After Action Review Report

Moyo wa Bana

May 2013

Monitoring, Evaluation, Learning Unit (MELU)
CARE Zambia

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ACRONYMS

AAR: After Action Review
CBI: Capacity Building Initiative
CBO: Community Based Organization
CBV: Community Based Volunteer
CHU: Child Health Unit
CHP: Child health Promoter
CHTWG: Child Health Technical Working Group
CHW: Community Health Worker
CIDA: Canadian International Development Agency
C-IMCI: Community Integrated Management of Childhood Illnesses
DHO: District Health Office
DSA: Daily Subsistence Allowance
DTSS: Department of Technical Services and Support
FGD: Focus Group Discussions
F-IMCI: Facility Integrated Management of Childhood Illnesses
GMP: Growth Monitoring Point
HF: Health Facility
HMIS: Health Management Information System
ICATT: IMCI Computerised Adaptation and Training Tool
IGA: Income Generating Activity
IMCI: Integrated Management Childhood Illnesses
M&E: Monitoring and Evaluation
MCDMCH: Ministry of Community Development Mother and Child Health
MELU: Monitoring, Evaluation and Learning Unit
MoH: Ministry of Health
MWB: Moyo wa Bana
NHC: Neighbourhood Health Committee
PA: Performance Assessment
PSU: Program Support Unit
PHO: Provincial Health Office
TA: Technical Advisor
TSS: Technical Support and Supervision
UNICEF: United Nations Children Fund
U5: Under five

Introduction

The *MWB* project conducted a rapid final assessment of its interventions to determine accomplishment of the set objectives. Having reached a milestone i.e. end of the extension phase and ultimately final project end, it was imperative that an assessment of this nature was conducted to establish the extent to which the project achieved its objectives around the extension phase while taking into account sustainability considerations sensitive to the mid-term evaluation recommendations. The assessment was conducted during the month of April 2013, one month before official project end and was facilitated by the *Monitoring, Evaluation and Learning Unit* of CARE Zambia. This was to facilitate objectivity and ensured the effective application of a rapid program assessment technique previously and successfully employed by CARE Zambia in Zambia and Rwanda, i.e. the *After Action Review (AAR).* The Moyo wa Bana project having conducted a comprehensive evaluation exercise at the end of the originally planned project end date, and taking into account the extension objectives which set out to strengthen sustainability measures, the project management team called for a rapid assessment of the project extension that ensured the immediate validation, uptake and internalisation of results and recommendations by program implementers and stakeholders.

Background

The Care Zambia *Moyo wa Bana (MwB) Capacity Building Initiative (CBI) Programme* was initially a four year project that commenced in early 2007 focusing on providing support for the *Integrated Management of Childhood Illness (IMCI).* The project worked 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 project 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 project was a build-on from previous CIDA/CARE collaborations in child health (2001-07). In total, the project operated in eleven selected districts of three of the ten provinces in Zambia,

- Northern *(Kasama, Mungwi, Mporokoso, Mpika)*
- Central *(Serenje, Kapirimposhi, Mumbwa)* and
- Luapula *(Mansa, Milenge, Samya, Kawambwa).*

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) which transitioned into the extension phase (2011-2013), district level Care Zambia staff were withdrawn leaving a core team of three secondments at the provincial level and programme team members in Lusaka.

In April 2013, the project commissioned a final assessment of the results of the extension phase to highlight achievements, challenges, lessons and recommendations for future programming.

Aims and Objectives

The assessment aimed to discuss the achievements of the Moyo wa Bana extension phase objectives. Specifically, the review of the MwB extension phase aimed to;

I. Establish extent to which planned activities of the project extension were achieved including value addition of extension districts
II. Validate evidence of project impact
III. Document lessons around the MwB implementation model
IV. Provide recommendations beyond project close

Methodology

The assessment employed the *After Action Review (AAR)* "a leadership and knowledge-sharing tool which brings together the team that is closest to the activity or project, when a critical milestone has been reached, to discuss successes and failures in an open and honest fashion." In the case of the MwB project, the milestone reached was the end of the project extension thus necessitating the capturing of lessons learned from past successes and challenges of the project. While the AAR was predominantly achieved through a workshop process, it was supplemented by a literature review and a field review. The technique was selected on the basis of its simplicity, being utility driven, in-expensive and time-saving especially that the project didn't plan or budget for a comprehensive evaluation exercise.

The AAR involved the following steps;

Development of Themes
Through consultations between the MwB project management and MELU, study themes/domains for the assessment were identified and included the following: Institutional capacity strengthening, IMCI policy advocacy, program support, program sustainability, monitoring, learning and documentation, planning, implementation and achievement of objectives and technical supervision and support.

4.2. *Literature Review*
Prior to conducting field related activities, the study team reviewed project documents which included project annual planning documents, mid-term evaluation report and sustainability/exit plans.

Field Review-Consultation with Beneficiaries
In order to obtain perceptions of the health facility and community based stakeholders on the project, the assessment process also made consultations with community health cadres through key informant interviews and focus group discussions in Mporokoso (Northern Province), Mansa (Luapula province) and Mumbwa (Central province) districts.

The focus group discussion participants included Child Health Promoters, Neighbourhood Health Committee members and Community Health Workers. Each group comprised of 9 – 14 participants.

A focus group discussion guide was developed and used to direct the discussion (Annex I). The discussions were facilitated by CARE staff in all the study sites with MoH staff helping in the mobilization of study participants. A total of 6 focus group discussions were conducted.

Six key informant interviews were conducted with IMCI focal point persons at 6 health facilities (2 in each district). Three health facilities were within five kilometers of the District Health Office and three were outside five kilometers. Face to face interviews were conducted with the aid of a semi-structured interview guide (Annex II)

After Action Review Workshop

A two day consultative workshop was held in Kabwe town bringing together stakeholders that worked closely with the project. A total of 29 participants attended the workshop and these included MoH and MCDMCH staff at national, provincial and district levels, CARE program support staff, project staff (including former MwB staff) and CIDA (Annex III-Full list of workshop participants). The workshop began by orienting the participants to the AAR approach and review process, and was followed by presentations on the MwB program approach and highlights of the mid-term evaluation. The AAR workshop participants were then divided into three groups to discuss the AAR themes as they relate to project performance at national, district and health facility and community levels. The discussion for each given theme was guided by the following traditional AAR questions;

I. What was supposed to happen?
II. What actually happened
III. What worked?
IV. What didn't? Why?
V. What could be done differently next time

Data analysis

The AAR is designed to perform on-site data analysis during the discussion of the review questions. This was achieved through the *Thematic Analysis* approach which involved systematically arranging the collected data into themes and aligning all relevant issues to each of the themes. Data collected during the focus group discussion was equally analysed by grouping it under the key areas of what was supposed to happen, things we did right and areas of improvement/recommendations. This was also achieved through group work and the detailed analysis outputs for each theme are found in Annex IV.

Limitations of the study

The AAR didn't bring together all the key participants who took part in implementing the MwB project such as CHU and key MoH staff were not in attendance during the workshop. Provincial staff close to the project were also not present though they sent representatives. Owing to the many themes and time limitations, the AAR did not provide an opportunity to thoroughly substantiate the obtained results. However, the cited limitations do not in any way undervalue the outcome of the exercise which enabled the majority of project stakeholders to reach consensus on project outcomes as well as provided key lessons for future programming and policy formulation and refinement.

Findings (according to themes at National, provincial, District, HF-Community level)

The results of the AAR are presented according to the discussion themes some of which were collapsed during final analysis.

Planning for IMCI

What was supposed to happen?

The project planned to incorporate IMCI planning and management tools into the MoH-(PHO & DHO) management systems, support PHOs and DHO during planning and budgeting and particularly the rollout and use of the IMCI planning and orientation guidelines during PHO and DHO planning processes, facilitate community involvement in planning, participate in the provincial Child Health/IMCI planning and reviews of action plans, share lessons with non project operated sites on the effectiveness of IMCI planning using the orientation and planning guidelines and recruit a *Technical Advisor (TA)* to strategically link and coordinate with central level and other child health stakeholders and develop learning and legacy products. The support to the district planning process was also to provide a platform for building the capacity of DHOs in the development of annual plans. A key element of the planning process is the analysis of the previous year's progress and collection and review of data was a critical activity expected to lead to effective planning. Key expected outcomes of the support to planning were to be the prioritisation of IMCI activities alongside resource allocation.

Things we did right

With regards planning, it was agreed that the project scored a number of positives particularly in involving stakeholders during the various planning initiatives leading to project activities being captured in the Ministry of Health action plans at all levels. It was also agreed during the AAR workshop that the project-government partnership in as far as planning is concerned was positive both ways in that the project engaged district and provincial health offices in developing the annual work plans and was also involved in the provincial and national planning for the MoH through the provincial and national planning meetings which had a focus on IMCI. The project also provided financial support to the planning process at all levels. A key outcome of this is that the DHOs started financing IMCI and increased funding to IMCI from the district grants, that prioritised activities in IMCI are implemented and action plans are being reviewed as required.

Areas of Improvement and Recommendations

However, there were areas that were identified as needing improvement in future. The complete institutionalization and the use of IMCI planning and orientation guidelines are yet to be fully realised. Key units (planning, implementation, information) from the relevant ministries should be brought on board in the effort to institutionalise IMCI. Constraints around financing for the IMCI program need to be addressed as a number of deliverables were not realised as a result of this. For example, bicycles for Child Health Promoters were not procured in the expansion districts due to competing needs. For the same reasons, monitoring activities were not conducted as required. Directly related to funding constraints was the human resource constraint which directly affected the execution of IMCI activities at all levels. It was recommended that in future, and in addressing the constraints around funding, the aspect of cost-sharing need to be given much more thought to

ensure full partner participation in financing IMCI. The planning exercise at the higher level should also work to harmonise relevant donor and government working conditions and policies to minimise on conflicts when it comes to seconding government employees to donor-funded initiatives e.g. DSA. There were also concerns that the MoH and CHU efforts in as far as IMCI is concerned didn't seem to be harmonised and there was need to identify a way of coordinating the two as well as other partners working on child health. It was however clarified that the CHU is already a coordinating body for child health matters but, may still lack in capacity to cover wider ground and it was recommended that ways of building the capacity of the CHU to better coordinate child health activities be further explored and supported as a build on of what the MwB project has achieved.

Institutional Capacity strengthening -Institutionalized IMCI pre-service training

What was supposed to happen?

Institutional capacity strengthening in IMCI was largely to be achieved by institutionalising IMCI in pre-service training for clinical and medical students. The project targeted to review training curriculum, print 40 IMCI pre-service hand books for Chainama School of Health Sciences, train 20 nursing school tutors and 4 lecturers, engage a consultant to support the adaptation of IMCI training materials, facilitate consensus building on the integration of IMCI in training and print adapted IMCI training materials (100) for Chainama School of Health Sciences curricula.

Things we did right

Consultations and consensus building among stakeholders resulted in the recommendation and decision (with MCDMCH being key to the decision) for IMCI training in institutions to be delivered as a computer based training (ICATT). The project was on hand to support this decision and facilitated the procurement of 22 desktop computers with headphones for the ICATT program and a laptop and a scanner for the CHU under the MCDMCH. A pre-service TOT ICATT training of 22 lecturers and clinical instructors with 5 facilitators has since been conducted making Chainama College of Health Sciences the first training institution to employ the ICATT individual approach in Zambia. A number of external and internal factors were identified during the AAR workshop as having facilitated the smooth execution of planned activities among them flexibility by all partners (e.g. CIDA granted authority for the payment of the revised government DSA), coordinated planning, high level commitment from CCHS to co-finance the training, readily available materials by key partners, the close consultations between CHU and Chainama College (who led the process) in determining the modalities for the pre-service as well as local ownership of the program demonstrated by project staff being stationed at the MoH further confirming the initiative as being a national agenda as opposed to being a project agenda.

Areas of Improvement and Recommendations

Areas that needed improvement in future included the need for early or timely engagement of stakeholders and improved information sharing on changes in aspects that affected project implementation e.g. changes in conditions of service, timely execution of initiatives (e.g. engagement of a consultant to support the adaptation of IMCI training materials was not fulfilled), there is need for a review meeting following the training of the first batch of students and the inclusion of IMCI in the medical school program. During the AAR discussions, there was also a strong

feeling that the program favoured more the pre-service candidates than the in-service and that there was need to put in place measures that will ensure that the in-service professionals equally benefited. Assurances were made during plenary sessions that these facilities will be scaled up to the provinces and districts so that already trained staff can also benefit. In addition, there were plans to also introduce the course in the private schools and colleges.

IMCI Policy and Advocacy

What was supposed to happen?

The project also worked to strengthen the ability of the central level to advocate for appropriate policy environment and increased support to IMCI. This was to be achieved in large part through the project facilitation of the development, printing and dissemination of legacy and learning products that highlights the projects experiences, achievements and tools around the three pillars of IMCI (Case management, Health Systems strengthening and the key community family practices/C-IMCI).

Things we did right

The project engaged the services of a Technical Advisor to lead the process of developing the legacy products and a consultant to document the Moyo wa Bana story. The whole process began with consensus building meetings to agree on the themes to be incorporated in the process of developing project legacy materials involving key stakeholders at provincial (Luapula, Northern and Central) and national levels which led to the adoption of the legacy materials/IMCI job aides to be developed. Once the legacy products were adopted and/or developed, they were presented for approval to the IMCI stakeholders Technical Working Group meeting at CHU. Once printed, these will be disseminated at the IMCI stakeholder dissemination workshop and it's envisaged that the stakeholders will among others adopt them as policy advocacy tools. The legacy and learning products are targeted at IMCI practitioners at national, provincial, district and health facility levels. According to the AAR workshop participants, the involvement of stakeholders at all levels, having a dedicated staff to legacy and learning products production, using existing IMCI national coordinating structures, high level interest and commitment by all stakeholders (CHTWG), all facilitated the smooth and timely implementation of the exercise.

Areas of Improvement and Recommendations

It was however; felt that the attribution in relation to ownership (naming or labelling) of the products needed to be exhaustively discussed by ensuring that key partners are also involved during the planning stage. It was however said (during plenary) that this was done and the challenge was that submissions for inclusion in the products continued to come in even beyond the deadline and some could have been left out on the basis of late submission which appeared like some partners were not consulted. There is also need to effectively communicate on the staffing changes from both the project as well as key partners to avoid disruptions in programming.

Program Support

What was supposed to happen?

The Program Support Unit (PSU) was to play a critical role in the implementation of planned activities and achievement of objectives by ensuring the timely provision of funds and logistics including goods and services to the MwB project team and partners.

Things we did right

Notable implemented PSU supported activities included recruitment of project staff, capacity building/orientation of staff and partners on CARE and donor policies (financial, human resources and procurement policies), ensuring smooth cash flow to the project (advances as well as procurement of goods and services) and other program support activities. The orientation of partners to CARE procurement and finance procedures smoothened implementation of activities as partners were able to effectively and efficiently handle donor funds. The project also designed a form to be used in the procurement of goods and services from local communities to avoid disallowed cost due to unacceptable documentation. All in all, the workshop was of the view that 95% (more perceptive than computed) of planned project activities were achieved through the support provided by the PSU.

Areas of Improvement and Recommendations

The following need to be taken care of in future programming;

- Competing demands for PSU services especially that the PSU is shared among different CARE projects
- Challenges in placing project personnel in government structures at national level
- Facilitating the provision of fuel to districts that do not have service stations

Program Sustainability

What was supposed to happen?

The extension phase was also designed to address project sustainability and a number of activities were planned that were to ensure sustainability. An exit and sustainability plan was developed that outlined activities to enable the sustenance of project interventions and outcomes. Sustainability was to be achieved through joint planning between CARE and government structures, project management meetings involving project stakeholders, making IMCI a regular agenda item in district, provincial and national meetings, partner coordination, lobbying for partner participation and funding for IMCI activities, introduction of IMCI training in learning institutions, appointment of C-IMCI/F-IMCI focal point persons and incentivizing the work of volunteers.

Things we did right

While it was early to accurately measure sustainability outcomes, the participants were of the view that the project managed to put in place measures that will ensure the maintenance of the project gains. The positioning of project staff in MoH structures helped in saving finances meant for rentals and utility bills further resulting in re-aligning the funds to activities. This also ensured that the internalisation of project interventions commenced early enough and was on-going throughout the life of the project. The same applied to the joint and integrated planning, budgeting and implementation which facilitated skills transfer at all levels. The cost-effective ICATT training introduced at Chainama College will not only ensure continuous training of health professionals in IMCI but will also bring in financial resources to the institution. Community and facility IMCI focal point persons were also appointed in the project operational sites. Continuous capacity building will also be assured through the establishment of provincial core training teams. Capacity building initiatives in supervisory and case management skills at all levels and the institutionalization of the IMCI assessment tools was another sustainability assurance. At community level, the support given

to volunteers and particularly bicycles, T-shirts, raincoats and bags will enable the volunteers to carry out their work to a certain extent.

Areas of Improvement and Recommendations

For sustainability to be fully achieved the following will still need to be addressed.

- Problems associated with limited resources at MoH e.g. staff shortage at all levels
- There is need to agree on mechanisms for increased IMCI budgeting with the MOH as well as on how to tap into stakeholder resources. The MoH budgeting process should improve further in committing resources to IMCI. There is also need for direct and more aggressive lobbying for increased funding towards IMCI activities from MOH funding sources including external partners.
- Need to work out measures for addressing the high attrition rates for trained IMCI staff at district and provincial level (attrition was however low at health facility level. Field work results from the 6 health facilities indicated that only one health facility experienced movement of IMCI staff in the last two years). It was therefore difficult to integrate IMCI into other activities due to inadequate number of trained IMCI supervisors.
- Work out modalities with MoH for the integration of C-HMIS into the mainstream MOH-HMIS
- Address the challenge of inadequate data capturing tools for community IMCI due to inadequate stationery. There is need to procure more stationery for use especially by community volunteers.
- Need to rehabilitate existing GMP or build permanent ones. This is an activity that was planned for in the exit plan but was not fully realised due to competing needs the priority intervention areas as identified by the DHOs in the project districts.
- There is need to continue with the interventions aimed at motivating community volunteers including the provision of job aides such as scales and other supplies for growth monitoring. There is need to also work towards promoting more community involvement in IMCI
- The training of additional IMCI supervisors should also be put on the agenda

Supportive supervision and TSS

What was supposed to happen?

The central level was to conduct technical supportive supervision to the provinces and the districts as well as IMCI supportive supervision to project and non-project supported provinces and districts. The central level was also to monitor IMCI training to ensure adherence to updated IMCI materials as well as conduct Performance Assessments to the 10 provinces of Zambia that integrates IMCI specific themes and applies standardised tools. Key elements of the TSS and the PA was to include gap identification, mentorship and feedback (written and oral). The project was also to support and participate in the DTSS Provincial and District quarterly review meetings. The project also planned to hold a 5-day supervisory skills training, support planning, logistic arrangement and monitoring of *Child Health Week* activities.

Things we did right

The planned training was done, supervision was incorporated in the performance assessments, CHW activities were monitored, gaps were identified, mentoring was done and routine monitoring was done and documented. The following were identified as things that worked very well in TSS and PA and ultimately translated into positive outcomes;

- Monitoring was incorporated into bi-annual PA and this was cost-effective
- Provision of sufficient logistics (including transport), trained supervisors were used, checklist were made available and written and oral feedback was given.
- Improved IMCI drug supply, rational drug use, improved skills management, improved GMP attendance, increased referrals to health facilities and improved data capturing were all attributed to the TSS and PA exercises.

Areas of Improvement and Recommendations

For the PA and TSS to be more effective, the following should be addressed

- Include more indicators on IMCI in the PA tool
- Lobby for more resources for comprehensive training-the training was compressed in order to accommodate the available logistics.
- Improve supply for data collection tools and under-five cards
- Routine monitoring visits should be conducted as scheduled. Meetings were not conducted in some areas. This also calls for realistic planning
- Time dedicated to the PA exercise should be increased. The workshop discussion also touched on the inadequacy of the PA tool which was said to collect limited data and needed to be revised. It was explained that the tool is being revised though the indicators on the tool will not be tampered with but complemented by a set of standards. It was also emphasised that the tool was not a recording tool but a management tool and the PA exercise was not just restrictive but allowed for observations outside the constituents of the tool.
- Lobby for increased supply of drugs and purchase timers as there is a shortage of timers for IMCI

Monitoring, Learning and documentation

What was supposed to happen?

During the extension phase, the project was to strengthen the M&E systems at all levels to respond to IMCI related data needs and to use project lessons to advocate for the scaling up of the MwB approach. The project set out to 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. To achieve this, the project was to recruit a *Technical Advisor (TA)* to strategically link and coordinate with the central level and other child health stakeholders and develop learning and legacy products, recruit a *Performance Assessment Specialist* to strengthen coordination and linkages between central level and other IMCI stakeholders and to supplement the *Data Entry Officer* and recruit a Data Entry Clerk (CHU). The project was also to conduct end of project assessments, update the logframe, document success stories, complete the project final report and formally disseminate the final project achievements and lessons to key stakeholders.

Things we did right

The following have been achieved and as most of these are project-end activities, they had not been completed at the time of the AAR workshop. The project was successful in facilitating the transformation of the IMCI monitoring tools into standard performance tools following the pre-test of the said tools in Lufwanyama, Mumbwa and Kasama districts. Production of legacy and learning

products is scheduled to be completed and disseminated at the project close meeting. A consultant was earlier engaged and had undertaken field visits and discussions with various beneficiaries at the DHO, health facility and community level as well as CIDA and MoH and MCDMCH on aspects to include in the legacy and learning products. The development of the learning and legacy products was nearing completion at the time of the AAR. On the integration of community-IMCI data into the HMIS, the Ministry of Health has shown support for the integration of Impact Indicators on mortality and morbidity (covering diarrhea, pneumonia, and malnutrition) as well as immunization coverage. Other key M&E activities that were successfully completed during the extension phase include the IMCI wrap-up study by CIDA covering Samfya, Kasama and Kapirimposhi districts and the After Action review with field work conducted in Mporokoso, Mansa and Mumbwa. A key outcome of the M&E support is the strengthened capacity of the CHU in data collection and analysis, inclusion of IMCI supportive supervision principles in the performance assessment tools standards and the commitment by the Ministry of Health to institutionalize the position of *Performance Assessment Specialist.*

Areas of Improvement and Recommendations

The sustainability of the data entry position at CHU still hangs in the balance as there is no permanent position in the establishment. The CHU structure should accommodate this and other critical positions. The IMCI approach was also unit focussed- the project design should not focus on a single unit or directorate but should involve all key departments of the Ministry which are critical to IMCI institutionalisation. The HMIS is yet to effectively incorporate community IMCI data and efforts at this should persist. Updating of the logical framework, training field staff on changes to the tools etc need systematic execution in future.

Perceptions from health facilities and community based volunteers

What was supposed to happen?

At health facility and community level, the study investigated;

- Capacity of health workers and volunteers to plan and support gender-sensitive community based IMCI activities that promote child health for under five (U5) girls and boys.
- Improved skills of IMCI health workers, improved DHO-HF-CBV collaboration and increased utilisation of child health commodities were key expected results that also formed the basis of investigation.

Community Level:

Things we did right

- Role of CHPs/CHWs: Volunteers understood and are performing the roles and responsibilities and in the three months prior to the AAR field work, they had performed child health functions including growth monitoring, nutritional support, referrals, disease prevention education, vaccinations, tallying, weighing etc
- Training: in all the 6 sites, community volunteers had been trained in IMCI and other child health support competencies including growth monitoring (weighing, tallying, U5 card reading), disease prevention, nutrition, health assessments etc. The training (supported by MoH, World Vision, CARE, and Malaria consortium) has benefited the volunteers, the health facilities and the

communities where the volunteers operate. The training was said to have resulted in improved management of U5 Children (U5 services and illness)- Case Management, referrals, education of parents, early health care seeking behavior and the trained CHPs have also made use of their acquired skills in mentoring the non trained CHPs. There has also been a change in mind-set manifested by the shift in dependence on traditional healers to increased utilization of health facility services as also observed through increased health facility deliveries.

- Support/ motivation: CHPs have received support and motivation largely from the health facility and NGOs in the form of trainings, bicycles, weighing scales, allowances during child health week, stationery (tally sheets, reporting forms), t-shirts, rain gear, mattresses etc.
- Supportive supervision: all CBVs reported that they receive regular supportive supervisory visits from the health facilities and periodically from the DHO, PHO and national level. These supervisory visits take various forms i.e. incorporated into outreach activities during monthly visits to the health post, monthly supervision during reporting, during growth monitoring and promotion and during child health weeks. All but one CHP group have been given feedback following supportive supervision visits.
- Health outcomes: without directly attributing to the MwB project, the following outcomes have been observed over the last two years
    - Male involvement in U5 activities and antenatal
    - Early seeking behaviour and reduced infant morbidity and mortality
    - Improved uptake and adherence to U5 services (vaccines) by parents
    - Improved hygiene- reduced incidence of diarrheal
    - Improved health for children
    - Reduced cases of malnutrition following sensitisation of communities on the value of the U5 clinic
    - Reduced stigma-mothers used to throw away cards indicating HIV+ which was said not to be the case now
    - Reduced distance to seek health care which has also resulted in reduced congestion at the health facility and ultimately reduced workload for health staff
    - Completion of U5 observations and activities as required
- Sustainability: The CHP were of the view that the project supported activities will be sustained owing to the capacity building that they have received, the GMP constructed, the tools that they are being supported with and the supportive supervision received from the health facilities.

Areas of Improvement and Recommendations

- Motivating volunteers: the lack of financial incentives came out as a key challenge (as did during the mid-term evaluation) in all the FGDs making it a strong case for consideration if volunteer work is to be effectively sustained. This continues to be the cry of many volunteers especially that they dedicate a considerable amount of time to supplementing health worker efforts at the health facility, health post and within the community. Volunteers called for this not just as payment for their efforts but to also contribute towards facilitating their work as they currently sacrifice their own resources in procuring items such as batteries for digital scales and bicycle parts. The indication from the discussions was that if this is not adequately addressed, there may come a time when future interventions will fail to attract volunteers and with the “more money

in your pocket" and "minimum wage" euphoria taking turns, it may not be long before the next generation of volunteers start demanding for financial compensation entirely before offering a service. During the focus group discussions, the CBVs also called for increased efforts in identifying more volunteers as the current crop is growing old and running out of steam. This will also help to address the high volunteer turnover especially for the untrained volunteers which was also cited as a common challenge in all the FGDs. The counter argument during the plenary session was that remunerating volunteers was neither feasible nor sustainable going by their numbers which even outstrip government health workers and will thus present the government with challenges in fulfilling the wage bill. The starting point, it was recommended should be to conduct nationwide needs assessment, volunteer census as well as a benefit analysis associated with the work of volunteers. The volunteer policy once finalized will also provide standardized guidance on remuneration for volunteers especially that volunteer motivation varied between organizations and the type of volunteer cadres in question. It was also learned during plenary that a few DHOs had come up with district specific volunteer guidelines/policy/frameworks but not all districts had the resources to take that route. Volunteers also called for district level recognition (including a visit from the DHO) of their work-another recommendation also made at mid-term.

- Volunteers also felt that if they were helped with start-up loans/grants for income generating activities, this would enable the community groups to mobilize resources for volunteer work and ensuring sustainability of their work. During the workshop discussion, this was said not to be a totally new idea even to the project as examples abound where CBOs and voluntary organizations in particular have been managing IGAs to finance their work. For example, volunteers at Chipata health centre are running a fee paying toilet and treatment supporters in Mporokoso are managing a hummer mill.
- Transport- not enough bicycles were distributed according to the volunteers. There were a number of volunteers who reported not having a means of transport. Despite the sustainability plan identifying the procurement and distribution of bicycles as a key exit activity, Mumbwa (also an expansion district) had all its CHPs reporting that they didn't receive any bicycles from the project. This was however clarified in the workshop that all MwB supported districts were allowed to prioritize activities and only those on the priority list were supported financially. However and for the future, there is need to seriously give consideration to equipping the volunteers with tools of mobility. The bicycles were said to be handy as they can also be used to quickly transport patients referred to the health facility.
- Provision of correct and adequate job aides: part of motivation for volunteer work is being equipped with the correct tools. While the project and the health facilities have been providing the CHPs with the necessary tools, it was felt that amounts, quality and consistency with which these are provided needed to be improved. These included stationery such as tally sheets, scales, pens, batteries for scales, weighing bags (which were commonly said to be of a wrong size), bicycle spare parts etc. There was confusion around the tally sheets which volunteers differentiated as "the MoH and the CARE ones" and called for the harmonization of the two. It was however clarified during the workshop plenary session that the two were one and the same and only differed on who supplied them.
- Continuous training of volunteers-was a recurring request among the volunteers who called for both refresher training for the already trained volunteers as well as training of the upcoming

volunteers. There were also "honorary" CHPs who had not been trained but were functioning as CHPs and there is need for instituting measures that will ensure the continuation of the capacity building program in IMCI for these volunteers.

- While the volunteers appreciated the supervisory visits conducted by the health facilities, they called for more frequent and "quality" visits. They were of the view that the current arrangement was not conducive as the health centre staff found it difficult to visit them due to staffing constraints and sometimes when they do visit, they have to cover a lot of ground in the shortest possible time and this dilutes the quality of the supervisory visit.
- All FGD reported inadequate and/or low quality GMP structures and there is need to embark on a vigorous construction and renovation of GMP shelters to supplement community efforts. It was common for volunteers to state that growth monitoring activities were conducted under trees, in churches and open spaces.

At health facility level

Things we did right

- All health facilities visited had at least one IMCI trained staff and movement of trained IMCI staff had stabilised compared to at mid-term and only one health facility reported IMCI trained staff having been transferred in the two years prior to the AAR.
- All facilities reported being subjected to supportive supervision from DHO and PHO (and sometimes national level) and performance assessments and in all cases, both verbal and written feedback was provided.
- The good coordination between the health facility, the CARE provincial staff and the community
- Supply of IMCI commodities and materials such as drugs, vaccines, tally sheets and even though the supply of U5 cards has persisted, cooperating partners such as UNICEF and World Vision have come in to fill the void.
- Training and retraining of health centre staff and CHPs. Those trained are now training the untrained CHPs.
- Supervision and monitoring of CHPs including monthly meetings with CHPs - CHP visits are now included in the HF work plan.
- Incorporation of IMCI activities in the work plan
- Use of other sources of funds e.g. Results Based Financing by the World Bank with 25% allocated to community activities including IMCI
- The capacity building of health centre staff and CHPs has resulted in reduced workload for the health facility staff, effective supervision of community activities, improved management of U5 children (with the integration of IMCI in routine diagnosis) all leading to reduced morbidity and mortality.

Areas of Improvement and Recommendations

- The challenge of transportation was not only unique to the volunteers but equally affected the health facility staff. Owing to the vastness of the health centre catchment areas, efforts should be directed at ensuring that the health staff are adequately catered for when it comes to transport. The inconsistent outreach visits to the community was partly attributed to this

challenge. Human resource constraints at health facility level coupled with untrained IMCI staff was also cited thus calling for continued IMCI capacity building for health facility level staff.

- The health facility staff also echoed the call of the volunteers for the construction and renovation of permanent Growth Monitoring Points most of which were said to be semi-permanent. The health facility further called for the construction of mothers shelters at health facilities.
- IMCI related tools and job aides need to be consistently made available at the health facility as with the community level. The health facility being the conveyor of IMCI tools and materials to the community level, any deficiency felt will be transferred to the community. Weighing bags just like at community level were said to be smaller than the required size and this should be addressed accordingly. There were calls that the preferred type of weighing scales is the analogue as opposed to the standing scales which when broken are difficult to repair. Stationary and particularly the issue of the tally sheets also came up at the health facility level and particularly the need to harmonise the "different" versions to reduce on confusion.
- The shortage of U5 cards continue to haunt IMCI efforts two years since this was highlighted in the MwB mid-term evaluation. There is need to find a long lasting solution to this problem as it was said to be negatively affecting attendance at growth monitoring points. While World Vision and UNICEF have come in to help with the supply, the health facility key informants and AAR workshop participants were not sure as to how long this help will last and what would happen if and when this assistance is withdrawn. CARE was to investigate with UNICEF on the nature and extent of their involvement in addressing this problem. There is also need to investigate further the possibility of districts printing or procuring IMCI stationery including tally sheets. The workshop participants were however reminded that U5 cards were not as easy to produce and that they were costly, estimated at $5 per card.

Conclusions

The Moyo wa Bana AAR set out to build consensus on the performance of the project over its two-year extension phase. Information collected at all levels and discussions held with the key stakeholders pointed to the project having achieved positive results in the promotion of IMCI and attributed the support to the observed and notable reductions in under-five mortality. Despite these achievements, questions were asked around sustainability assurances particularly around work with volunteers and supply of job aides for supporting IMCI interventions. Key lessons from the work of the project and its key partner (MoH/MCDMCH) should further be explored particularly around interactions with volunteers and the value of volunteer work on health outcomes. There is also need for rigorous evidence on the correlation of IMCI and child morbidity and mortality outcomes. These areas need further research and documentation as they have potential to contribute to the broader knowledge base.

ANNEXES

Annexes I: CHP/CHW/NHC FGD Guide

Name of Note Taker/Facilitator:
Note taker to record the following:
Community Name (s):
Name of Health facility:
Number of Participants:
Date:
Notes to the facilitator:

# of NHC participants:
# of CHP participants:
# of CHW participants:
Male:
Female:

1. *Thank the participants for joining in the discussion*
2. *Explain why you are conducting this FGD*
3. *Explain the FGD process*
4. *Encourage participation by emphasizing that there is no wrong answer*
5. *Ask for permission to take notes/record discussion*
6. *Ask for permission from the participants to start the FGD*
7. *Do not record or write down their names (Give them identification numbers if you want to capture interesting quotes)*

Role of NHC/CHW/CHW

1. What is there role in child health?
2. In the last three months what activities did they perform in relation to child health? Probe for the following?
    a. Weighing children and preparing tally sheets at the growth monitoring points
    b. Sensitizing the community family and community practice related to child survival
    c. Conducting referrals to the health facilities
    d. Distribution of ITNs
    e. Participation in child health week activities
    f. Collecting community and household morbidity data on under-five children

Capacity Building

3. How many have received training and in what competency? When was the training done? Who provided/facilitated the training?
4. How has the training helped them in their work?

Support and Motivation of Community volunteers

1. What support do they receive from the health facility? Probe for the following
    a. How is the supply and availability of job aids, equipments and drugs at the health facility and growth monitoring points? Also probe for scales, tally sheets, U5 cards
    b. Have the growth monitoring points been renovated in the last two years? Have new ones been constructed?
    c. How are the volunteers motivated? Probe if they have received any bicycles in the last two years? What support have they received in the repair of bicycles? Who has provided this support-community or health facility?
2. Supportive supervision to NHC, Health facility provided by the district/ provincial- DHO monitoring supervision in HIV/AIDS and Gender –in the last one year, have they been visited by MoH staff for monitoring and supervision? Probe if it was health facility, district, provincial or national staff who visited? What did the visit involve? Did they receive any feedback?

Health outcomes sustainability

3. In relation to child health, what are the most significant changes that you have observed in the last one-two years in the communities and households that you work in? What facilitated these changes?
4. Looking to future, do you think your work will continue to influence these changes and why?
5. What challenges are you likely to face if any? Probe if volunteer retention is an issue…..volunteer capacity….Health staff commitment
6. How can these challenges be addressed?

Annex II: Key Informant Interview guide-Health Facility Level

Name of health facility:
Title of staff interviewed:
# of health staff:
Approx distance from town:

1. How have you been working at this health facility? What do you know about the moyo wa bana program?
2. What support have you received from the DHO for IMCI activities?
3. Have you received support from anyone else?
4. Has the DHO and PHO IMCI supervisors visited you ever since you were trained? When was the last visit? What was the nature of the visit? Probe for monitoring visits and supervisory visits?
5. Has the health facility been subjected to a bi-annual performance assessment and quarterly IMCI assessment? Were the results of the most recent one communicated to you?
6. Staffing of IMCI staff at the health facility (does the health facility have a trained IMCI staff?) How many staff have received IMCI training? How has the training helped? Have any of the IMCI trained staff left the health facility in the last 1 year?
7. As a percentage, how much time do you spend on IMCI related activities? What is the nature of the IMCI activities at HF level?
8. How is the supply and availability of job aids, equipments and drugs at the health facility and growth monitoring points? Also probe for scales, tally sheets, U5 cards
9. Have the growth monitoring points been renovated in the last two years? Have new ones been constructed?
7. How is the supply and availability of job aids, equipments and drugs at the health facility and growth monitoring points? Also probe for scales, tally sheets, U5 cards
8. Have the growth monitoring points been renovated in the last two years? Have new ones been constructed?
9. How is the 10- 14 % budget allocated to the health Facility for community related work supporting IMCI activities?
10. How often do you visit the communities for IMCI? In the last three months, did you visit the communities to support IMCI activities? What constitute these visits?
11. What worked well…probe on IMCI planning, implementation, monitoring, supervision and support and community level support.
12. What did not work well
13. Recommendations for future programming

Annex III: List of participants and groups assessed

1	John kabongo	SAVE The Children (former PM-MwB)
2	Grace Chonya	CDMCH
3	Kennedy Makulika	CARE-MELU
4	Rosie s. Mwaba	CDMCH
5	Hamweemba Lyone	CDMCH
6	Yambayamba Edgar	DMO
7	Ernestina C. Chisha	CDMCH
8	Virginia Mwanguka	CDMCH
9	Martha Chiwete	CARE-MwB Project
10	Chrisoah C. Minyoi	DMO
11	Lenon Muale	CARE-MwB Project
12	Lailai Kinkungwe	CDMCH
13	Helen Chirwa	CARE-MwB Project
14	Elizabeth Nkhoma	CARE-MwB Project
15	Elvis Chlongoa	DMO
16	Obrien manshikila	PATH (former M&E MwB)
17	Milika Nasenga	CDMCH
18	Dr John Masina	DMO
19	Virginia Michelo	CARE PSU
20	Cathryn Mwanamwambwa	CARE PSU
21	Stanly Banda	CARE-MoH
22	Dr k Chisenga	PHO
23	Sabina Miti	CARE PSU
24	Luhana Constance	DHO
25	Madani Thiam	CIDA
26	Dennis O'brien	CARE
27	Peter Chabwela	CARE PSU
28	Yvonne Chama	CARE PSU

Annex IV: AAR workshop Analysis tables

District and Community Level Group					
Theme	**What was supposed to happen?**	**What actually happened?**	**What worked?**	**What didn't work?**	**What would you do differently next time?**
Supportive supervision and TSS	• Planning and logistic arrangement • Training of staffs in supervisory skills • Gap identification using standardized tool • Mentorship • Written and oral feed back	• Trained supervisors were used • Check list available • Gaps identified • Mentorship done • Written and oral feedback done	• Rational drug use • Improved skills in case management • Improved Logistical support and supply of IMCI drugs <u>COMMUNITY</u> • Improved GMP attendance • Improved data capturing • Increased referrals to health facility	- Integration of IMCI activities into other activities - Inadequate supplies and drugs for IMCI - Inadequate number of timers for IMCI	- Foster the integration of IMCI activities into other activities - Lobby for increased allocation of drugs and supplies - Purchase timers

Monitoring, Learning and documentation	- Mentorship - Documentation of success stories - Report writing	- Report writing at all levels - Integrated IMCI into TSS and PA - Conducted quarterly TSS	- Success stories documented - Reports were written - Mentorship was conducted - Feedback was provided	- Comprehensive IMCI data not captured in the PA tool - Data for community IMCI not incorporated in the local HMIS - Inadequate data collecting tools for community IMCI	- Advocate for incorporation C-IMCI data into the national data - Revise the PA tool - provision stationery
Planning , implementation and achievement of objectives	- Collection and review of data - Analysis of the previous year's progress - Prioritization of activities - Resource	- Involvement of partners in planning at all levels - Actual planning conducted - Implementation prioritized activities	- Involvement of partners in planning at all levels - Actual planning conducted - Implementation prioritized activities	- Less partner contributions - some objectives not achieved due to competing needs/programs	- Lobby for improved funding - Lobby for full partner participation

	allocation - Partners participation - community participation in planning	- Action plans reviewed	- Action plans reviewed	- Inadequate monitoring activities conducted due to funding constraints	
Program Sustainability e.g. ***implementation of exit plan***	- Planning for resource mobilization - Continuous monitoring and provision of supportive supervision - Continuous capacity building - Lobby for partner participation - Lobby improved	- Planning for resource mobilization - Continuous monitoring and provision of supportive supervision - Continuous capacity building - Lobby for partner participation - Lobby improved funding towards IMCI activities - Appointment of C-IMCI/F-IMC focal point	- Training of the core teams in C-IMCI and F-IMCI - Capacity built in planning at all levels - institutionalization of the IMCI assessment tools - Appointment of C-IMCI/F-IMC focal point persons - Capacity built in supervisory/ case management skills at	- Continuation of the incentives provision - Inadequate data capturing tools for community IMCI due to inadequate stationery - Ownership of the program was a challenge at community level	- Lobby for partner participation at all levels - Procure adequate quantities of stationery - Lobby for increased funding towards IMCI activities from MOH funding. - Train more supervisors.

	funding towards IMCI activities - Appointment of C-IMCI/F-IMC focal point persons - Provision of incentives to the volunteers	persons - Bicycles, T-shirts, rain coats and bags distributed to volunteers though not adequate	all levels - Analysis and utilization of data at community level and health facility level	- Difficult to integrate IMCI into other activities due to inadequate number of trained IMCI supervisors. - Few GMP points rehabilitated or built. - Inadequate equipment (scales) and supplies for growth monitoring and promotion	- Advocate for full community involvement
Provincial Level Group					
Theme	**What was supposed to happen?**	**What actually happened?**	**What worked?**	**What didn't work?**	**What would you do differently next time?**

Monitoring, Learning and documentation	• Incorporate monitoring into bi annual performance assessment • Conduct 5 day supervisory skills training • Support quarterly district integrated meetings • Strengthen IMCI supervision during PA • Monitoring of child health week activities • Routine integrated monitoring of IMCI and other	• Monitoring incorporated into PA • Training conducted • DIM supported • Supervision done during PA • Child health week activities monitored • Routine monitoring done and documented	• Incorporated monitoring into bi annual PA was cost effective and worked well • Trainings were conducted and • Planned 2, implemented • Strategic team composition • Sufficient logistics, man power, enough time to plan, enough transport • Provision of logistics	• Less indicators on IMCI in PA tool • Training compressed due to lack of logistics • Meetings not supported in some areas • Not enough time for comprehensive supervision during PA • Inadequate data collection tools/under five cards • Planned routine visits not conducted scheduled	• Add more indicators on IMCI in the PA tool will add value • Lobby for more resources for comprehensive training • Realistic planning • Plan for supervision independent from PA • Conduct monitoring as scheduled

	child health activities and documentation of findings				
Planning , implementation and achievement of objectives	• Mentor capacity development during the development of annual plans in the districts • Support DHMTs during development of annual work plans • PHO to mentor, monitor and supervise IMCI trained staff	• Attend and participate in planning launch • Give financial support to districts during the development of annual work plans • Incorporate mentorship, monitoring and supervision of IMCI trained staff into bi annual PA	• Engaged district and provincial health offices. 1st in planning for the project for the whole year, 2nd presentations during provincial and national planning launches with a focus on IMCI. Also during mentorship and supervision • District and project team	• Aspect of cost sharing did not work • Institutionalization and the use of IMCI planning and orientation guidelines did not work	• Bring on board all key units from the ministry of health i.e. planning, implementation and information

			planned together. District begun considering financing IMCI from district grants		
Program Sustainability e.g. implementation of exit plan	• Exit and sustainability plan developed • Personnel from MOH used as program focal point persons • Joint planning • Project management meetings/review meetings • IMCI to feature in provincial, National district	• ICAT introduced at Chainama which is cost effective and could be used by Chainama as an IGA • Participation in MOH stakeholders organized forums. Sustainability plans in place and implemented through stakeholders	• ICAT introduced at Chainama which is cost effective and could be used by Chainama as an IGA • Participation in MOH stakeholders organized forums. Sustainability plans in place and implemented through stakeholders	• Institutionalization of the C-HMIS • MOH not budgeting for IMCI to acceptable levels • Project has not managed to put in place mechanism to reduce attrition of IMCI trained staff	• To agree on clear steps with MOH on how to integrate C-HMIS into the main stream MOH HMIS • Agree on mechanisms for increased IMCI budgeting using MOH and stakeholder resources

	meetings • Introduce IMCI training in learning institutions • Partner coordination	meetings, pa • Used MOH partner forum to meet other stakeholders and agreed on such issues as where trainings were needed and who was to be trained	meetings, pa • Used MOH partner forum to meet other stakeholders and agreed on such issues as where trainings were needed and who was to be trained		
Supportive supervision and TSS	• Incorporate monitoring into bi annual performance assessment • Conduct 5 day supervisory skills training • Support quarterly district integrated	• Monitoring incorporated into PA • Training conducted • DIM supported • Supervision done during PA • Child health week activities monitored	• Incorporated monitoring into bi annual PA was cost effective and worked well • Trainings were conducted and • Planned 2, implemented • Strategic team composition • Sufficient	• Less indicators on IMCI in PA tool • Training compressed due to lack of logistics • Meetings not supported in some areas • Not enough time for comprehensive supervision during PA • Inadequate data collection tools/under	• Add more indicators on IMCI in the PA tool will add value • Lobby for more resources for comprehensive training • Realistic planning • Plan for supervision independent from

	meetings • Strengthen IMCI supervision during PA • Monitoring of child health week activities • Routine integrated monitoring of IMCI and other child health activities and documentation of findings	• Routine monitoring done and documented	logistics, man power, enough time to plan, enough transport • Provision of logistics	five cards • Planned routine visits not conducted scheduled	PA • Conduct monitoring as scheduled
National Level Group					
Theme	**What was supposed to happen?**	**What actually happened?**	**What worked?**	**What didn't work?**	**What would you do differently next time?**

Institutional Capacity Strengthening - **Institutionalized IMCI pre-service training**	Review Curriculum for Clinical Officer and medical students to include IMCI	Curriculum has not been reviewed *because the content is already included in the current curriculum the only difference was the packaging of the information. It was agreed that the ICATT approach will be used and was to be included in the curriculum.*	The College led the process in determining how pre-service IMCI training in conjunction with CHU. Flexibility by parties involved. CIDA granting authority to pay the revised govt. DSA	Timely execution Hiring consultant. Inclusion of IMCI in medical school curriculum Holding of a review meet after training first batch of students,.	Timely engagement of all stakeholders The inclusion of IMCI in the school of medicine The College and CHU to hold a meeting after training the first batch of students
	Print materials	150 copies of ICATT materials • Director's guide • Participants Guide • Chart booklet Procured 22 multimedia Desktop Computers and 1 laptop and scanner inclusive of Microsoft office 2010 22 licenses.	Material were readily available from partners. Procured computers, laptop and scanner All materials were available during the training Very coordinated planning High level commitment by all payments	Information sharing	Improved information sharing

	Train 20 tutors nursing schools & 4 lecturers from Chainama	XX lecturers XX Clinical Instructors (Chainama College only)	Training all the key actors in the training of clinical officers both at the college and clinical areas. High level commitment from CCHS to co-finance the training Local ownership of the programme by placing of project staff in the Ministry and was viewed as national agenda and not project driven.	At least one tutor in all schools of nursing but 2 were already trained in ICATT. Tutors from the 2 schools of nursing could not be trained due to the revised GRZ allowances.	Training institutions to include training of ICATT trainers in their action plans
IMCI POLICY ADVOCACY	Dev legacy material themes Engage consultant Legacy mat dev and printed Dissemination workshop	Legacy materials have been developed Engaged In process Scheduled for 16th May 2013	Involvement of all stakeholders at all levels Having a dedicated staff to ensure timely implementation Use of existing IMCI national coordinating structures. High level interest and	Attribution of ownership as implied by naming of legacy materials was not discussed during the consensus meeting.	Ensure consensus meeting agenda is comprehensive by involving key partners in the preparation phase. Effective communication on changes on staff turnover.

			commitment by all stakeholders(CHTWG)		
	Monitoring, learning and documentation	Recruited data entry clerk - CHU Recruited Performance Assessment Officer - DTSS	Increased data collection and analysis capacity of CHU. Inclusion of IMCI supportive supervision principals in the performance assessment tools standards The commitment by the Ministry to institutionalize the position.	Sustainability of data entry position at CHU – no position on the establishment Unit focused approach	CHU structure to accommodate all critical positions. HMIS to be comprehensive to capture critical IMCI related information CHU to advocate The project design should not focus on a single unit or directorate but should involve all key departments of the Ministry which are critical to project objectives and outcomes.

	Planning, implementation and achievement of objectives	Integrated planning & budgeting.	Project activities were captured in the Ministry action plans at all levels.	Human resource constraints and conflicting conditions and policies for government personnel conditions of service and donor requirements.	Harmonizing of donor conditionality towards conditions of service of civil servants (allowances)across donors and Government.
Program Support	Implementation Work plan Provide funds and logistical support to facilitate smooth implementation	95 percent of work plan activities implemented Funds and logistics provided	Orientation of partners to CARE procurement and finance procedures smoothened implementation of activities as partners were able to handle donor funds Designing of form used in the procurement of goods and services from local communities to avoid disallowed cost due to unacceptable documentation	Competing demands for various actors Provision of fuel to districts that did not have service stations	Placement of project personnel in national structures

Program Sustainability	Continuity of projected supported activities post project implementation	Joint planning, budgeting and implementation of activities were done. Ministry staff trained in Result Based Management Positioned project staff within Ministry structures	Joint and integrated implementation of activities. Helped save funds meant for rentals and utility bills re-aligned to activities	The Ministry had Limited resources (HR shortages, erratic funding, etc.)	

Annex V: Comparison of Results by Districts

Mporokoso	Mansa	Mumbwa
Bicycles distributed- 2010	Bicycles distributed	No bicycles distributed
• Support for GMP construction/ Renovation • GMP construction done- Model GMP	No GMP Constructed & 1 renovated	GMPs constructed using community resources- 10 Resources- GMA and Business house
Lack of records at HP		
• Supportive supervision done to some HP • Volunteers come to HF monthly	Remote HP are supported while nearby HP send patients to HF- feedback is given	Monthly visit done monthly (reporting)- EHT
Mapping of volunteers	Mapping was not done	
Training done by CARE/ MoH- No refreshers (2009/ 10) WV & JSI were also mentioned- training	Almost 100% CHPs trained- 2007, 2009 ToTs CHP trained, Supervisors Plan-trained CHWs ICCM-Malaria Consortium	CHPs trained CARE, MoH & WV

Mporokoso	Mansa	Mumbwa
Supervision- Quarterly/ Monthly visits- DHO	• Supervision- Planned Quarterly DHO but informal visits done frequently • PHO also visit	Supervision- Quarterly DHO
Staff trained in IMCI- None left (3 staff)	Staff trained in IMCI (35 trained 9 left)	6 staff trained non left (Non trained in Supervisory)
50% time allotted to IMCI	80% time allotted to IMCI	75% time allotted (5 minutes, conventional 10 minutes)
10% HF budget used for C-IMCI	10% used for C-IMCI	10% not used for C-IMCI- Small grants