment
- 100% of newly trained IMCI health workers received paediatric HIV/AIDS training between October 2010 and March 2011 and 40% of previously trained health workers.
- In Central Province the PHO has expanded HIV information sessions to caretakers of children who were patients at the children's wards at the local hospitals, and

encouraged the caretakers to know their status and share this with their spouses and obtain follow-up
- All MwB programme supported DHOs undertook to orient and update health workers on PMTCT and adult and paediatric ART and VCT
- At the community level Child Health Promoters (CHPs) have received basic HIV training

➢ Mainstreaming Gender

The programme intended to mainstream gender and programme design is strongly focused around 'gender sensitive' health system IMCI programmes, IMCI capacity development and supervision and community based IMCI activities and programmes. However this has proved difficult and the evaluation team found that there appears to have been no consistent, uniform approach or strategy for achieving gender mainstreaming. This should however be seen in the context of the Zambian Government's approach to gender. The Government adopted the National Gender Policy in March 2000 to be used as a major yardstick for measuring government commitment to gender mainstreaming. However this has yet to be fully operationalised, including within the MoH where it will need to feed down to PHO, DHO, health facility and community level. CHU has therefore not prioritised the development of a gender strategy at the present time given the current scenario; although there is a commitment to this once the MoH begins to operationalise the national policy

There have however been some positive moves in the MwB programme regarding gender:
- Discussions have been held between Care Zambia and MoH staff at the PHO and DHO level regarding gender mainstreaming aimed at balancing gender within health care services and there is a willingness to take this forward.
- Community data is gender disaggregated and providing useful data
- Advocacy is ongoing for the inclusion of gender disaggregated HMIS data into the national HMIS.
- In some communities men are becoming more involved in taking the under 5's to health facilities for under 5 clinics and/or treatment. This is assisted by the fact that men are encouraged to go the front of the queue if they do so.
- In some communities men are more willing to take the under 5s to growth monitoring points if their wife is ill or unable to take the child. Again men are encouraged to go to the front of the queue.
- Women are also said to be equal partners when it comes to spearheading community level IMCI activities. This was demonstrated in CHP representation where in some communities, the number of female CHPs surpassed that of men. For example, Muchinga Health zone of Chilumba RHC in Kapirimposhi only has female Child Health Promoters.

Improved skills of IMCI trained health workers to assess and treat children U5 according to updated IMCI case management protocols

CHU has facilitated IMCI training in case management and supervision for both Provincial and District level staff, as well as on-the-job training for health workers and training in Community-IMCI. Saturation levels in terms of training in IMCI reflected a considerable improvement during the programme period with some MwB supported districts exceeding the national target of 80% saturation during the evaluation period. However on-going restructuring of the MoH has

recently resulted in the movement and redeployment of many MoH staff and saturation levels have been affected, including in the MwB supported Districts and Provinces.

A positive development during 2010 has been the inclusion of IMCI in pre-service training for nurses, advocated for by CHU. This has now been incorporated and is an examinable component. Discussions regarding the inclusion of IMCI into the School of Medicine and Chainama School of Health Sciences curricula are also currently being held. IMCI has recently been included in the curriculum for the new cadre of Community Health Worker to be introduced by the MoH.

Throughout the MwB programme CHU has been supported with the development and/or updating of IMCI protocol and guidelines for dissemination to PHOs and DHOs. This has included the updating of the community and facility IMCI training manuals and materials, including standardising the C-IMCI supervisory tool for all stakeholders implementing IMCI in the country. Adaptations to the generic WHO/UNICEF IMCI guidelines to better conform to Zambia's changed disease burden have also been made. Incorporating, for example, HIV guidelines, new guidelines for diarrhoea management, use of RDT to assess and classify fever, inclusion of the care for the newborn guidelines into the IMCI algorithm and subsequent health worker training in HIV assessment, classification and referral guidelines. CHU finalised the revision and printing of the National IMCI Orientation and Planning Guidelines during 2010/2011 and oriented Provincial and District health staff, in all nine Provinces, in planning for child health/IMCI.

There is ample evidence that the MwB programme has improved the skills of IMCI trained health workers through a focus on in-service training, spearheaded by CHU. Better practice by health workers is reflected in better case management and the holistic screening of under 5 children. Improved case management is reflected in the systematic screening of children, shorter consultation and waiting times, clear identification of need and referrals to higher level health institutions and a reduction in the recall numbers to health centres. The evaluation team found that health centres, even in the most basic conditions, were able to produce the IMCI chart booklets and note that treatment has improved often leading to less drugs being prescribed and fewer stock outs. However there are still some concerns regarding timely reporting and requisition of drugs needed. Health workers reported being accorded more time during supportive supervision visits for discussion and the provision of advice, information and education regarding child health.

Regular technical support and supervision visits have proved critical in terms of mentoring and assisting health workers in the use of IMCI case management protocols and are valued both by the health workers themselves and at central, PHO and DHO levels. CHU supervisory and technical visits to provinces and districts is scheduled to happen within two months of post health worker IMCI training, when health worker performance is assessed and a debriefing held. DHMTs are then expected to follow up the CHU report. However this can be affected by changing priorities of the CHU, for example the need to respond to crises such as the measles outbreak which impact on planned IMCI activities.

CHU has been responsible for the procurement and printing of IMCI materials for CHU, PHOs and DHOs and during the four year programme this has included:

- chart booklets
- wall charts
- modules
- participants work books

- facilitators manuals
- new U5 cards
- pre-service handbooks

The IMCI materials are helping facilitate training at all levels of health provision and have improved service delivery by health workers.

Outcome 2: Improved institutional performance of the Child Health Unit of the MoH and the Directorates of selected Provincial and District Health Offices to plan and deliver sustainable, gender sensitive IMCI capacity development and supervision to primary health care workers

The MwB programme aimed to support the improved institutional performance of CHU, the PHO and DHO in terms of capacity development and supervision to health care workers. The main areas of change were identified as:

- Enhanced capacity of PHOs to deliver facility and community IMCI training to the District
- Enhanced capacity of PHO and DHO staff to provide IMCI and child health supportive supervision and follow-up after training to health workers
- Improved HIV/Aids, gender and volunteer support information incorporated into supervision visits with clinic health workers by DHOs

Enhanced capacity of PHOs to deliver facility and community IMCI training to the District
A key success of the programme at the Provincial level has been the establishment of core IMCI training teams, consisting of 1 Course Director, 1 In-Patient Instructor and a number of classroom facilitators. The target was to establish one for each of the three programme Provinces however this has been exceeded in all cases; Luapula Province has three core training teams and Northern and Central Province both have two. This has removed the need to bring in external trainers and thus reduced some of the cost of the trainings. It also means that Districts are now capable of undertaking the training of community Child Health Promoters with minimal technical support from the MwB programme and so sustainability into the future is promising. The existence of core training teams is also facilitating some low level scaling up of IMCI implementation in non MwB programme areas in the three Provinces.

The provision and supervision of IMCI training by the programme PHOs has however been affected by resource difficulties within the MoH and the reduction of financial allocations to PHOs during the programme period from 2009 onwards. In order to ensure continuation of the programme and advances in IMCI, Care Zambia has subsidised and supported training initiatives undertaken by the programme PHOs. It is therefore an excellent achievement that some of the programme districts have achieved over 80% saturation of IMCI trained health staff during the programme period, leading to improved coverage and quality case management for children under 5. However this is a fluid situation at present given the restructuring within the MoH and gaps have emerged in programme districts. The CHU IMCI training inventory has continued to be updated and the situation is being monitored. In all PHOs and DHOs the training inventory is available and utilised as a planning tool, helping with the identification of gaps relating to IMCI coverage and Provincial and District level attrition. The inventory is increasing being used by PHOs and DHOs to help guide decisions on staff placements despite constraints imposed by the centralised MoH staff deployment system.

Reaching and maintaining the target saturation level of 80% remains a challenge given the current resource constraints, MoH restructuring and high staff turnover. Some health facilities (not included in the study) were reported as being currently manned by classified daily employees. One positive outcome during 2010 was the ability of PHOs to secure additional external funding for IMCI training, including support from WHO, UNICEF and Plan International. In addition, non MwB districts in Northern Province have recognised the positive outcomes of the programme and during 2010 selected, and paid for themselves, a number of health workers to attend the MwB IMCI training

Enhanced capacity of PHO and DHO staff to provide IMCI and child health supportive supervision and follow-up after training to health workers

PHOs act as the MoHs link with lower level health structures, training institutions and civil society and ensure that the priorities and scope of the hospital and district medium term expenditure framework and action plans reflect what is provided in the NHSP. They are also responsible for supervising the implementation of health service delivery in their areas and providing necessary technical support to all health service institutions.

During the MwB programme period all relevant PHO managers were supported and oriented in the use of child health and IMCI training data for assessment, planning and improvement and supervisory skills training. DHOs organised training for health centre staff in IMCI and IMCI supervisory skills at the community level and IMCI update training. All MwB partner PHOs are involved in mentoring DHO staff in IMCI/child health management. As part of this role, documents and records regarding IMCI and routine child health are monitored at the District level.

MwB PHO partners are scheduling quarterly technical support and supervision visits to the MwB districts, in liaison with the DHOs. During these visits an IMCI checklist is used and PHO and DHO staff observe health workers and case management, look at records and check health facilities. Provinces are ensuring that IMCI monitoring is incorporated into pre-existing monitoring visits such as performance assessment and technical support visits. All performance assessment teams have at least one person with IMCI supervisory skills. There has been a marked improvement in Provincial reviews of performance in child health, reflected by the experience sharing at meetings and documentation of lessons learned.

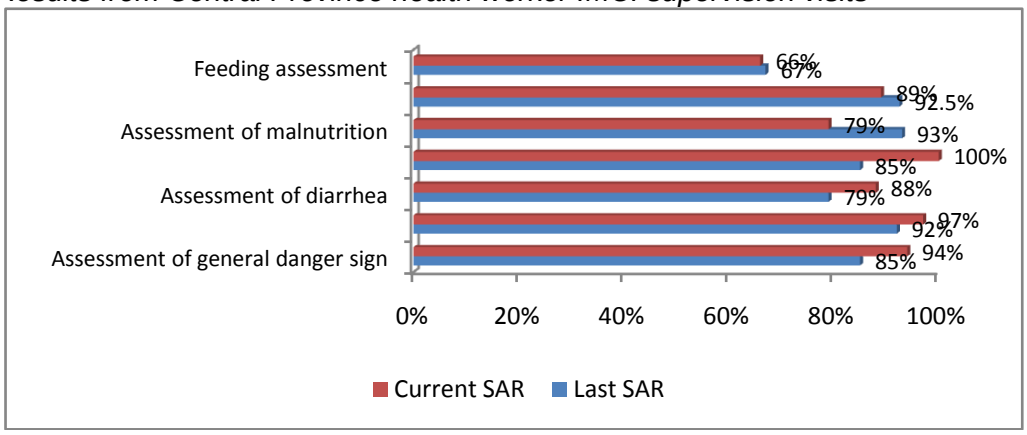
Technical supervision and support visits are seen as essential to follow up IMCI training and undertake reviews of facilities, including equipment, drugs and materials. Challenges faced at the health facility level include understaffing and the multiple and competing roles of health centre staff. Monitoring visits to MwB programme sites reflect that IMCI has been strengthened, in part due to IMCI trained staff now forming part of the Provincial and District performance assessment teams. Improvements at the health centre level that have been noted include: improved case management of under 5s, improvement in the requisition and availability of essential IMCI drugs, chart booklets and other supplies.

In the current context MwB Districts are finding that it is proving difficult to secure the necessary funding and resources for regular technical support and supervision visits to health centres and communities. Most Districts are carrying out such visits quarterly but are having to integrate the focus on IMCI and child health with other health care issues. Given the problems this would seem to be a sensible approach – ensuring IMCI and child health issues are still supported on a regular basis. The value of technical support and supervisory visits has been voiced by many at

all levels of the health system and would appear to be essential in terms of ensuring future quality of service provision and sustainability of IMCI and child health services.

Between October 2010 and March 2011 the MwB programme in Central Province followed up 31 health workers from 18 facilities:

Results from Central Province health worker IMCI supervision visits



During the same period 21 centres were visited in Luapula Province:

Results from Luapula Province Health worker IMCI supervision visits

Area Assessed	**MANSA**		**SAMFYA**		**MILENGE**	
	2009	**2010**	**2009**	**2010**	**2009**	**2010**
	Score	**Score**	**Score**	**Score**	**score**	**Score**
Assessment of general danger sign	61%	90%	59%	86%	49%	85%
Assessment of cough/difficult breathing	78%	95%	60%	92%	70%	90%
Assessment of diarrhoea	73%	80%	70%	85%	75%	86%
Assessment of fever	65%	90%	67%	88%	71%	85%
Assessment of malnutrition	50%	75%	50%	65%	60%	62%
Assessment of immunization and Vit A	50%	82%	50%	67%	51%	65%
Feeding assessment	56%	80%	58%	80%	64%	76%

Northern Province:

Results from Northern Province health worker IMCI supervision visits:

Area assessed	Kasama		Mungwi		Mporokoso	
	04/10-09/10	10/10-03/11	04/10-09/10	10/10-03/11	04/10-09/10	10/10-03/11
	Score		*Score*		*Score*	
Assessment of general danger sign	100%	91%	90%	79%	89%	100%
Assessment of cough/difficult breathing	93%	82%	90%	79%	89%	83%
Assessment of diarrhea	86%	72%	80%	71%	100%	83%
Assessment of fever	93%	82%	100%	79%	89%	92%
Assessment of malnutrition	100%	91%	80%	93%	100%	92%
Assessment of immunization and Vit A	93%	100%	100%	100%	89%	100%
Assessment for HIV	50%	64%	40%	57%	44%	58%
Feeding assessment	64%	64%	50%	57%	56%	58%

Improved HIV/Aids, gender and volunteer support information incorporated into supervision visits with clinic health workers by DHOs

PHOs and DHOs have been responsible for ensuring that all offices and health facilities have the National HIV/AIDS Policy and the HIV/AIDS Workplace Policy, have been oriented on them and use them where possible in implementing activities. Many health facilities now offer PMTCT and ART services and some offer VCT services. Male circumcision is also available at some service points. CHPs in MwB programme areas continue to play a pivotal role in sensitising the communities on the dangers of HIV and AIDS and distributing condoms. The MwB programme had hoped to be able to collect data on the number of children referred for HIV testing (according to the HMIS register). However this has not proved possible. Data is available for the numbers tested and the result of the test but not generally in terms of referrals.

Gender mainstreaming has proved a challenge and it remains difficult for DHOs to move this forward as the national policy on gender has yet to be fully operationalised within the MoH. However some progress is being made within MwB programme areas. For example Central Province has established a Gender Co-ordination Point in order to facilitate the implementation of the National Gender Policy and also has a Gender Focal Point Person. The MwB programme in Luapula Province organised a gender mainstreaming workshop, training twelve frontline health workers (5 male and 7 female) including Focal Point Persons at the PHO and DHOs and two other staff from each level. Northern Province, with support from MwB, conducted a three-day gender mainstreaming training with participants from the PHO and DHOs. Specific targets were set following the training in terms of the orientation of staff in gender. At the health facility and community level progress has been made by MwB in that all health centres now submit data/reports which are gender disaggregated for outpatient attendance and growth monitoring. In additional MwB community data generated by the CHPs and submitted to the health facilities is gender disaggregated, although as yet this has not been incorporated into the HMIS.

MoH has finalised and is now beginning to implement the National Health Community Health Worker Strategy. This aims to develop a cost-effective, adequately trained and motivated community based health workforce that will contribute towards improved management of malaria, child and maternal health and common preventable health conditions. The first cadre of community health workers is currently undergoing the one year training course, which includes IMCI, at the Ndola Biomedical School campus.

There is also the issue of the 14% (originally 10%) grant available from the District's financial allocation to the communities. These funds are intended to support community activities and be planned for and spent by the community members themselves on community priorities. However the evaluation team found no consistent approach or understanding to this funding within the MwB programme areas visited. Some Districts have supported communities in accessing it, for example to build growth monitoring points. Other Districts have allocated the funding to the health facility level but there has been little support for assisting communities to access this. It is however a potential source of sustainable funding for volunteer support initiatives.

There is strong evidence that the MwB programme has further clarified the roles and responsibilities community health volunteers can play in supporting the performance of the health system – as a health systems strengthening measure. The CHPs appear to have been accepted by communities as health agents and that they have a role to play in promoting the health and well-being of children in the community. This has traditionally been the role reserved for traditional healers; as the role of health workers was to wait for clients to come to their health facilities and treat them as need arose. The persistent and repeated encounters between CHPs and community clients has established and deepened this new role; with positive learning taking place on both sides (see the Learning Cycle diagram below).

Outcome 3: Enhanced institutional performance of selected district Directorates and clinics to plan and support gender-sensitive, community-based IMCI activities and programmes that promote child health for under 5 girls/boys

The MwB programme aimed to support the enhanced institutional performance of districts and health facilities in terms of the planning and supporting of community based IMCI activities. The main areas of change were identified as:

- Improved collaboration between DHO, health facility staff and volunteers for effective implementation of C-IMCI
- Enhanced capacity of health workers and volunteers to support communities to implement key family and community practices
- Increased utilisation of commodities that enhance U5 child health by families with U5 children

Improved collaboration between DHO, health facility staff and volunteers for effective implementation of C-IMCI

MwB support at the District level has enabled programme Districts to mobilise IMCI and organise resources more effectively for IMCI at health facility level and within the community (C-IMCI). The evaluation team found evidence of an excellent interface between the Districts, health facilities and communities. DHOs have strengthened their planning and budgeting to ensure IMCI is part of the planning cycle and resource allocation. The MwB programme had aimed for 75% of DHO C-IMCI budgeted funds to be utilised for C-IMCI (nationally only 10% of this budget is actually allocated to IMCI). However the continuing unfavourable resource environment has impacted on this achievement. During the reporting period October 2010 to March 2011 Luapula Province allocated 50% of funds against what was budgeted; Northern

Province 70% and Central Province 60%. This remains a source of concern and a key challenge for the two year extension period.

Despite the on-going difficulties C-IMCI has however remained a priority for the programme DHOs. DHMTs continue to support initial training, and some refresher training, of CHPs and support the monthly follow-up provided by health facility staff. DHOs are also holding quarterly meetings with health facilities and communities to discuss C-IMCI and its challenges and the collection and submission of the community data. Health facility staff are conducting supportive supervision for community volunteers implementing C-IMCI.

Monthly meetings are called by health facility staff for members of the Neighbourhood Health Committees and CHPs at which data collection, referral and follow-up support for children U5 is discussed and any difficulties addressed. The health facility then submits the monthly reports to the DHO. At all levels – community, health facility and DHO – the community data collected by CHPs is increasingly being used to help inform planning and the targeting of interventions for children U5.

Examples of C-HMIS data collected by CHPs:

C-HMIS data collected by CHPs from October 2009 to March 2011 (data verified by NHCs and FPPs)

	October 2009 to March 2010 HH data			*October 2010 to March 2011 HH Data*		
Central Province (Kapiri & Serenje)	*Boys*	*Girls*	*total*	*Boys*	*Girls*	*total*
Births	*621*	*532*	*1153*	*735*	*641*	*1376*
Deaths	*9*	*4*	*13*	*7*	*10*	*17*
Referral by CHP to HF	*578*	*619*	*1197*	*1120*	*745*	*1865*
Total births in 6 months	*621*	*532*	*1153*	*735*	*641*	*1376*
Total deaths in 6 months	*9*	*4*	*13*	*7*	*10*	*17*

C-HMIS/HH Data collected by CHPS from April 2009 to March 2011 (data verified by NHCs and FPPs)

	Oct-08 – Jan 09			*Apr-09 – Sept 09*			*Oct-09 - Mar 2010*			*Apr 10 - Sept 10*			*Oct 10 -Mar 11*		
Luapula Province	*Boys*	*Girls*	*Total*	*Boys*	*Girls*	*Total*	*Boys*	*Girls*	*Total*	*Boys*	*Girls*	*Total*	*Boys*	*Girls*	*Total*
Births	*N/A*	*N/A*	*N/A*	*482*	*622*	*1104*	*389*	*457*	*846*	*404*	*469*	*873*	*1251*	*1334*	*2585*
Deaths	*N/A*	*N/A*	*N/A*	*22*	*46*	*68*	*18*	*34*	*52*	*23*	*19*	*42*	*37*	*32*	*69*
Referrals by CHPs to HF	*N/A*	*N/A*	*N/A*	*546*	*878*	*1124*	*490*	*670*	*1160*	*504*	*683*	*1187*	*1050*	*998*	*2048*
Total births in 6 months	*N/A*	*N/A*	*N/A*			***1104***			***846***			***873***			***2585***
Total deaths in 6 months	*N/A*	*N/A*	*N/A*			***68***			***52***			***42***			***69***

* The missing data for 2008 is due to the fact that the initiative was just being introduced in the project sites and as such data collection was not fully developed.

C-HMIS/ HH Data from April 2009 to March 2011 (data verified by NHCs and FPPs)

Northern Province	Apr - Sept 2009			Oct - Mar 2010			Apr - Sept 2010			Oct 10 - March 2011		
	Boys	Girls	total	Boys	Girls	total	Boys	Girls	Total	Boys	Girls	Total
Births	386	447	833	1010	1143	2153	1,426	1,389	2,815	779	842	1,621
Deaths	76	91	167	77	87	164	30	39	69	12	17	29
Referrals by CHP to HF	542	961	1503	1193	1198	2391	1,110	1,097	2,207	451	453	1,904

Strengthened planning and targeting at the District level for IMCI and C-IMCI has also led to increasingly well harmonised plans for the implementation of Child Health Week.

During the last Annual Performance Assessment in Mwungi District, Northern Province, the DHMT reported clear evidence of a reduction in presentation at facilities for childhood illnesses in Moyo wa Bana areas in comparison to others. This is seen as reflecting the changes in knowledge, attitude and practice in terms of child health interventions at the community level following information and education provided by CHPs, CHWs and health facility staff. Caretakers of children under 5 in four selected communities reported reduced disease burden over the last three years to the evaluation team and therefore fewer visits to the health facilities. There is also evidence of an effective referral system of children under 5 by CHPs to health facilities and then follow up once the child returns to the community.

Following the phasing out of Care MwB support staff at the District level in June 2010 it can be observed that strengthened capacity to support and work with health facilities and communities continued and there is a real sense of ownership and engagement with IMCI and C-IMCI at all levels. As a District MCH Coordinator remarked: 'Moyo wa Bana is the baby of the District'.

In the current context however difficulties do remain at this level including adequate funding to ensure regular technical support, supervision and monitoring, including the cost of fuel; gaps in IMCI trained district health supervisors and the loss of trained Focal Point Persons for IMCI due to MoH restructuring and redeployment. Funding for in-service and C-IMCI training and the availability of stationery, including the national shortage of U5 cards also remain key issues.

Enhanced capacity of health workers and volunteers to support communities to implement key family and community practices

At the health facility level there is clear evidence that in-service IMCI and C-IMCI training is resulting in better case management and the establishment of strong linkages between health facility staff and local communities. Health facility staff are providing on-going support and supervision for community volunteers, that is the CHPs, CHWs and members of the Neighbourhood Health Committees. Community level data is being gathered and collated by health facility staff and is informing district level planning and targeting of services for under 5 children.

Community volunteers are active in the provision of information, education and service provision to caretakers of children under 5 and other members of their communities. This often includes: health education, hygiene and sanitation information, feeding and child nutrition advice, encouragement for HIV testing, assistance at growth monitoring points and under 5 clinics at health facilities, treating minor cases, collection of data, record keeping, visits to community members and follow-up following visits to health facilities. Volunteers are highly motivated,

usually by their desire to see healthy, happy children, and cover wide areas, some travelling 20 kilometres or more to meetings at their nearest health facility.

Another key success is the increasing use and development of growth monitoring points, often with community support for their erection. This has considerably reduced the distance for most caretakers with children under 5 and has thus increased attendance. One community visited by the evaluation team has introduced penalties if children under 5 are late in presenting at growth monitoring sessions and under 5 sessions. These penalties may include fines, collecting water for the health facilities and sweeping compounds.

Verbal and community data evidence points towards a reduction in the number of deaths of under 5 children in MwB programme areas and a reduction in the disease burden (for example, malaria, diarrhoea and RTI).

The challenges faced at the health facility level are focused on the need for regular District support and supervision visits to health facilities and gaps in IMCI and C-IMCI trained staff in some areas due to fluidity of personnel within the national health system. At the community level challenges include: insufficient numbers of CHPs in some areas; the lack of refresher courses; difficulties in obtaining stationery (especially U5 cards); equipment requirements such as weighing scales, batteries and thermometers; transport for CHPs (bicycles); accessing the 10-14% community allocation in the District grant and last, but by no means least, the requirement for some on-going incentives in terms of the voluntary nature of the work.

Increased utilisation of commodities that enhance U5 child health by families with U5 children
Community volunteers are actively promoting the distribution and use of ITNs to pregnant mothers and under 5 children and this is being supplemented by distribution by the MoH via the health facilities. Data collection would support the fact that increasing numbers of households are using ITNs and using them correctly. During the reporting period October 2010 to March 2011 Luapula Province reported that 65% of children under 5 in the programme areas were sleeping under ITNs and 57% in Northern Province. This exceeds the target set of 50%.

The use of safe water is also being promoted by community volunteers – advising to either use chlorine or boil the water. The study found that chlorine is increasingly available, particularly in Northern Province, partly through the work of the Care Zambia PRISM social marketing project. However, communities in Kapirimposhi cited the challenge of not being able to easily access chlorine. Coincidently, the PRISM project is not operational in this district. In the last reporting period Luapula Province reported that 55% of households in programme areas were reported as using treated/clean drinking water; Northern Province 52% and Central Province 35%. All exceeding the target set of 25%.

4.2 Sustainability of Achievements

Based on the outcome analysis provided above, and bearing in mind the broader country and institutional contexts, the following observations regarding sustainability in terms of the MwB programme as a model for a high intensity low resource IMCI approach can be highlighted.

Outcome 1: Improved institutional performance of the Child Health Unit of the MoH & the Directorates of selected provincial & district health offices to manage all aspects (planning, budgeting, resource mobilization, monitoring) of the implementation of gender sensitive health system IMCI programmes that mainstream HIV/AIDS

Institutional performance within CHU has been strengthened during the MwB programme and capacity to coordinate and lead the child health and IMCI agenda with partners would appear to be sustainable into the future by the current Child Health Specialist and IMCI Officer. Evidence based planning and decision making and the mainstreaming of HIV/AIDS has also been strengthened. The updating of IMCI case management protocols would appear to be sustainable into the future although actual IMCI training will be subject to resource availability within the health system. The latter being of some concern given recent resource constraints, allocations to District level and the percentages available for IMCI related activities. Additional support with the development of advocacy and gender initiatives by CHU will be necessary.

The fact remains however that CHU is an under staffed and under resourced department. It has limited capacity to be proactive and often has to be reactive, for example responding to outbreaks such as measles when all other activities, including IMCI, have to be postponed. The secondment of Care Zambia employees to the unit was not without difficulty and although additional programme support was provided it was not always possible to contribute to the promotion of IMCI at a strategic level. Given the two remaining years of the project discussions should be held regarding the potential mechanism for supporting CHU with additional strategic inputs, particularly assisting CHU to advocate for appropriate policy environment and increased support to child health/IMCI. The MwB programme will need to work to establish linkages with key MoH Directorates, including the Directorate of Public Health, DTSS, the Directorate of Human Resource and Administration and the Directorate of Planning and Policy if lessons learned and benefits gained from the MwB model are to encourage scale up and influence and inform national policy. This may be developed jointly by Care Zambia and CHU and where appropriate directly by Care Zambia. A longer-term solution is to continue to lobby MoH for the deployment of additional senior IMCI personnel to CHU.

Outcome 2: Improved institutional performance of the Child Health Unit of the MoH and the Directorates of selected Provincial and District Health Offices to plan and deliver sustainable, gender sensitive IMCI capacity development and supervision to primary health care workers

There is strong evidence that Institutional capacity has been improved at all levels, CHU, PHO and DHO, in the planning and delivery of IMCI capacity development and supervision to primary health care workers. PHOs have established successful core training teams to deliver facility and community IMCI training to the Districts. This has greatly enhanced future prospects for sustainability. However in-service training courses still cost money and the current resource environment is already impacting on the number of IMCI trainings that can be supported. This is of concern for the future given the below target saturation levels and the movement of trained

IMCI health care workers from MwB districts resulting in gaps in coverage. However a positive viewpoint is that skilled IMCI health care workers can take with them to other districts the benefits of the MwB programme approach and thus hopefully contribute to a wider roll out of the IMCI approach. Also pre-service training of nurses in IMCI has now been agreed and incorporated in the curriculum and on-going discussions with medical schools bode well for the future. The new cadre of Community Health Workers will also receiving basic training in IMCI as part of their one-year course. An additional glimmer of hope has been shown by non MwB districts actively supporting and directly funding the MwB training of some of their primary health care workers during 2010/2011. It will remain important for CHU to monitor the situation with regard to IMCI training coverage and saturation and to retain a focus on the need for on-going trainings. Financial support for IMCI training has been secured by PHOs during 2010/2011 from WHO, UNICEF and Plan International and PHOs should continue to develop their linkages with external donors relating to IMCI interventions.

It is generally agreed that supportive supervision and follow-up after IMCI training to health workers is essential in terms of motivation and accuracy of case management. The MwB programme has supported the development of an excellent process of supportive supervision and follow-up by both PHOs and DHOs, based on materials developed by the programme. This approach would appear to be institutionalised within the health system of the programme areas and, dependent on the movement of PHO and DHO staff, should be sustainable into the future. However visits focusing exclusively on child health and IMCI are no longer possible given the current resource environment. A positive note here is that both PHOs and DHOs have recognised the value of such visits and are now integrating child health and IMCI into other supportive supervision. The programme also designed a checklist tool to use in capturing information on how C-IMCI is being implemented, also aimed at strengthening the focus on IMCI during the integrated supportive visits which broadly cover health issues This has resulted in a continued focus on child health and IMCI at all levels. It would also appear that HIV/AIDS is well integrated into supervision visits.

It is not clear that gender or volunteer support are clearly incorporated into supervision visits and this will require further attention during the final two years of the programme. Further developments regarding the National Gender Policy and proposed National Volunteer Strategy will inform the process.

Outcome 3: Enhanced institutional performance of selected district Directorates and clinics to plan and support gender-sensitive, community-based IMCI activities and programmes that promote child health for under 5 girls/boys

The implementation of C-IMCI has been an evident success of the MwB programme. Districts and health facilities have developed their capacity to support the training and follow-up of community volunteers in child health and C-IMCI, including Community Health Promoters, Community Health Workers and members of Neighbourhood Health Committees. The results appear to be impressive with community members reporting reduced child mortality and a reduction in the disease burden for under 5's. Knowledge, attitude and practice around child health for the under 5's has improved and communities are reporting positive feedback regarding the interventions of the MwB programme through the work of the community volunteers.

However it must be remembered that the success of the C-IMCI initiatives are dependent upon volunteers and sustainability will be dependent upon their continued involvement. Some areas have already lost small numbers of volunteers, finding work/furthering their studies or joining

other voluntary initiatives. CHPs report that they are covering large areas and find it difficult to provide all the support needed and collect all the data required by the MwB programme.

Sustainability into the future must therefore address the concerns of the volunteers. These centre around training, incentives and equipment. On-going and refresher training is seen as essential by the community volunteers in order that they still are able to retain authority and respect regarding child health and IMCI initiatives within their communities. A minimum of 4 CHPs per zone has also been suggested which is much higher than current coverage. Incentives is a difficult area but one key requirement would seem to be bicycles – both essential for covering the large areas and an incentive. Other incentives may include kit bags, T-shirts, umbrellas and boots. Some communities are also lacking in basic equipment, for example weighing scales, batteries for scales and thermometers. Stationery is also an on-going problem. These are all areas that require attention during the final two years of the MwB programme if sustainability into the future is to be addressed and benefits maintained. The programme should also continue to draw lessons from the previous Moyo wa Bana project, which also trained CHPs in entrepreneur skills and established a revolving fund, for innovative ways of addressing the challenges faced by volunteers.

It is pleasing to see increasing usage of both ITNs and chlorine/safe water. A positive development has been the linkage of MwB programme community volunteers (eg CHPs) with other voluntary initiatives. One which is proving extremely useful is the link between the MwB programme and the Care Zambia PRISM programme – a social marketing programme for chlorine and family planning commodities. A sizeable number of CHPs have also been taken on as PRISM promoters and now combine their work, visiting households to both sell commodities and promote child health practices for the under 5's. PRISM agents are able to retain part of the proceeds of the sale of commodities and this acts as a very good incentive and helps to make the voluntary inputs more sustainable into the future.

4.3 Mechanism of Programme Implementation

The aim of the MwB CBI programme is to work with and through MoH partners at central, provincial and district level to build capacity for IMCI programming. In order to achieve skills transfer Care Zambia recruited and placed IMCI technical staff at the District, Province and National level to work closely with health managers. Care Zambia's technical staff's roles included mentoring, coaching and capacity enhancement on all the three components of IMCI service delivery at all levels. See Annex 7 for the original organisational structure and Annex 8 for Relationships between Project Partners. As part of the Exit and Sustainability plan devised and implemented in 2010/2011 (as this was expected to be the final year of the project) District level staff and Provincial level support staff were withdrawn, leaving three Provincial Coordinators and the programme team at the Care Zambia Lusaka office.

To guide the MwB programme a Project Steering Committee (PSC) was established, consisting of representatives from the MoH, Care Zambia, Care Canada and CIDA. The PSC meets twice a year to provide technical advice, review activities undertaken and discuss and approve forthcoming workplans and budgets. This seems to have proved a successful initiative and has helped guide and support the programme, although there have been delays due to the difficulties of coordinating meeting dates.

A Programme Management Committee has also been established consisting of representatives from Care Zambia, CHU, PHOs and DHOs. The purpose of these meetings is primarily designed to bring all programme staff together at least twice a year to review progress and address any emerging issues, to review progress to date and to plan for future interventions, in addition to consider any difficulties and issues that require addressing. The meetings help support programme planning and also help promote ownership within the MoH and facilitate 'learning by doing'. Reviewing progress enables the programme team to revise the risk register and alert the donor to changes that are likely to affect implementation of the planned activities even before the close of the period of performance. However the meetings are costly and have been difficult to schedule at times due to competing priorities within the MoH. Overall meetings are seen to be useful and a positive management initiative. The successful implementation of the exit and sustainability plan (Year 4) is partially attributable to such meetings enabling in-depth discussions of the operational details of the phase-over to MoH.

Care Zambia

Care Zambia has primary responsibility for oversight and delivery of the programme, ensuring ongoing capacity building of Government of Zambia stakeholders, promoting learning and utilising field data to inform policy discussions relevant to child health. Care Zambia is also responsible for the ongoing provision of material and technical support, including training, for MoH partners.

Care Zambia has grown from directly implementing MwB, prior to the CBI programme, to supporting the capacity development of a public sector partner. Despite no concrete experience of this within the Zambian context Care Zambia has excelled and the methodology used has developed over the last three years to address the previous parallel systems which operated during the first MwB project. Strong, productive relationships have been developed within the MOH and extremely positive feedback was received at Provincial and District levels by the evaluation team regarding the Care Zambia seconded staff. Care Zambia recruited and managed the placements within the MoH well and as a result the experience overall has been a positive one and capacity has been developed. The experience at central level has however been less successful (see below).

Care Zambia has been responsible for compiling progress reports, data and anecdotal evidence as specified by relevant stakeholders, including CIDA and GRZ. Monitoring reports to CIDA developed over the period of the programme, providing full accounts of implementation of activities relating to the outputs and outcomes. It is noted however that reports only provide details of the preceding six months and there is little cumulative evidence or data over the actual programme period to the date of the report. There is little documented evidence in terms of cumulative achievements to date and it is therefore difficult to obtain a clear picture as to overall progress on an on-going basis or progress against an original baseline. There also seems to be less information provided in terms of the management of the programme and the actual mechanism of implementation. Overall there has been little documentation or dissemination of evidence and lessons learned to assist in the influencing of policy.

Data collection and monitoring appears to be reactive rather than proactive and time has been lost due to concern and delays around finalising the original baseline and also the updating of the logical framework. The latter is still not ideal with a large number of indicators, many of which could be improved upon and there appears to be uncertainty regarding how to measure certain indicators. The logframe performance assessment conducted among CARE employees with a stake in the MwB programme revealed a number of indicators which were either not clear

or whose measurements varied across provinces. Gender is for example narrowly measured with indicators only relating to disaggregation, publishing gender strategy/plans and training health managers in gender sensitisation. As gender is an important cross-cutting issue for both the project and the MoH, there is need to broaden parameters for its measurement. Another problematic indicator relates to children referred for VCT. In some provinces/districts, this was said to be measured in others this was not so. Some reported the data being captured by other partners such as ZPCT. The logframe analysis also revealed that there was inconsistency in the way certain indicators were measured. It is important therefore that the programme team revise indicators to make them easily measurable and also to align them to the programme focus for the remaining two years. This need not be a complete overhaul of the logframe but a simple exercise aimed at identifying positive, helpful changes.

There is little formal interaction between the different Care Zambia Programme and Project Managers and so the sharing of information and experience is limited. Given the potential benefits of coordinating approaches, for example the MwB and PRISM programmes, regular meetings would prove useful. Another challenge faced by the project is the lack of budget line for M&E specific monitoring visits. There is a need for the project to plan and budget for this in order to ensure compliance with data quality requirements.

In terms of linkages and support from CARE Canada it appears that this was particularly helpful in the early stages of the programme when strong technical support was provided in terms of implementing institutional development programmes with public sector partners. As the programme has become more established, this specific technical support has shifted somewhat to a more strategic programme oversight role, with technical inputs as warranted. CARE Canada also directly manages the relationship with the CIDA head office.'

Central Level (CHU)
The MwB programme aimed to support CHU through the appointment and placement by Care Zambia of an Assistant Programme Manager (APM) at CHU. The APM would work in liaison with the Care Zambia Programme Manager to support CHU to effectively manage its roles by strengthening its institutional performance. The initial focus was to improve communication and provide quality oversight to PHOs and all its mandates. Progress has been made in terms of strengthening the performance of CHU however there still appears to be gaps in terms of capacity at the strategic level.

Difficulties have been experienced at the national level in terms of the placement of Care Zambia personnel at CHU and how best to work with and support the unit. The initial placement left after two years at CHU, spending the last few months of his contract working from within the Care Zambia office. The situation was regrettable and CHU felt that it had not been consulted fully by Care Zambia in the recruitment process. It was therefore agreed with CHU that a replacement should be sought and that this time recruitment would be handled jointly. This was finalised in late 2010 and a six month contract was offered to the candidate (based on the anticipation of the programme concluding in March 2011). The option for extension of the contract was available but the candidate decided not to renew. On both occasions there appears to have been some concern regarding the ability to work productively within CHUs current structure and to contribute meaningfully to the strategic level as required.

It is anticipated that the Institutional Assessment of CHU will provide recommendations in terms of how to continue to support CHU's institutional strengthening, in particular at the strategic level. Given the two remaining years of the programme there continues to be the potential for Care Zambia to work with CHU in the implementation of the MwB programme. However given

difficulties to date, care should be taken in terms of identifying and agreeing support activities for CHU and how best to structure this. It may be that for the remaining period Care Zambia, in liaison with CHU, might recruit a high-level professional to support capacity building at the strategic level and that that person might be based either part-time at CHU and part-time at Care Zambia offices or full-time at Care Zambia offices.

CHU is the responsible, mandated unit on IMCI and child health and is therefore the source of authority for policy and guidelines reflecting IMCI whether within the Directorate of Public Health and Research or to other Directorates. MwB should therefore continue to work to strengthen CHU and its capacity to engage with other stakeholders. This process may require MwB to work with other stakeholders in order to cultivate the right environment for CHU to engage and gain influence for embedding the updated IMCI algorhythms.

CIDA

The remit of the evaluation team did not include assessing the role of CIDA. However it is worth noting that Care Zambia and the CIDA office in Lusaka have worked well together, the latter providing good insight and follow-up to monitoring reports. CIDA as a partner however has proved quite demanding for Care Zambia, particularly in terms of revisions requested to the original logical framework and frequent requests for information placing demands on the Care Zambia MwB team. CIDA has its own priorities and has pushed for Care Zambia to take these forward. However this has not always been easy, for example gender is a CIDA priority but has so far not been a priority with the Zambian MoH. Care Zambia has therefore found it difficult to satisfy both partners. Care Zambia have found the annual monitoring visits of the CIDA external monitor extremely helpful however the evaluation team noted that unfortunately, and unusually, these monitoring reports were not made available to either the MwB programme or the evaluation team, despite requests to CIDA. However it should be noted that the external monitor has provided extremely useful verbal debriefings for the programme team at the end of each visit.

5. Conclusions and Lessons Learned

The following section provides an overview of the main conclusions and lessons learned from the evaluation of available information and data to date regarding the MwB CBI programme. It should be noted that some of the issues outlined as lessons learned may require a further level of analysis beyond these mid-term evaluation findings.

Conclusions

Based on evidence available to date it would appear that the MwB CBI programme has supported enhancements in the health and well-being of Zambian boys, girls, men and women through the development of sustainable, equitable and holistic child health services. Programme statistics available to date, and verbal feedback from DHOs and within the programme's target communities, would also suggest that the programme has contributed towards the expected impact 'improvements in child survival among 200,000 female/male children under 5 in project areas'. However it was not possible to verify this during the evaluation process.

There has been good progress towards managing the three outcomes, particularly at the PHO, DHO and community levels and there is solid evidence of capacity building at all levels. Care Zambia has developed and supported strong relationships within the MoH and managed the process of embedding staff well, although difficulties have been encountered at the national level. The programme period has seen encouraging saturation levels for training in IMCI and superb results are evident in C-IMCI, with strong performance at the District, health facility and community levels in terms of training and supporting community volunteers in the provision of C-IMCI.

Concerns remain regarding issues of sustainability, including training, technical support and supervision at all levels and the retention of community volunteers, particularly amidst on-going resource constraints and restructuring within the MoH. However, the restructuring process should also be viewed as an opportunity, in that the restructuring of DHOs may have the effect of enhancing capacity for undertaking innovations; compared to the uneven distribution of leadership under the previous establishment arrangements.

There has been a lack of documented evidence regarding cumulative progress to date. It is important that evidence relating both to results and what has been learned is packaged and disseminated in such a way as to encourage scale up and assist with influencing national policy.

The MwB programme has demonstrated that a high intensity low resource IMCI approach is possible however there are still questions around whether a roll-out of this approach by the Zambian health system can be sustained in the current resource environment. Scale up is essential as the programme covers only 11 out of the 72 districts in Zambia. As the WHO multi-country IMCI evaluation reported: a significant reduction in under- 5 mortality will not be attained unless large scale intervention coverage is achieved. However the WHO evaluation also found that IMCI is worth the investment, it costs up to 6 times less per child correctly managed than current care. The MwB approach can provide a viable and sustainable contribution to the Zambian health sector but evidence of the positive outcomes of the programme must be used directly in the remaining two years to influence national policy, linking to broader issues at the central policy and funding level.

Lessons Learned

Programme Design & Implementation

- All partners should be involved in all stages of programme design and implementation. There is a need to carefully marry expectations and agreement should be reached at the very start between all parties in terms of priorities and that agreed priorities are 'doable'. Experience has shown that full participation by the MoH reinforces ownership and positive results.
- Experience has shown that Care Zambia has often been dependent on CHU for things to happen and smooth implementation to take place against agreed workplans, for example: meetings, workshops and payments. Clear agreement is required at inception regarding workplans and implementation requirements, taking into account human resource and capacity issues.
- A more critical look at existing health structures at the national level is required at the design stage of a programme to assess where influence and advocacy initiatives will be of most value.

Programme Management/Implementation

- An important lesson has been that global knowledge on effective interventions exists and these interventions can be effectively transplanted within the constraints and capacities that exist on the ground. The MwB CBI initiative was credited for not being 'too rigidly prescriptive' in its interactions with the health system, while keeping a determined focus on its goals. This approach allowed health system actors room for learning, by both health system managers and communities. The programme was also appreciated by health managers for its readiness to work interactively in order to assist with addressing system bottlenecks that were in line with its set goals.
- The MwB initiative may have innovated by undertaking what would pass for the (feasible) minimum (sub) package of IMCI interventions in the Zambian context – although this package still needs to be fully determined. The programme now faces the challenge of taking this minimum package into policy and implementation guidelines – a task that that will require closer and collaborative approaches between MwB and the CHU.
- Experience has shown that capacity building support for the public sector by an NGO can be difficult compared to direct implementation and takes time, flexibility, patience and perseverance on the part of all partners. The process can have 'ups and downs' which can be beyond the control of the programme but which must be accommodated, before achieving the desired outcomes and impact. On-going public sector funding support and accountability for programme interventions is critical
- The importance and value of a Programme Manager being strong both strategically and operationally was noted by both partners and the evaluation team.
- Relationships between Care Zambia and MoH staff are crucial. The positive relationships in terms of embedding Care Zambia staff within the MoH structure was a learning experience for all Care Zambia programmes. Collaboration between NGOs and government departments promotes teamwork, encourages efficient resource utilisation, is cost effective and prevents duplication of work. However it is only through iterative mentored learning and practice that a sense of ownership and responsibility are really embedded at all levels.
- The MwB CBI phase-over exit strategy in Year 4 proved successful and a learning experience. Responsibility for training and monitoring IMCI activities was handed over to DHO staff, while the programme continued to give financial and technical support at a reduced level. During the transition phase, partners were all fully involved and planned together how to continue with activities as funding was slowly being withdrawn.

- Clear record keeping and the development of progress reports, reflecting cumulative progress to date are essential. Monitoring should be proactive, not reactive, and evidence generated used to influence at the national level within the MoH structure.
- Experience to date shows that advocacy does not always result in policy change immediately but can assist in changing perceptions and behaviour at the PHO/DHO/health centre level in strengthening a supportive environment. For example, DHOs and health facilities are now supporting community volunteers through support visits, meetings and the provision of stationery. In turn this has motivated the volunteers to continue collecting household data and referring under-five children. This in turn, is helping to improve the health of children under-five in the programme areas.

Working with MoH

- MoH resource constraints affect all parts of child health and IMCI programme implementation and roll-out.
- MoH restructuring and on-going human resource issues in the health sector affects saturation levels in terms of IMCI training and potential coverage. It will always be difficult to retain MoH staff given MoH priorities and restructuring. This is beyond the control of Care Zambia.
- Transfer of programme assets to a public sector body is difficult. The transfer of assets to MoH in Years 3 and 4 meant that hybrid arrangements had to be introduced regarding finances, procurement etc to satisfy all stakeholders, including donors and partners.
- It has proved easier to provide technical support and capacity building to Provinces and Districts as opposed to the national level. This is due to the many demands at the national level. However the national level is key in terms of influencing policy and flexible ways need to be found to continue to build capacity at the strategic level.
- Health managers have learned that it is necessary to be stricter with the use of earmarked resources if positive results are to be achieved from planned interventions. Clear prioritisation of interventions should be accompanied by discipline in the use of earmarked scarce resources. “If we had been in-charge of allocating resources to the MwB project, we would have easily diverted some to other needy unbudgeted / unfunded interventions – in response to new needs (usually from central level directives)” – replied a health worker in response to a question by the evaluation team on what was new and different about the MwB programme.
- Consistent technical support and supervision motivates at all levels and filters down – CHU, PHO, DHO, health facilities, communities. Health managers saw and identified gaps in their work routines: “We have learned that supportive supervision is important to get the health workers motivated for higher performance. Training in IMCI without follow-up support supervision and performance assessments merely lead to health workers ignoring what they learned..... We now plan accordingly with each IMCI training programme undertaken”; commented a health system manager.
- Having more than one set of IMCI trainers at Provincial level assists the province to undertake training. If core team personnel are redeployed to other provinces, the original province remains with a cadre of IMCI trainers.
- Good relationships and liaison between health facilities and communities is vital. The role of community volunteers is critical and it is worthwhile to invest in the community. Districts have taken ownership of this approach and are continuing to support health facilities and communities even now that Care Zambia District staff have been withdrawn.
- The appointment of IMCI Focal Point Persons has enhanced the ability to advocate for and ensure resources at all levels are directed towards IMCI implementation.
- Refresher trainings have improved Child health/IMCI case management in the health facilities and are key to performance improvement and motivation.

- Saturation of IMCI trained staff contributes to the adherence to the IMCI strategy

Community level

- Holistic IMCI screening of sick children has improved the quality of care provided.
- Community data on mortality and morbidity is providing reliable information for resource allocation during planning at the community, health facility, District and Provincial levels.
- With routine monitoring and supervision, community volunteers are able to use community generated data for decision making and development of community action plans
- Improved accessibility of GMP points within the community has increased the number of under five children attending monthly GMP sessions and the provision of GMP shelters has motivated community members to work together for the benefit of their children.
- Frequent monitoring of GMP sessions by health facility staff and the presence of NHC zonal leaders have motivated and encouraged CHPs
- Using CHPs has reduced the patient/client load of health care providers at health centres and has increased the referral and follow-up of the under fives.
- Providing basic working tools like scales and under-five cards and incentives such as bicycles and t-shirts is an important motivation for community volunteers.
- Community members have learned that “community health volunteers can undertake some [health promotion] tasks, and with all intended positive benefits, just as well as can health workers”. As such there is now increased trust (by both health workers and community members) in the services provided by community health volunteers. The activities of CHPs have established a role for the health system in the everyday-life and well-being of communities; thereby extending the effective reach of the health system into the community.

6. Recommendations for the MwB Programme Extension Phase

This section outlines specific recommendations for both the improvement of operational performance of the MwB CBI programme in the remaining two years and longer-term sustainability of its outcomes. Following the specific recommendations a suggested policy angle for the remaining phase is outlined in Section 7.

6.1 Care Zambia

- Care Zambia should concentrate on developing closer linkages with MoH structures at the national level, including the Directorate of Public Health, the Directorate of Technical Support Services and the Directorate of Planning and Policy. This will be essential in terms of sharing lessons learned and evidence gained from the MwB CBI programme for advocating for the wider adoption of the IMCI approach in Zambia. This can be developed both in collaboration with CHU or directly by Care Zambia as appropriate given capacity issues at CHU. As part of this Care Zambia should explore the potential of participation in a wider variety of national level MoH meetings and working groups, for example meetings of the Sector Advisory Group meetings, Joint Annual Reviews and the HR Technical Working Group.

- Allied to this is the need for Care Zambia to carefully and systematically plan how to support a more proactive approach to monitoring during the final two years of the programme. It is recommended that a monitoring strategy is designed for the final two years, focusing on documenting and disseminating lessons and evidence, both quantitative and qualitative, with activities culminating in the final evaluation of the programme at the end of the two years and the dissemination and promotion of final evaluation findings. It is also important that the logframe for the MwB programme is reviewed and updated as appropriate and that programme progress reports provide cumulative progress to date against the agreed outcomes and agreed baseline information.

- Care Zambia is implementing a number of programmes within the health sector and it is important to identify and support more formal ways for Programme Managers to share experience and consider linkages. Programmes are often working with the same stakeholders, particularly at the community level for example the PRISM agents and MwB child health promoters, but there is currently only limited interaction between Programme Managers. A more integrated approach would be beneficial in terms of planning for future sustainability, particularly at the community level.

6.2 Central Level

- Continued ways of supporting capacity building within CHU based on the recommendations of the CHU Institutional Assessment should be explored. It is important that agreement is reached between CHU and Care Zambia regarding on-going MwB programme support for the institutional strengthening of CHU as soon as possible. It may be that this support can be provided by the programme team at the Care Zambia Lusaka office or that an additional person is required. Any recruitment should be undertaken jointly between Care Zambia and CHU and careful consideration should be given to the length of contract available and remuneration so as to attract high calibre applicants.

- CHU and Care Zambia should document the critical interventions that can form part of the sub-package of IMCI interventions of value for effective intervention in high intensity, low resourced settings, at the management, health facility and community levels. This sub-package could then be tested in the three new districts and the additional amount of funding needed (per capita) to fully implement the sub-packages should be costed. When this is completed CHU should then be supported to develop policy guidelines for the nationwide scaling up of the sub-package and to push for their adoption.

- CHU capacity development for training will need to focus on systemic sustainability. Given the restructuring within the MoH and redeployment of many IMCI trained staff from MwB programme areas the need is not just for training itself but also the supervision and monitoring of training, ensuring for example that all training schools incorporate IMCI and that their curricula is regularly reviewed and updated as appropriate. That is not to say that training is not important. The remaining two years will need a continued focus on the monitoring of saturation levels of IMCI trained health workers at all levels of the health system and the provision of IMCI training to fill gaps, identified by the CHU training database.

- Ensuring continued practice for supportive supervision and monitoring visits by CHU to the Provincial and District levels remains essential and should be prioritised. Evidence is showing that these visits are critical in terms of motivating all levels of health workers to continue the prioritisation of IMCI and for CHU to make sure that IMCI is integrated through all levels: community, health facility, District, Provincial and national.

- The strengthening of CHUs capacity in terms of communications both with partners and with the lower levels of the health system should continue, maximizing IT support and back up as appropriate.

Provincial

- Ensuring continued practice for supportive supervision and monitoring visits by PHOs to the District and community levels remains essential and should be prioritised. It is accepted that IMCI is integrated into a wider focus for such visits given the current resource environment. However the MwB programme should ensure that PHOs are still undertaking regular visits where IMCI support is considered a priority. Care Zambia seconded staff at the Provincial level should continue to provide support and help to institutionalise IMCI supportive supervision at all levels.

- Effective use and support of the Provincial IMCI training teams is also required during the final two years. There should be close liaison with both CHU and DHOs regarding training needs and the planning process. Both initial and refresher training in IMCI and C-IMCI should be considered. Care Zambia seconded staff should continue to support PHOs in developing approaches to external donors for financial support for IMCI training. In addition. non MwB districts should be encouraged to financially support their health workers in IMCI training provided through the MwB programme.

- One new district in each of the three programme provinces has been added for the final two years. However total national coverage will remain limited. Therefore it is important for Care Zambia and CHU to find ways of working with PHOs to spread impact and broaden the rolling out of the MwB IMCI programme approach.

- Provinces report directly to the DTSS with data for the HMIS. It is therefore important Care Zambia seconded staff trace the movement of information and impact and how best the MwB programme can inform national policy, including the potential incorporation of community data within the HMIS.

District

- Excellent progress has been made at the District level in terms of institutionalising the IMCI approach and this has been sustained following the departure of the Care Zambia seconded staff during 2010. However MoH redeployment has meant that many positions in the DHO have changed recently and some of the DHMT with IMCI training have been moved. It is therefore important for the PHOs and Care Zambia Provincial secondments to make sure that on-going support is provided as appropriate to the DHOs to ensure the continued prioritisation of IMCI and C-IMCI.

- Supportive supervision visits to health facilities and communities by the district teams remains vital (see above).

Health Facility

- Health facilities should continue to have at least one trained C-IMCI member of staff in order to support IMCI initiatives at the community level.

- Access to basic IMCI equipment, materials and drugs should be monitored by the MwB programme and addressed where possible.

Community

- Maintaining the motivation of community volunteers is essential. The MwB programme should continue to investigate and support ways of retaining volunteers and addressing issues of sustainability into the future, taking into account Government of Zambia progress with this issue. At a basic level this will include the need to make sure that all communities have basic equipment such as weighing scales and thermometers. Volunteers will also need access to stationery, particularly U5 cards. Finally the provision of bicycles to those volunteers without would make a tremendous difference in terms of motivation and coverage.

- Where possible training for additional CHPs should be supported to ensure adequate coverage. An ideal scenario is 4 CHPs per zone, although this is probably an unrealistic level given the resources available for the remaining two years of the MwB programme.

- Care Zambia should consider supporting the mapping of volunteers in all its programme/project areas to provide a database of community volunteers. This would help to ascertain the number of volunteers working with more than one programme/project and could form the basis for discussions regarding enhanced integration and longer-term sustainability issues. This could also inform national policy development.

- Communities, health facilities and districts should be supported to consider the more effective use of the community 10%-14% available in budget allocations at the health facility level. This could play an important role in future sustainability. Examples of how the allocation could be used include successful income generating initiatives which provide income for volunteers and motivation for their continued role in health care provision.

Additional Areas:

- Advocacy: MwB partners will need to consider and agree what is meant by and needed in terms of advocating for IMCI and its appropriate resourcing. External consultancy support may be helpful to take this forward and assist in the development of an advocacy strategy for the remaining two years of the programme.

- Gender: The MwB programme can continue to build awareness and knowledge in terms of gender mainstreaming, given that this is a donor priority. However it should be acknowledged that this will be a slow process and incremental gains will be largely dependent upon the progress made by the MoH in operationalising the National Gender Policy.

7. Potential Child Health Policy amendments and IMCI operational guidelines

This final section outlines a suggested policy angle for the remaining two year phase of the MwB Programme.

Background

IMCI as an approach for the clinical care of children is not an entirely new concept in Zambia. Perhaps the first spirited attempt to make the IMCI approach operational in Zambia was undertaken by BASICS (a USAID-funded international NGO) working in the Copperbelt and Lusaka provinces, implemented in Ndola rural district [then comprising of Masaiti, Lufwanyama and Mpongwe districts] and Chongwe district (1995 – 1999/2000). The start of this initiative was quickly followed by programmes under the WHO and UNICEF, working in close collaboration with the Ministry of Health, as a means to popularise IMCI as a life-saving approach for effective care of children. A number of health workers were trained and organised to try to make this operational. However, progress was made difficult due to the high cost of the required training as well as health workers being too overloaded with work to go through with the required IMCI algorithms for effective clinical care outcomes. With time, and as the health sector human resource crisis took root along with other factors such as funding constraints, IMCI as a practical approach to effective clinical care of children began to lose momentum.

Moyo wa Bana

The MwB IMCI/CBI approach can thus be seen as yet another attempt to promote the IMCI approach as a practical and workable way, even within high disease intensity and resource constrained settings, for the effective clinical care of children under 5 years old. As with others before it, the MwB initiative worked very closely with the Ministry of Health, selecting 3 provinces [Central, Luapula and Northern provinces] and in districts which had recorded the highest Under-5 mortality rates. This report has captured some of the key outcomes and impacts of the Programme in these three provinces. In addition to the other findings already presented in this report, a key finding of interest was that health managers at the provincial and district levels were quite upbeat about IMCI, this time around. The managers were keen to look for the money wherever they can find it (if not from MwB or the MoH); just to ensure that they had more IMCI-trained personnel. Neighbouring districts surrounding where MwB was being implemented were impressed with the health outcomes among children under-5 in the MwB districts – and thus sometimes sought assistance and support from the MwB districts so they too could be included in the programme. Not only did the MwB initiative produce results, but it also changed the health worker perception of IMCI being a somewhat 'time-wasting, good for nothing approach' to providing clinical care to children Under-5. The new perception on IMCI was eloquently put by one health centre in-charge (a nurse by professional training) who amusingly and confidently said, *"this time I am able to treat children Under 5 with confidence for better outcomes. This has meant that I no longer make unnecessary referrals to the next level. This is also good for patients who do not need to waste their money and other resources on referrals".*

Frontline health workers have been empowered with an important tool for effective clinical care provision with some learning in the process; learning which has reinforced their belief and confidence in the care they give. The CHPs and communities spoke highly of the MwB CBI initiative and credited it with the effective care they now received for children under-5 years old, whether from the health centre or the community. A stronger bond had been created between

health workers and caretakers of children under 5. But perhaps more important was the perception by the evaluation team that members from communities had found and accepted a role for the (modern) health system in the day-to-day affairs of their community life and well-being. This role had previously been reserved for traditional healers and the role of community members was to go out to health centres if they needed some service. A longstanding barrier to modern health services reaching beneficiaries at the grassroots appears to have been broken. This breakthrough has potentially big future returns from effective community participation in preventive and promotive health interventions if replicated country-wide. In this regard, the MwB CBI approach requires support in taking lessons learned into health policy and implementation guidelines within the Ministry of Health.

Suggested policy angle for the remaining phase

With the two-year extension granted, what then would the next phase of the programme look like if it were aimed at taking the lessons learned into health policy and implementation guidelines? To start with the MwB initiative has to prioritise its actions, knowing that funding is limited. The following section was developed based on the various suggestions received and the general approach to policy making in the MoH. While not too rigid, the framework and/or sequence of events can be varied as appropriate.

1. Working with the PHOs, DHO, and Health Facilities, the MwB programme should replenish supplies, equipment and close the skills gaps (IMCI and CHP trainings) as outlined in this report. This will help to maintain the model set-up as learning sites for other districts to be included in the approach.

This suggestion comes as a result of feedback from staff at community and health centre levels. The additional issues outlined below were discussed during the evaluation and/or during the evaluation validation workshop.

2. Working with the CHU, the MwB programme needs to distil lessons learned into concrete ideas to inform child health policy and implementation guidelines; spelling out all issues and tasks - inclusive of supportive supervision and performance assessments. The review may also need to identify and overcome any gaps within the MwB approach. The proposed guidelines will group IMCI activities into packages (and sub-packages) of interventions for effective outcomes from employing IMCI. These packages can then be costed into the required additional per capita spending (if necessary). This stage may comprise of the following sub-activities:
    - A consultant reviews the MwB experience and draws out key issues to inform child health policy and guidelines
    - The key issues are then reviewed by an implementation expert committee comprising experts from CHU/PH&R, DTSS, HRA, WHO, UNICEF, MwB, PHO, DHO and Health facility personnel. The issues are reviewed and validated from a policy and implementation perspective
    - The consultant, working closely with CHU and MwB compiles a consensus policy draft, possibly costed for implementation purposes after the extension period.

3. Following this stage, it may become necessary for the packages and resulting funding implications to be piloted and validated in the 3 new districts as proposed within the two-year extension (time and funding permitting).
4. With the above done, the MwB programme would then work closely with CHU for their ownership of outputs from the above. A wide stakeholder/expert meeting would be called by

CHU (and funded through MwB) where the consensus findings can be presented, discussed and updated as per a consensus agreement. The resulting document will form the initial policy draft on IMCI-Child health amended policy and guidelines. The ownership of this initial draft will have shifted more to the CHU and the Directorate of Public Health and Research (PH&R). The resulting document will then be taken before the technical working group (TWG) of the MoH under the Directorate of Public Health and Research. The TWG will discuss this further and make recommendations on policy options for the MoH in the light of facts presented.

5. After the recommendations of the PH&R TWG the updated document then becomes owned by the Ministry of Health and will be presented at the Senior Management Meeting, chaired by the Minister of Health. The policy recommendations will be tabled, discussed and policy options evaluated. This meeting will then agree on and come up with the policy framework and operational guidelines for the frontline staff.
6. The resulting pre-final draft document will (in)form the MoH policy recommendation to government (and with its funding implications) for adoption by the national Cabinet into a government policy framework. In this regard, the Ministry of Finance and National Planning (MoFNP) will be alerted of funding implications as well; thus making it easier for MoH to make a case for any required additional funding.
7. The final policy document, now signed by the Minister of Health, will serve as a source for drafting new policy implementation guidelines by the CHU on behalf of the PH&R directorate in MoH. These implementation guidelines will then be shared with other relevant directorates, such as Planning, DTSS and through them to PHOs and DHOs. The policy recommendations become part of the routine annual planning budgeting, programme M&E, revised PA tools and thus brings into focus the effort on IMCI as a key component of decision making relating to health worker incentives, reward and promotion.

The above processes and outcome measures will serve to (i) motivate health workers and serve as an incentive for adhering to the IMCI algorithms in the clinical care of children Under-5 years old; (ii) ensure long-term sustainability, and (iii) ensure improved quality of clinical care in the public health system overall.

ANNEX 1

Terms of Reference for the
Mid-term Evaluation of

Moyo wa Bana II

(ZMB036 – ZM330)

March 31, 2011

Prepared by: CARE ZAMBIA

1. Introduction

This mid-term evaluation of the Moyo Wa Bana II (MwB) child health programme reflects CARE's and its partner's (Child Health Unit (CHU) at the Ministry of Health) commitment to improve its capacity and services as well as account for progress made since the start of the programme in early 2007.

The objective of this ToR is to describe CARE's proposed approach to the mid-term evaluation. The exercise will focus on the process of programme implementation and uses data and information from the programme's monitoring system and other sources to assess progress towards achievement of results and to provide lessons learned and recommended actions to guide the programme through the two-year extension phase.

The ToR are partly based on initial consultations during the Project Steering Committee (PSC) meeting in April 2010, a subsequent *mini* PSC on 23rd June 2010 and CARE Zambia's discussions with eight District Health Offices, WHO, UNICEF and the CHU in July/August 2010.

Consultations revealed consistent expectations to focus on challenges and lessons learned with an emphasis on replicability and sustainability while also including a comparison with the baseline study. It was suggested that the evaluation look at aspects of the health system, health worker skills (case management) and community practices (health-seeking behaviour). It is also expected that the exercise demonstrates how MwB has influenced IMCI at the three levels of government.

2. Background

MwB is a four year programme that commenced in early 2007 and has been extended for additional two years until mid 2013. It is funded by the Canadian International Development Agency (CIDA) with CAN$ 10.3 million for the four-year period 2007-2011 and is building on previous CIDA/CARE collaboration in child health (2001-07). The budget for the two-year extension amounts to around CAN$ 2 million. The main thrust of the project is to work with and through partners at central (MoH/CHU), provincial and district level and build their capacity to advance child health in Zambia which is critical for the country's long-term development prospects. The programme currently operates in eight selected districts of three of the nine provinces in Zambia. During the extension phase, the programme will work with Provincial Health Offices (PHO) only.

The three outcomes (abbreviated version) of the programme to be achieved are:

1. Improved institutional performance to manage the implementation of IMCI programmes;
2. Improved institutional performance to plan and deliver IMCI capacity development and supervision;
3. Enhanced institutional performance to plan and support community-based IMCI activities and programmes

8. Purpose and Objectives

The purpose of this mid-term evaluation is to systematically and independently assess programme implementation as well as factors that enabled and constrained the achievement of results to date. Value added from this evaluation is expected to be achieved through documenting lessons learned that can be immediately utilized to inform the programme extension phase.

CARE Zambia proposes to conduct a Utilization-focused evaluation which will include aspects of building the evaluation capacity for key partners. This type of evaluation "begins with the premise that evaluations should be judged by their utility and actual use …. … the focus is on intended use by intended users"[1] by identifying lessons learned and providing evidence-based recommendations for the extension phase (see specific objective #4 on next page). This will ensure that the questions asked and information provided meet the needs of CARE and partners and that the evaluation adds value. The intended users are the MoH at central, provincial and district level, CARE, CIDA as well as key stakeholders in child health such as WHO and UNICEF.

The evaluation will have summative (e.g. achievement of results, effectiveness of implementation mechanism) as well as formative elements – suggesting a way forward. This is also compatible with CIDA's evaluation approach outlined in the CIDA Evaluation Guide (October 2004, p.1): "Evaluations … are carried out to inform … about what results are being achieved, what improvements should be considered, and what is being learned." The design of the evaluation intends to balance accountability requirements and learning objectives in order to maximize buy-in from relevant partners and stakeholders and enhance the evaluation capacity of partners through collaboration in the design and implementation of this exercise.

[1] Patton, Michael Quinn, Utilization-Focused Evaluation; 1997, p.20

The specific objectives of the evaluation are:

1. To assess progress towards the achievement of programme results (including unintended results) – specifically the three programme outcomes in comparison to the baseline and initial targets;
2. To assess the sustainability of these achievements and suggest – if necessary - how to improve sustainability;
3. To document and assess the mechanism of programme implementation to date, and provide suggestions for improvement;
4. To identify lessons learned and provide evidence-based recommendations to guide the extension phase.

9. Coverage and Scope

The evaluation will involve CARE Canada, CARE Zambia, CHU/MOH as well as other key stakeholders. It is planned to cover at least one province in depth as well as selected districts during the field visit phase (see Methodology section for more details).

Within the specific evaluation objectives outlined above, the evaluation is tasked to explore and answer the following key questions. The list is not comprehensive and will be reviewed and completed during further consultations and the establishment of the evaluation team and work plan.

Specific evaluation objectives	**Key Questions**
Achievement of project results – specifically the three programme outcomes	1. Have key activities been implemented and planned outputs been achieved? 2. Have the three programme outcomes been achieved? 3. Did the programme have an effect on child health above and beyond other external influences (plausibility assessment)? 4. How do partners, stakeholders and communities perceive the achievements? 5. How did external factors and events hinder or support the achievement of results? 6. How have gender issues been addressed by the programme?
Sustainability of achievements	7. Which achievements can technically and financially be sustained by partners and stakeholders (differentiate between central, province, district, community)? 8. Which achievements are at risk? 9. What are the factors that support or hinder sustaining achievements?
Mechanism of programme	10. What is the quality and nature of the relationship and coordination mechanism with partners and their effects on

implementation	implementation? 11. How did government structures and systems affect implementation – including commitment, resources, health personnel; 12. What was the added value CARE provided at central, provincial and district level? 13. How has evidence and information produced by the programme been used to improve programming and the provision of services?
Lessons learned and recommendations	Lessons learned and recommendations will be based on the findings in respect of the above and during consultations with partners and stakeholders.

10. Methodology

While the specific methodology and tools will be outlined by the evaluation team as part of establishing the evaluation work plan, this section proposes the methodological approach that will blend quantitative and qualitative analysis.

The project has been subject to an extensive baseline study in (including surveys at household and health facility level). The study was completed in March 2009. In parallel CARE, CIDA and MoH partners reviewed the logical framework (LFA) in order to better reflect the aspect of capacity building and to decrease the number of indicators. This process was completed in July 2009 with the approval of the revised LFA by CIDA. In addition to routine progress monitoring, reporting and annual planning exercises implemented by CARE, CIDA contracted an external consultant to conduct semi-annual monitoring visits. Furthermore, annual Project Steering Committee meetings are held to review progress and discuss the way forward.

CARE proposes the following: In a first step, available monitoring and reporting data – provided by CARE Zambia, MoH (HMIS) and partners will be compiled, structured and analysed in a systematic way:

- Secondary (HMIS) data analysis at national/province/district level re child health indicators; DHS (2007), IMCI HF survey (2008/9), Malaria survey (2006/08 data); Nutrition survey (National Food and Nutrition Commission);
- Baseline survey, CHU Institutional Assessment report, MwB semi-annual progress reports and other relevant programme documents;
- Logical framework analysis based on performance data provided by the programme. The evaluation team will be tasked to comment on progress on each indicator and rate performance (e.g. using a rating scale such as 5 – excellent; 4 – good; 3 – satisfactory; 2 – inadequate; 1 –

poor). This would be followed by a bottom-up rating of outputs and outcomes. Validation of selected performance indicators will be conducted during field work phase.

The second phase will entail discussions with the MoH and field visits to at least two of the three provinces, selected districts, health facilities, volunteers and communities for an in-depth analysis of achievements. This will involve meetings, interviews, focus group discussions and observations.

Preliminary results and findings will then be validated and discussed during a workshop with representation from all supported provinces, districts and the CHU. The objective is to develop lessons learned and recommendations. The evaluation team will facilitate the workshop.

11. Conduct of the Evaluation

This section details the roles and responsibilities of the various players involved in the evaluation process.

12. CARE Zambia

The Monitoring, Evaluation and Learning Unit (MELU) of CARE Zambia facilitates the evaluation process and ensures – in consultation with CARE CANADA, CIDA and the CHU/MoH):

- quality of the ToR,
- selection of qualified and experienced external evaluators,
- usefulness of the evaluation methodology,
- quality of reporting.

CARE Zambia will provide technical and managerial backstopping as needed during the evaluation, and facilitate the follow-up of lessons learned and dissemination of evaluation results and lessons-leaned. CARE Zambia will contract the external consultant(s) and bear related costs (travel, per diem, fees). In addition, CARE Zambia will second one MELU staff to be part of the evaluation team.

The CARE Zambia MwB team plays an important role during the evaluation process. The team will provide secretarial support and assist in gathering relevant information. The team – with support from partners – will also be tasked to coordinate and facilitate certain activities (e.g. preparations for interviews and fieldwork activities) and to participate in the evaluation process. The team will support the preparation of the evaluation by collating available background documentation, reference material and monitoring data and will ensure that such information is up-to-date, valid and comprehensive.

13. CARE Canada

CARE Canada will support the development of the ToR, the selection of evaluation team members, offer methodological and technical advice during the evaluation process and facilitate consultations with CIDA.

14. Ministry of Health (Zambia)

As mentioned in section 3, the evaluation also intends to enhance MoH/CHU evaluation capacity through collaboration in the design and conduct. To achieve this, it is suggested that the MoH seconds one to two relevant staff members from provinces/districts – where the programme has not been implemented – to join the evaluation team.

15. Evaluation Team

The evaluation team will:

- Conduct desk review of programme documents to gain an understanding of the context and environment in which MwB operates;
- Conduct desk review of other secondary data as outlined in section 5;
- Design the specific evaluation approach and details of the procedures to be used, within the budget and timeframe available;
- Develop an evaluation work plan based on the ToR and the methodological approach, i.e. evaluation protocol and instruments; The plan specifies the tools for data collection and analysis, information sources, the tasks of the evaluation team members, and outlines a detailed schedule of activities;
- Encourage partners, stakeholders and beneficiaries to communicate concerns, ideas, questions and suggestions to the evaluation team during the evaluation process and actively solicit their views;
- Facilitate a validation/lessons learned workshop with main partners and stakeholders;
- Draft the report according to the reporting timeframe and template;
- Ensure a logical and plausible link between information gathered and analysed and results and conclusions presented;
- Record all aspects of methodological choices, assumptions, and limitations of the evaluation process and present a critical review during a debriefing with the Review Panel and as part of the evaluation report;
- Keep records of material collected and analysed, which will be submitted to CARE for reference.

The evaluation team will consist of three to four core members including the team leader. Additional team members will be added based on need and available resources. The team members will include independent and external evaluators. External evaluators do not have any particular affiliation with CARE, CIDA or the MoH in their regular positions. Internal independent evaluators could include: staff of CARE, CIDA and its partners not directly involved with the subject under review. It is suggested that the team consists of at least one external evaluator as team leader, one CARE Zambia/MELU staff member and one MoH secondee. The team members will be jointly selected by CARE and CIDA. The team should provide the following experiences and skills (complementary set):

- Experience in complex evaluations and the required quantitative and qualitative evaluation methodologies;
- All members are to have strong writing skills, provide evaluation findings accurately and in a timely fashion
- Understanding of current trends and challenges in child health at global/regional level and in Zambia;
- Understanding of institutional capacity building;
- Ability to draft concise reports and communicate the evaluation results clearly; and
- Ability to interact with team members and stakeholders in a sensitive and effective way.

The team leader is accountable for delivering the products of the evaluation, which include (1) evaluation work plan, (2) draft and final reports, (3) evaluation brief and (4) validation/lessons learned workshop. The purpose of this workshop is to present a summary of the major findings and lessons learned to relevant stakeholders and partners. He/she is expected to ensure that the information provided in the report is valid and complete and that the evaluation team works in a coordinated and efficient manner, both when physically together, or as a "virtual" team.

16. Timetable and Reporting

The evaluation will be conducted during May/June 2011. This is due to the fact that implementation activities will have ceased end of March and data for the period October 2010 to March 2011 is available by then. May is also conducive for travel (accessibility of health facilities and communities) as the rainy season has come to an end.

The primary function of the evaluation report is to inform CARE, CIDA, MoH and other relevant stakeholders about the findings, conclusions and lessons learned developed through the evaluation

process. The evaluation team is expected to follow a progression in logic to arrive at useful and valid interpretations of the information collected.

The team leader will provide a draft report not later than two weeks after the data collection has been completed, based on the following structure. The numbers in brackets indicate page limits in order to ensure a concise document:

1. Executive Summary (2)
2. Introduction (1)
3. Project Profile / Background Information (3)
4. Evaluation Methodology (4)
5. Evaluation Findings (20)
6. Conclusion / Lessons Learned (4)
7. Recommendations for extension phase (4)
8. Annex (unlimited)

The Annex should include at least the ToR, evaluation work plan (incl. Schedule), list of people met, list of documents reviewed and tools used (e.g. interview guides, questionnaires).

The draft report will be sent to CARE, CIDA and MoH, which will be given two weeks to submit their comments to the evaluation team leader. The evaluation team will review the comments and suggestions received and issue the final report. The evaluation will work in English.

ANNEX 2

Evaluation Framework: Moyo wa Bana II Evaluation May – June 2011

	Key Question	Sub-Questions
Results Achievement	To what extent has the project achieved the three programme outcomes (as per the agreed logical framework and in comparison to the baseline and initial targets)?	1. Were key activities implemented and planned outputs delivered? 2. Have the three programme outcomes been achieved? 3. Did the programme have an effect on child health above and beyond other external influences (plausibility assessment)? 4. How do partners, stakeholders and communities perceive the achievements? 5. How did external factors and events hinder or support the achievement of results? 6. How have gender issues been addressed by the programme? Areas to investigate may include: 7. What were the key variances between planned and actual results? 8. How did internal factors and events hinder or support the achievement of results? 9. How has HIV/AIDs mainstreaming been addressed by the programme?
Mechanism of programme implementation	How successful has been the mechanism of programme implementation?	1. What is the quality and nature of the relationship and coordination method between partners and their effects on implementation 2. How did government structures and systems affect implementation – including commitment, resources, health personnel 3. What was the added value CARE provided at central, provincial and district level? 4. How has evidence and information produced by the programme been used to improve programming and the provision of services? Areas to investigate may include: 5. To what extent has there been active participation of partners and beneficiaries in overall project design, planning, implementation and monitoring? 6. To what extent are there clear definitions, understanding and acceptance of the roles and responsibilities of partners? 7. Did roles and responsibilities differ to that foreseen? 8. What are the strengths and weaknesses of the relationship and coordination between partners?

		9. To what extent have project risks been identified, monitored and action taken to mitigate them? 10. Is the project monitoring system efficient and effective in tracking changes and progress towards results? 11. How could the mechanism of programme implementation be improved? 12. What is the level of knowledge concerning the project among health sector stakeholders in Zambia (eg government, civil society, other donors)? 13. How does the project link to other IMCI programming and/or health sector reform initiatives in Zambia?
Sustainability of achievements	To what extent are the achievements considered to be sustainable?	1. Which achievements can technically and financially be sustained by partners and stakeholders – at central, provincial, district and community levels? 2. Which achievements are at risk? 3. What are the factors that support or hinder sustaining achievements? Areas to investigate may include: 4. Was/is the project exit and sustainability plan appropriate and implemented? 5. To what extent is there adequate institutional capacity and commitment to maintain benefits/results over time at central, provincial, district and community levels? 6. To what extent are domestic policies and the institutional environment conducive to long-term maintenance of results? 7. Is gender mainstreamed and can this be sustained? 8. Is HIV/AIDS mainstreamed and can this be sustained?
Lessons learned	What lessons, positive and negative, can be learned from implementation of the project to date?	1. What have been the major enabling and inhibiting factors that have affected the success of the current project?
Recommendations	What are the main programming and operational improvements that should be considered for the final years of the project to enhance performance and sustainability?	2. What changes in programming and/or operations should be considered (if any) to improve performance and sustainability?

ANNEX 3

Moyo Wa Bana II
Mid-Term Evaluation May-June 2011-05-10
Workplan

1. Introduction

Moyo Wa Bana (MwB) is a four year programme that commenced in early 2007 and has been extended for additional two years until mid 2013. It is funded by the Canadian International Development Agency (CIDA) with CAN$ 10.3 million for the four-year period 2007-2011 and is building on previous CIDA/CARE collaboration in child health (2001-07). The budget for the two-year extension amounts to around CAN$ 2 million. The main thrust of the project is to work with and through partners at central (MoH/CHU), provincial and district level and build their capacity to advance child health in Zambia which is critical for the country's long-term development prospects. The programme currently operates in eight selected districts of three of the nine provinces in Zambia. During the extension phase, the programme will work with Provincial Health Offices (PHO) only.

The three outcomes (abbreviated version) of the programme to be achieved are:

4. Improved institutional performance to manage the implementation of IMCI programmes;
5. Improved institutional performance to plan and deliver IMCI capacity development and supervision;
6. Enhanced institutional performance to plan and support community-based IMCI activities and programmes

The purpose of this mid-term evaluation is to systematically and independently assess programme implementation as well as factors that enabled and constrained the achievement of results to date. Value added from this evaluation is expected to be achieved through documenting lessons learned that can be immediately utilized to inform the programme extension phase.

The specific objectives of the evaluation are:

5. To assess progress towards the achievement of programme results (including unintended results) – specifically the three programme outcomes in comparison to the baseline and initial targets;
6. To assess the sustainability of these achievements and suggest – if necessary - how to improve sustainability;

7. To document and assess the mechanism of programme implementation to date, and provide suggestions for improvement;
8. To identify lessons learned and provide evidence-based recommendations to guide the extension phase.

2. Evaluation Questions

Within the specific evaluation objectives outlined above, the evaluation is tasked to explore and answer the following key questions.

Specific evaluation objectives	**Key Questions**
Achievement of project results – specifically the three programme outcomes	14. Have key activities been implemented and planned outputs been achieved? 15. Have the three programme outcomes been achieved? 16. Did the programme have an effect on child health above and beyond other external influences (plausibility assessment)? 17. How do partners, stakeholders and communities perceive the achievements? 18. How did external factors and events hinder or support the achievement of results? 19. How have gender issues been addressed by the programme?
Sustainability of achievements	20. Which achievements can technically and financially be sustained by partners and stakeholders (differentiate between central, province, district, community)? 21. Which achievements are at risk? 22. What are the factors that support or hinder sustaining achievements?
Mechanism of programme implementation	23. What is the quality and nature of the relationship and coordination mechanism with partners and their effects on implementation? 24. How did government structures and systems affect implementation – including commitment, resources, health personnel; 25. What was the added value CARE provided at central, provincial and district level? 26. How has evidence and information produced by the programme been used to improve programming and the provision of services?
Lessons learned and recommendations	Lessons learned and recommendations will be based on the findings in respect of the above and during consultations with partners and stakeholders.

The above list will be reviewed by the evaluation team and a framework for specific areas of discussion relating to the three programme outcomes will be discussed and agreed during the initial meeting of the evaluation team on 27 May 2011.

3. Methodology

The evaluation team will work closely with Care Zambia and the Zambian Ministry of Health, yet independently, to conduct the evaluation and produce a report based on the findings.
It is anticipated that Care Zambia and the Ministry of Health will provide all necessary data, information and support required for the evaluation team to carry out their tasks smoothly and effectively.
Methodology will include:

- The review of existing monitoring and reporting data provided by Care Zambia, MoH and partners, including:
    - Annual and semi annual reports (narrative and financial)
    - Logical framework analysis reports
    - Baseline survey
    - Project Steering Committee reports
    - Internal programme management reports
    - Workplans

- Extracting relevant information (quantitative and qualitative) from published and unpublished reports (grey literature), including reports on DHS (2007) and similar surveys, and other relevant reports from reputable sources, including:
    - IMCI HF survey (2008/9)
    - Malaria survey (2006/08)
    - Nutrition survey (National Food and Nutrition Commission)

- Conducting meetings, interviews and/or focus group discussions with key project stakeholders, including intended beneficiaries (see below) – using participatory methods of enquiry such as semi-structured interviewing techniques focusing on 'what', 'why' and 'how' questions. Also addressing, as appropriate, issues relating to strengths/successes to date; difficulties/weaknesses to date; perceived opportunities and perceived threats in the remaining programme period.

- Observation at health facilities and within target communities

Perceived Programme Stakeholders
Lusaka

• Care Zambia staff
  ○ Assistant Country Director
  ○ Health Sector Director
• Project Management Coordinator CHU
• Project Steering Committee

- Project Management Committee
- CHU Lusaka
- Other organisations involved in child health initiatives eg UNICEF, WHO, JICA, Plan, USAID

Provinces
- PHOs
- Clinical care specialists/MCH Coordinator (Provinces)
- Care Zambia: Assistant Project Manager (Provinces)

Districts
- DHOs
- MCH Coordinators (Districts)
- Care Zambia: Clinical Coordinator (Districts)
- Care Zambia: Community Coordinator (Districts)

- Health centre staff and health workers

- Neighbourhood Health Committees
- Child Health Promoters
- Community Health Workers

- Women with children aged 5 and under

- Men with children aged 5 and under
- Caretakers/family carers
- Local community representatives

4. Schedule

The evaluation team leader is contracted for a period of 25 days – 5 preparatory work in the UK, 15.5 days travel to and work in Zambia and 4.5 days report writing. The work in Zambia will be undertaken by the full evaluation team between 25 May and 11 June and the evaluation report should be submitted in draft to Care Zambia not later than two weeks after return to the UK ie by the 25 June.

Discussions are on-going regarding the exact schedule for time spent in Zambia however it is felt essential that at least two provinces and a range of districts are visited to ensure adequate coverage. It may prove necessary to split the evaluation team (comprising of 4 members) into two if timing proves difficult.

Draft schedule:

Date	Time	Activity
26/05/2011	AM	Consultant Arrives
26/05/2011	AM	Briefing-CARE Zambia Team
26/05/2011	PM	Preparatory meeting-Evaluation Team
27/05/2011	AM	Briefing MoH/Interviews-Lusaka based stakeholders (MoH)
30/05/2011	AM & PM	Travel to provincial site 1/Interviews with PHO/DHO Kasama/CARE staff
31/05/2011	AM	Interviews: Kasama Health facilities & CHW/FGD
06/01/2011	PM	Interviews: Kasama Health facilities & CHW/FGD
06/02/2011	AM	Interviews: Mungwi DHO staff
06/02/2011	PM	Interviews: Mungwi Health facilities & CHW/FGD
06/03/2011	AM-PM	Interviews: Mungwi Health facilities & CHW/FGD
06/04/2011	AM-PM	Travel to Kapirimphoshi/Kabwe (depending on accommodation availability)
06/05/2011	AM-PM	Day of rest
06/06/2011	AM	Interviews DHO-Kapiri-mposhi
06/06/2011	PM	Interviews: Kapirimphoshi Health facilities
06/07/2011	AM	Interviews with PHO/CARE staff
06/07/2011	PM	Travel to Lusaka (afternoon)
06/08/2011	AM-PM	Preliminary Analysis/Preparing for Validation W/S
9//6/2011	AM-PM	Preliminary Analysis/Preparing for Validation W/S
06/10/2011	AM	Validation workshop/Debriefing CARE
06/11/2011	AM/PM	Departure-consultant

Within the above schedule, meetings/interviews/focus group discussions will be scheduled with the stakeholders identified above. It is envisaged that meetings with the Child Health Unit (MoH), PHOs and DHOs should be of sufficient length to enable discussion around the implementation of the Moyo wa Bana programme and also for evaluation team members to review appropriate documentation for validation purposes.

5. Evaluation Team

The evaluation team will be comprised of:

- Sally Monkman (Team Leader): International consultant
- Peter Chabwela: Care Zambia, Programme Support Manager: Monitoring Evaluation and Learning
- Ministry of Health Representative – to be confirmed

- Zambia national consultant – to be confirmed

6. Outline of Evaluation Report

The evaluation report will include the following:

9. Executive Summary (2)
10. Introduction (1)
11. Project Profile / Background Information (3)
12. Evaluation Methodology (4)
13. Evaluation Findings (20)
14. Conclusion / Lessons Learned (4)
15. Recommendations for extension phase (4)
16. Annex (unlimited)

The Annex will include at least the ToR, evaluation work plan (incl. Schedule), list of people met, list of documents reviewed and tools used (e.g. interview guides, questionnaires).

ANNEX 4

STAKEHOLDERS CONSULTED

Affiliation	Name	Role
Care Zambia:		
	Cathryn Mwanamwambwa	Regional Director
	Mary Simasiku	
	Kathleen O'Brien	Assistant Country Director Programmes
	Francis Mangani.	MwB Programme Manager
	Obrien Mashinkila	MwB Project Management Coordinator - Monitoring & Evaluation
	Maureen Mubanga	Ex MwB Programme Manager
	Mrs Sabina Miti	PMC, Kasama

	Mr Fred Njobvu	PMC Kabwe (formerly DMC in Luapula)
Ex Care Zambia	Martin Chanda	Former Programme Management Coordinator at the CHU
Ministry of Health:		
Directorate of Policy and Planning	Dr Simoonga	Director Policy and Planning
CHU	Dr Kalesha	Child Health Specialist
	Mr Vichael Silavwe	Chief IMCI Officer
Northern Province:		
DHO Kasama	Dr K Chisenga	District Medical Officer
	Mrs Doris Mwape	Nursing Office, MCH
	Ms Grace Nanyinza	Principal Nursing Officer, MCH
	Mrs Nalisa Musonda	District Nutritionist
	Mr Felix Silwimba	District Health Information Officer
DHO Mungwi	Dr B Chituwo	District Medical Officer
	Mrs Lissah Chomba Susiku	MCH Co-ordinator
	Mr Yotamu Zulu	District Health Planner
	Mr Victor Chaampa	District Health Information Officer
Chisanga UHC (Kasama)	Mr Peter Lisompwe	Health Centre In-Charge
	Mr Lawrence Banda	Former Care Zambia DMC
Mukonge RHC (Kasama)	Mr Sidney Simukoko	Health Centre In-Charge
	Mrs Ireen Kunda	Midwife Nurse
Chimba RHC (Mungwi)	Ms Bernadette Chisanga	Health Centre In-Charge
Zambia Baptist Association Clinic (Mungwi)	Mrs Grace Chonya	Health Centre In-Charge
Central Province:		
PHO Kapiri Mposhi	Dr B Kafulubiti	Clinical Care Specialist
DHO Kapiri Mposhi	Mr Passwell Simuuza	Clinical Care Officer
	Mrs Grace Sichone	MCH Coordinator
	Mr Muyumbwa Kamenda	District Health Planner
	Mr Edgar Yambayamba	District Nutrionist
Luansimba RHC	Mrs Sharon Matimba	Health Centre In-Charge
Chilumba RHC	Ms Kelita Chingande Lemond	Health Centre In-Charge
WHO	Dr. Mary Katepa- Bwalya	National Professional Officer Child + Adolescent Health
ZISSP Offices	Mary Kaoma	ZISSP Programme Manager
UNICEF	Rodgers Mwale	
CIDA	Greg Saili	

CHAI	Dr. Yekoyesew Worku	
External Evaluator	Anne Gillies	Independent Monitor

ANNEX 5

EVALUATION VISIT SCHEDULE

Date	Organisation	Informant & affiliation
Thursday 26 May	Care Zambia	Programme Manager
Friday 27 May	MoH CHU	Chief IMCI Officer
Monday 30 May	Kasama	
Tuesday 31 May	Chisanga RHC - Kasama	In-Charge
	Chisanga RHC - Kasama	FGD: CHPs/NHCs/CHWs

	Kasama DHO	Nutritionist
	Kasama PHO	MCH Officer
	Care Zambia	PMC Northern Province
Wednesday 1 June	Chisanga RHC - Kasama	FGD: Mothers with children U5
	Kasama DHO	Information Officer
	Mukonge RHC - Kasama	FGD: Mothers with children U5
	Mukonge RHC - Kasama	FGD: CHPs/NHCs/CHWs
	Mukonge RHC - Kasama	In-Charge
Thursday 2 June	Zambia Baptist Association Clinic Mungwi	FGD: Mothers with children U5
	(as above)	FGD: CHPs/NHCs/CHWs
	(as above)	MCH Focal Point Person
	Mungwi DHO	MCHC, Planner, Information Officer
Friday 3 June	Chimba RHC – Mungwi	Nurse In-Charge
	(as above)	FGD: Mothers with children U5
	(as above)	FGD: CHPs/NHCs/CHWs
	Kasama Hospital	District Medical Officer
Monday 6 June	Kapirimposhi DHO	Clinical Care Specialist, Planner, MCHC
	(as above)	Nutritionist
	Lwansimba RHC - Kapirimposhi	FGD: CHPs/NHCs/CHWs
	(as above)	Nurse In-Charge
	Central Province PHO	Clinical Care Specialist
Tuesday 7 June	Central Province Kabwe	PMC – Care MwB
	Chilumba RHC - Kapirimposhi	Nurse In-Charge
	(as above)	FGD: CHPs/NHCs/CHWs
Lusaka:		
Monday 6 June	Care Zambia	Programme Manager MwB
		Regional Director – Northern Region
		Health and HIV/AIDS Director
		Assistant Country Director - Programmes
		Programme Management Coordinator M&E MwB
		Former Programmer Manager MwB
		Former PMC, CHU
	WHO	National Professional Officer Child + Adolescent Health
Tuesday 7 June	MoH CHU	Dr Kalesha
	ZISSP	Mary Kaoma

	UNICEF	Rodgers Mwale
	CIDA	Greg Saili
	CHAI	Dr. Yekoyesew Worku
	MoH Directorate Policy and Planning	Director Policy and Planning
Wednesday 8 June	Care Zambia	Planning meeting of evaluation team
Thursday 9 June	Care Zambia	Planning meeting of evaluation team for validation meeting
Friday 10 June	Care Zambia	Validation Meeting with stakeholders

ANNEX 6

LIST OF DOCUMENTS REVIEWED

Moyo wa Bana Programme Documents

• Final Project Implementation Plan January 2008
• Semi Annual reports to CIDA:
  ○ April 1- September 30 2008
  ○ October 1 2008 – March 31 2009
  ○ April 1 – September 30 2009
  ○ October 1 2009 – March 31 2010
  ○ April 1 – September 30 2010
  ○ October 1 2010 – March 31 2011

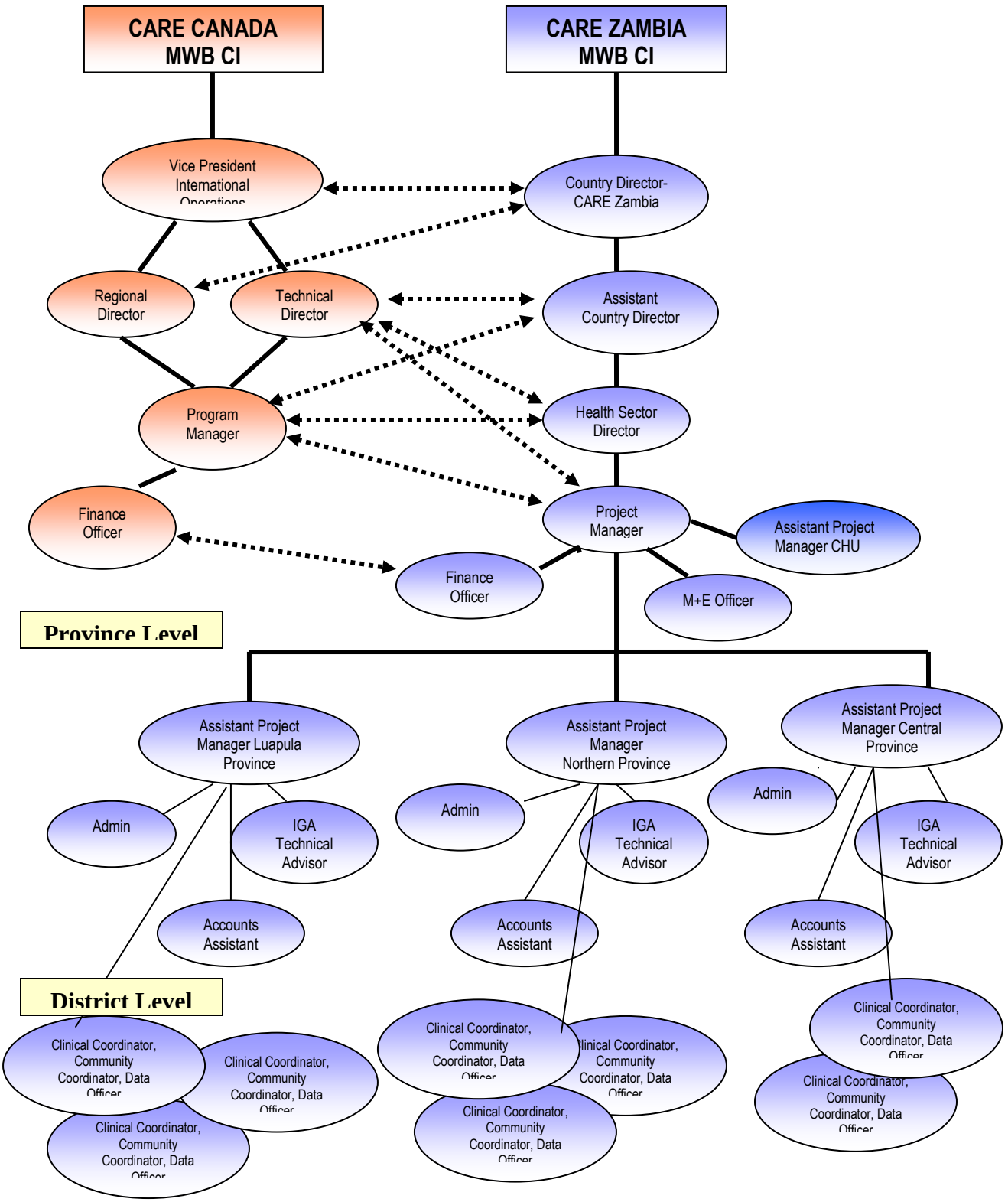
- Programme Annual Workplans and Narratives
- The Programme Exit and Sustainability Plan
- Programme logframe (updated)
- Moyo wa Bana IMCI Project Phase II Final Evaluation Report April 2006

Government of Zambia Documents

- Zero draft National Health Strategic Plan 2011- 2015
- Zambia Demographic and Health Survey 2007
- National Community Health Worker Strategy in Zambia August 2010
- IMCI Supportive Supervision Reports:
    - Northern Province (Kasama, Mungwi and Mporokoso) and Central Province (Kapiri Mposhi) March 2011
    - Luapula Province and Serenje District February 2011

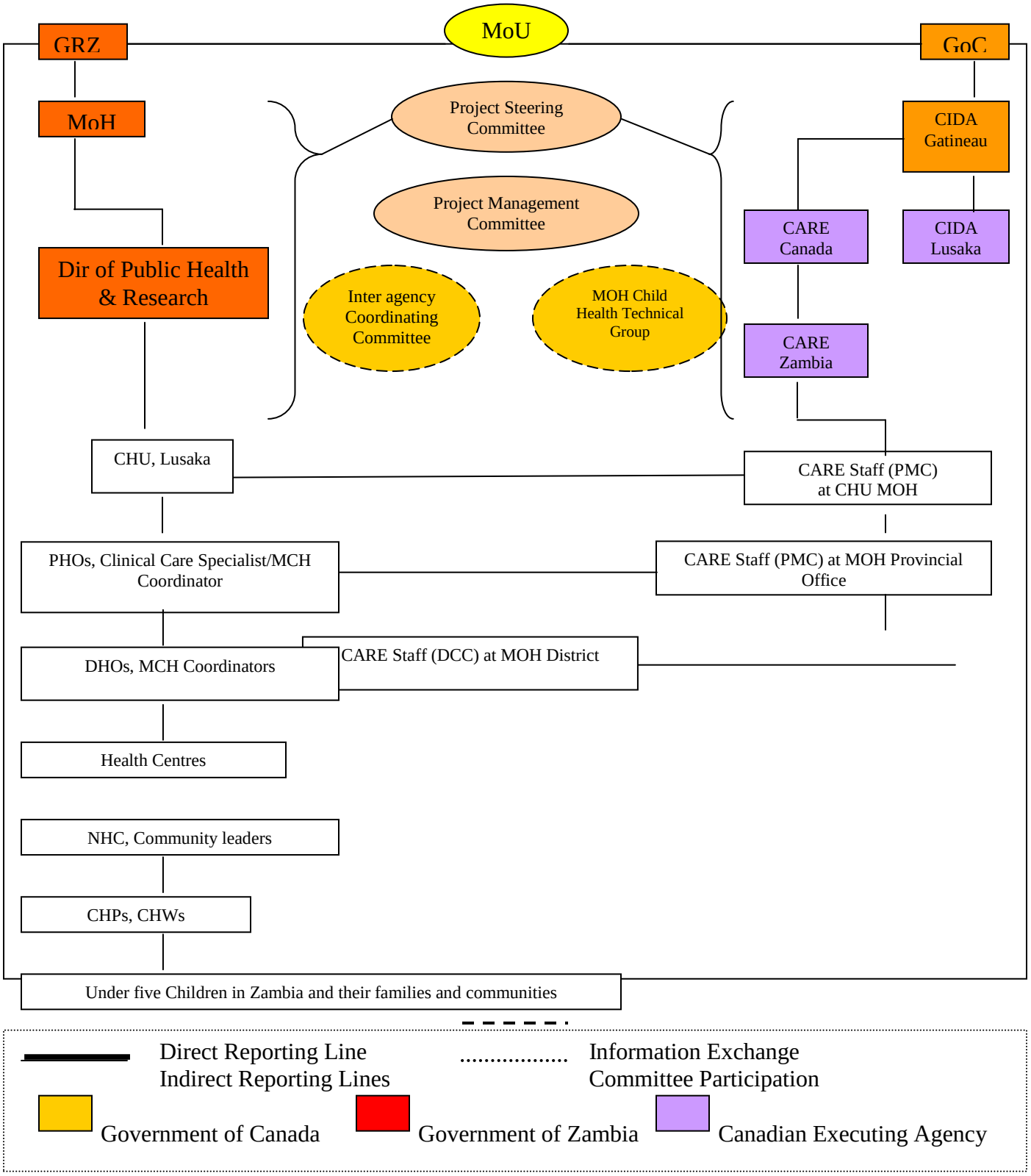
ANNEX 7

ORGANISATIONAL STRUCTURE



ANNEX 8

RELATIONSHIPS BETWEEN PROGRAMME PARTNERS


MoU
GRZ
GoC
MoH
Project Steering Committee
CIDA Gatineau
Project Management Committee
CARE Canada
CIDA Lusaka
Dir of Public Health & Research
Inter agency Coordinating Committee
MOH Child Health Technical Group
CARE Zambia
CHU, Lusaka
CARE Staff (PMC) at CHU MOH
PHOs, Clinical Care Specialist/MCH Coordinator
CARE Staff (PMC) at MOH Provincial Office
DHOs, MCH Coordinators
CARE Staff (DCC) at MOH District
Health Centres
NHC, Community leaders
CHPs, CHWs
Under five Children in Zambia and their families and communities
Direct Reporting Line
Indirect Reporting Lines
Information Exchange
Committee Participation
Government of Canada
Government of Zambia
Canadian Executing Agency

ANNEX 9

MwB CBI Programme Logframe

		Targets for Year three	Achievement
Result	**Indicators**		
Improvements in child survival among 200,000 female/male children under 5 in project areas.	*a) U5 mortality* *b) U5 incidence rate (morbidity) for malaria, diarrhoea & acute respiratory disease (pneumonia)* c) *U5 case fatality rate for malaria, diarrhoea & acute respiratory disease (pneumonia)*		
Outcome 1 Improved institutional performance of the Child Health Unit of the MoH & the Directorates of selected provincial & district health offices to manage all aspects (planning, budgeting, resource mobilization, monitoring) of the implementation of gender sensitive health system IMCI programmes that mainstream HIV/AIDS.	1. Existence of costed results based annual plans/budgets that include facility and community IMCI at CHU, PHO and DHO	All project sites (CHU,PHO and DHO) will have cost based action plans/budget	100%. all levels CHU, PHO and DHO have available plans that include facility and community IMCI
	2. % of budgeted funds allocation for child health/IMCI disbursed to CHU, PHO and DHOs	80% of budgeted funds allocated for child health/IMCI disbursed to CHU, PHOs and DHOs	80% of the budgeted funds allocated for child health/IMCI were disbursed to CHU
	3. % of budgeted funds spent on child health/IMCI at CHU, PHO and DHO	75% of budgeted funds are spent on child health	100% budgeted funds were spent on child health
Outputs 1.1Increased ability of CHU to coordinate and lead the child health and IMCI agenda with	4. # of consultative meetings between CHU and stakeholders to review child health/IMCI progress & advocacy	28 meetings (4 ICC; 24 TWG) of planned consultative meetings between CHU and stakeholders held to review progress per year	100%of planned meetings between CHU and child health stakeholders were undertaken (all planed TWG, ICC and other meetings for child health)

		Targets for Year three	Achievement
Result	**Indicators**		
partners	5. Annual plans that include technical and management support and supervision by CHU to PHO and DHO	80% annual plans at all levels of MoH- CHU, PHOs and DHOs that include technical and management support and supervision	100% of plans at all levels (CHU, PHO, DHO) include technical and management support supervision
	6. New IMCI protocols published and disseminated to PHO and DHO	100% of new IMCI protocols available at all PHOs and DHOs	100% of both project and non project operated sites have new IMCI published protocols
1.2 Increased evidence based planning and decision making for child health at CHU, PHO and DHO	7. % of decisions based on reviews of child health indicators and data	25% of decisions are based on reviews of child health indicators and data	100% of planning decisions are based on the reviews of child health indicators form the HMIS and other child health reports.
	8. # of PHO & DHO preparing child health data that is gender disaggregated (where applicable)	2-PHOs and 5-DHOs will prepare gender disaggregated data	100% of targeted sites have data disaggregated by gender only and by attendance. (HMIS currently does not capture gender disaggregated data)
1.3 Increased ability of CHU to advocate for appropriate policy environment and increased support to child health/IMCI	9 Advocacy action plan developed and a degree of implementation for 3 key child health issues (gender, C-HMIS & volunteer strategy agreed)	Advocacy action plans developed for 3 key child health issues	Advocacy issue are routinely included in the all MOH annual action plans
	10. # of evidence based child health recommendations put forward by the CHU and supported by the ICC	10 recommendations per year are put forward by CHU and supported by the ICC	80% of the recommendations put forward by CHU to ICC are supported
1.4 Increased capacity for CHU to mainstream HIV/AIDS and gender into child health/IMCI	11. Gender mainstreaming strategy/plans published	Gender mainstreaming strategy is available at all PHOs and DHOs	Gender mainstreaming strategy/plan has not developed nor published, but gender issues & HIV/AIDS are catered for Child health action plans and guidelines
	12. % of health workers trained in paediatric HIV/AIDS as part of IMCI training	50% of previously trained health workers received paediatric HIV/AIDS training; whereas 100% of newly IMCI trained health	40% of previously trained health workers received paediatric HIV/AIDS training; 100% of newly IMCI trained health workers have be trained in paediatric HIV/AIDS

		Targets for Year three	Achievement
Result	**Indicators**		
		workers will be trained in paediatric HIV/AIDS	
	13. # of health managers who receive gender sensitization training	50% of all project sites health managers receive gender sensitization training	Training yet to be conducted
1.5 Improved skills of IMCI trained health workers to assess and treat children U5 according to updated IMCI case management protocols	14. Health worker post test training scores average 80% correct IMCI assessment and treatment	post IMCI test training scores average 80% of health workers passing the training	
	15. % of health facilities that have an IMCI charts booklets for use by health worker	100% of health centres with IMCI trained health workers	64% of health centres have at least IMCI trained health workers (This is according to IMCI health facility survey 2008).
Outcome 2 Improved institutional performance of the Child Health Unit of the MoH & the Directorates of selected provincial & district health offices, to plan & deliver sustainable, gender sensitive IMCI capacity development & supervision to primary health care workers.	16. Proportion of Health facilities with 60% IMCI trained health workers trained on updated IMCI case management protocols	80% of health facilities will have 60% of health workers trained in new IMCI updated materials	• **Luapula province**- 100% of health facilities have 60% of health workers trained in new IMCI updated materials. (48 health workers were trained in IMCI since the last reporting period) • **Northern province**- 100% (43/43) of health facilities have 60% of health workers trained in new IMCI updated materials • **Central Province-** 93.5% of health facilities have 60% of health workers trained in new IMCI updated materials

		Targets for Year three	Achievement
Result	**Indicators**		
	17. % of health facilities that receive IMCI trained semi-annual supervision and technical support visits	50% of health facilities receive support supervision that include IMCI	• **Luapula province-** 100% of health facilities received supportive supervision that include/integrates IMCI (30 health workers were trained in supervisory skills training since the last reporting period) • **Northern province-** 100% of health facilities receive supportive supervision that integrates IMCI • **Central Province**- 100% of health facilities received supportive supervision that integrates IMCI
Outputs 2.1 Enhanced capacity of the PHOs to deliver facility and community IMCI training to the district	18. # of PHOs with one core trained IMCI training team (1 course director, 1 in-patient instructor, 6 facilitators)	All 3 PHO sites will have one IMCI core training team	• **Luapula province-** has available one (2) IMCI training core team (2 course director, 1 in patient instructor and 12 facilitators) • **Northern province**- NP-PHO has two trained IMCI training teams(2 Course Directors, 2 In-patient Instructors and 17 Facilitators • **Central Province**- now has in place two (2) IMCI training core team (2 course director, 3 in patient instructor and 12 facilitators)
	19. % of health worker training sessions that utilise updated manuals and guidelines	100% of health worker training team sessions utilize updated manuals and guidelines	• **Luapula province-** 100% of IMCI trainings that took place in the period under review utilised updated IMCI materials • **Northern province**- 100% of IMCI health worker training sessions utilized updated manuals and guideline

		Targets for Year three	Achievement
Result	**Indicators**		
			• **Central Province**- 100% (24/24) of IMCI health worker training sessions utilized updated manuals and guideline

		Targets for Year three	Achievement
Result	**Indicators**		
2.2 Enhanced capacity of PHO and DHO staff to provide IMCI and child health supportive supervision and follow-up after- training to health workers.	20. % of IMCI errors detected for which appropriate feedback is given during the IMCI supervision visit	50% of errors detected during support supervision are provided written feedback during the support visit	• **Luapula province**- 100%of errors detected during support supervision were provided with written feedback • **Northern province-** 100% 2/2 errors detected & appropriate feedback given during support supervision <u>Errors detected:</u> 1. H/W forgetting to carry out feeding assessment 2. Not assessing for HIV • **Central Province-** 93% of errors detected during supportive supervision were provided with written & verbal feedback during the supportive visit
	21. # of IMCI trained supervisors (trained using new protocols) at each PHO/DHO	At least 4 trained IMCI supervisors using new IMCI protocols at each PHO & DHO	• **Luapula province-** 54 health worker staff at both PHO and DHOs were trained using new IMCI protocols • **Northern province-** 19 PHO/DHO (PHO-5, DHO-14) IMCI trained supervisors using new IMCI protocols • **Central Province-** 50 health workers are trained as IMCI supervisors using the new IMCI protocols
2.3 Improved HIV/AIDS, gender and volunteer support information incorporated into supervision visits with clinic	22. # of children referred for HIV testing according to HMIS register	10% of children referred for HIV/AIDS testing according to HMIS	• **Luapula province**- not available • **Northern province**- 282(133 males & 149 females) under-five children were referred for HIV testing

		Targets for Year three	Achievement
Result	**Indicators**		
health workers by DHOs			• **Central Province**- not available
	23. % of monthly HF child health reports that include gender disaggregated data	50% of health centres submit reports which is sex disaggregated	• **Luapula province**- 100% of the health centres submit data/reports which is sex disaggregated-especially community based data. • **Northern province**- 100%(43/43) of health centres submit reports that include gender disaggregated by sex during growth monitoring & outpatient attendance • **Central Province**- 100% of health facilities submits reports which are sex disaggregated on growth monitoring, promotion and attendance
	24. % of health facilities with a copy of the National HIV/AIDS, volunteer strategies/plan and CHU gender strategy	50% of health facilities with a volunteer, HIV/AIDS and gender strategy	• **Luapula province**- no information • **Northern province**- 100 % of health facilities have a copy of the National HIV/AIDS • **Central Province**- 100% of facilities have HIV/AIDS and 42% have gender strategy guidelines
Outcome 3 Enhanced institutional performance of selected district Directorates & clinics to plan & support gender-sensitive community based IMCI activities & programmes that promote child health for	25. % of DHO funds allocated vs. budgeted for C-IMCI	75% of DHO C-IMCI budgeted funds are utilized for C-IMCI (Nationally, only 10% of the DHO budget is allocated C-IMCI)	• **Luapula province**- 40% of funds were allocated against what was budgeted • **Northern province**- 45% of C-IMCI budgeted funds were utilized for C-IMCI • **Central Province**- 39% of C-IMCI budgeted fund were allocated for community interventions

		Targets for Year three	Achievement
Result	**Indicators**		
under 5 girls/boys.			
	26. % of volunteers trained in C-IMCI by DHO	75% of the total number of CHPs are trained vs. the planned number to be trained	• **Luapula Province**- 80% out of the total percentage of CHPs planned to be trained were trained in the period under review (194 volunteers were trained since the last reporting period) • **Northern Province**- Cumulative total of CHPs trained is 85% (597 out of 700) planned number to be trained in 3 years under review (234 volunteers) • **Central Province**- 527/600 (88%) CHPs trained
	27. % of C-IMCI health facility supervisors conducting supportive supervision to volunteers implementing C-IMCI	25% of health facility supervisors in project operated health centres conduct support supervision to volunteers implementing C-IMCI (majority of supervision will be conducted by NHCs)	• **Luapula province**- 100% of health facility based C-IMCI supervisors conducted supportive supervision to the community volunteers (30 health workers were trained since the last reporting period) • **Northern province**- 75%(36/48) C-IMCI health facility supervisors conducting supportive supervision to volunteers implementing C-IMCI • **Central Province**- 100% of health facility supervisors conducted support supervision
3.1 Improved collaboration between DHO, health facility staff and volunteers for effective implementation of C-	28.#/% of U5 referrals to health facility from C-IMCI trained volunteers	50% of trained C-IMCI volunteers conduct effective referral of under 5 children to the health centres (low number because of poor	• **Luapula province**- 80% of U5s that were attended by trained volunteer and were needing medical attention were referred to

		Targets for Year three	Achievement
Result	**Indicators**		
IMCI		records keeping at facilities)	the nearest health facility • **Northern province**- 350/520 (75%) C-IMCI volunteers conducted effective referrals of under-5 children in the community • **Central Province**- 67% trained CHP conducting effective referrals(feedback response from facility under discussion)
	29.# of monthly meetings between DHO, HF staff and volunteers	1 meeting per month is held between by DHOs health centres and the volunteers	• **Luapula province**- 1 per month. 12 meetings were held in the period under review among DHOs, health centres and the community volunteers • **Northern province**- 12 meetings were held between DHO, HF staff & volunteers • **Central Province**- 15 meetings were conducted between DHOs, health facility staff and volunteers
	30.# of monthly HH mortality & birth data reported to health facility by volunteers	90% of health facilities receive monthly HH mortality and birth data from the community volunteers	• **Luapula province**- 100% of health facility received housed hold community data as submitted by trained volunteers • **Northern province**- 100 % health facilities receive HH mortality and birth data from community volunteers o **Births**- 2,815 (1,426 males, 1,389 females) o **D eaths**-69 (30 males, 39 females • **Central Province**- 100% of trained

		Targets for Year three	Achievement
Result	**Indicators**		
			C-IMCI trained health workers were promoting key family & community practices during outreach services
3.2 Enhanced capacity of health workers and volunteers to support communities to implement key family and community practices	31. % of C-IMCI trained health workers promoting key family and community practices during outreach visits	80% of trained C-IMCI trained health workers promoting key family and community practices during outreach visits	• **Luapula province**- 100% of the trained health workers were promoting key family and community practices • **Northern province**- 100% of trained C-IMCI health workers were promoting key family & community practices during outreach visits • **Central Province**- 100% of trained C-IMCI trained health workers were promoting key family practices during outreach services
	32. # of community led initiatives that support and strengthen child health and safety in the community	20 community led initiatives are undertaken by the community during the life of the project	• **Luapula province-** 15 community led initiatives were undertaken • **Northern province**-14 Community led initiatives were undertaken by the community • **Central Province**- 12 community led initiatives were undertaken by the community
	33. # of mothers and children attending GMP and outreach C-IMCI services	100 mothers and children attend EACH GMP and outreach C-IMCI post per month in the project sites	• **Luapula province**- 100 mothers and children attended GMP and outreach CIMCI post per month in the project operated sites • **Northern province**- An average of 150 mothers and children attend each GMP and outreach C-IMCI

		Targets for Year three	Achievement
Result	**Indicators**		
			post per month in the project sites • **Central Province**- 80 - 120 mothers/children attended each GMP session
3.3 Increased utilization of commodities that enhance U5 child health by families with U5 children	34. % of U5 children (m/f) reported as sleeping under ITNs	target 50% of under 5 children are sleeping under ITNs	• **Luapula province**- 60% of children U5 in project catchment areas were reported as sleeping under ITNs • **Northern province-** 57% - 59,654 children were reported to sleep under ITNs out of a total population of 103, 650 under five children • **Central Province-** 70% of children U5 in project catchment areas was reported as sleeping under the ITNs. 36% CHP data (HMIS does not collect this data)
	35.% of households using treated/clean drinking water at the HH	25% of HH using treated/clean drinking water	• **Luapula province**- 45% of households in the project operated sites were reported as using treated/clean drinking water • **Northern province**- 56% of HH are using treated/clean water • **Central Province**- Data to be submitted